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NUTRITION COUNSELING & EDUCATION SKILL DEVELOPMENT

Kathleen D. Bauer
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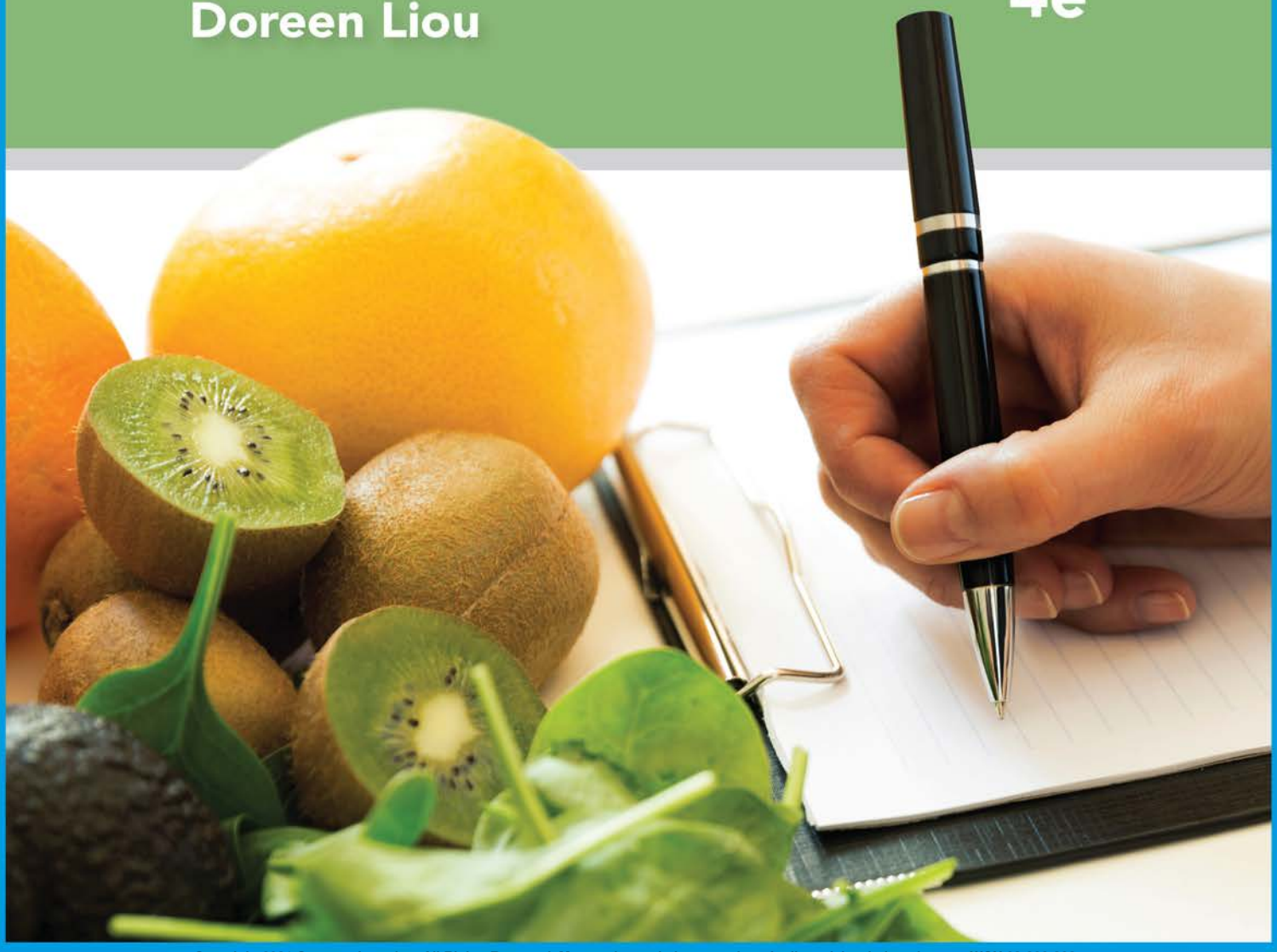

FOURTH EDITION

NUTRITION COUNSELING & EDUCATION SKILL DEVELOPMENT

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CENGAGE

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***Nutrition Counseling & Education Skill Development,* Fourth Edition**
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To my husband, Hank, and my children, Emily so mee Rose and Kathryn sun hee Rose, and my grandchildren, Kathleen hweng jae Rose, and Wyatt LeMeune.
Thank you for your patience, love, and support.
KDB

To my dear sister, Janet Liou-Mark, for your inspirational example of passion and perseverance. God is our sure foundation, a rich source of salvation, wisdom, and knowledge.
DL

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Preface

Welcome to the Fourth Edition

The fourth edition of this book continues to provide a step-by-step approach guiding entry-level practitioners through the basic components of changing food behavior and improving nutritional status. Behavior change is a complex process, and there is an array of strategies to influence client knowledge, skills, and attitudes. To be effective change agents, nutrition professionals need a solid foundation of counseling and education principles, opportunities to practice new skills, and knowledge of evaluation methodologies. This book meets all of these needs in an organized, accessible, and engaging approach.

Intended Audience

This book was developed to meet the needs of health professionals who have little or no previous counseling or education experiences, but who do have a solid knowledge of the disciplines of food and nutrition. Although the book addresses the requirements of nutrition professionals seeking to become registered dietitians, the approach focuses on skill development useful to all professionals who need to develop nutrition counseling and education skills. The goal of the book is to enable entry-level practitioners to learn and use fundamental skills universal to counseling and education as a springboard on which to build and modify individual styles.

Distinguishing Features

- **Practical examples:** Concrete examples, case studies, and first-person accounts are presented representing a variety of wellness, private practice, and institutional settings.
- **Action based:** Exercises are integrated into the text to give students ample opportunity and encouragement to interact with the concepts covered in each chapter. Instructors can choose to assign the activities to be implemented individually at home or used as classroom activities. Students are encouraged to journal their responses to the exercises as a basis for classroom discussions, distance learning, or for documenting their own reflections. Instructors can assign journal entries and collect them for evaluation. Reading journal entries allows instructors to gain understanding of how students are grasping concepts. Each chapter has a culminating assignment and a case study that integrates all or most of the major topics covered throughout the chapter.
- **Evidence-based:** Science-based approaches, grounded in behavior change models and theories, found to be effective for educational and counseling interventions, are analyzed and integrated into skill development exercises.
- **Nutrition Counseling Motivational Algorithm:** To guide the process of integrating counseling theories and approaches, a motivational algorithm is presented leaning heavily on Client-Centered Counseling, Motivational Interviewing, and the Transtheoretical Model. The algorithm provides a framework for nutrition counseling students to visualize implementation of a counseling session.
- **Cultural sensitivity:** The population of the United States is increasingly heterogeneous, moving toward a plurality of ethnic, religious, and regional groups. To have effective interventions, nutrition counselors and educators need to appreciate the influence of how membership in these diverse groups greatly influences our health beliefs, behaviors, and food practices. Although a chapter is devoted to exploring diverse cultural groups, cultural influences regarding behavior and attitudes are integrated throughout the book.
- **Putting it all together—a four-week guided nutrition counseling program:** The text includes a step-by-step guide for students working with volunteer adult clients during four sessions. The objective of this section is to demonstrate how the theoretical discussions, practice activities, and nutrition tools can be integrated for an effective intervention.
- **The Nutrition Care Process (NCP):** The NCP was developed by the Academy of Nutrition and Dietetics to provide a framework for nutrition interventions. This framework is integrated throughout the text and highlighted in relevant areas.

New Edition Highlights

All chapters of the new edition have been updated to incorporate the latest professional standards, government guidelines, and research findings. In particular, resources and references were updated throughout the entire book.

Selected Chapter-by-Chapter Updates

The sequential flow of the chapters follows the needs of students to develop knowledge and skills during each step of the counseling and education process.

CHAPTER 1 Preparing to Meet Your Clients

- Recent studies regarding factors affecting food behavior were integrated throughout the chapter.

CHAPTER 2 Frameworks for Understanding and Attaining Behavior Change

- Discussion of the Transtheoretical Model has been expanded and coverage of Motivational Interviewing has also been expanded and updated to reflect Miller and Rollnick's most recent four-process model.

CHAPTER 5 Developing a Nutrition Care Plan: Putting It All Together

- The most recent Nutrition Care Process guidelines were incorporated into this chapter. Discussion of healthy eating guides was expanded including Harvard University's Healthy Eating Plate.

CHAPTER 7 Making Behavior Change Last

- Incorporating sleep hygiene in nutrition counseling has been added.

CHAPTER 8 Physical Activity

- This chapter was updated to include the 2018 Physical Activity Guidelines for Americans.
- The physical activity protocol for health practitioners (Exercise Is Medicine) developed by the American College of Sports Medicine and the American Medical Association was incorporated throughout the chapter.
- A discussion of the U.S. Olympic Athlete's Plate graphic was added to this chapter.
- The section on the benefits of physical activity was updated and expanded.

CHAPTER 9 Communication with Diverse Population Groups

- The discussion of population trends was updated and expanded.
- Culturally sensitive approaches for working with LGBTQ individuals were added.
- The cross-cultural intervention guideline, the 4 Cs of Culture, was added.

CHAPTER 11 Keys to Successful Nutrition Education Interventions

- A new lesson plan was added using constructs from the Social Cognitive Theory.

CHAPTER 12 Educational Strategies, Technology, and Evaluation

- Smartphone and web-based tracking apps were added.

CHAPTER 13 Professionalism and Final Issues

- A review of telehealth and telenutrition was added.
- The importance of self-care and ways in which to reduce the risk of occupational burnout was addressed.
- The framework of the dietetics profession as established by the Academy of Nutrition and Dietetics was updated.
- The review of social media sites was updated.

Acknowledgments

Thank you to all the reviewers and the individuals who shared their expertise and assisted in the development of the manuscript. Your insights and comments were invaluable to the fourth edition. We greatly appreciate the staff at Cengage Learning for their encouragement and tireless work shepherding us through the process. A special thanks to Samantha Rundle, Content Manager for Health and Nutrition, and Courtney Heilman, Product Manager, Health & Nutrition. In addition, we want to acknowledge the valuable research and editing assistance of Lauren Kulik, Montclair State University graduate assistant. We would also like to thank the following reviewers for their valuable comments as we revised this edition.

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Kathleen D. Bauer, PhD, RDN, is the founder and has been the director of the Nutrition Counseling Clinic at Montclair State University for more than fifteen years. She teaches both undergraduate and graduate nutrition counseling courses. Publications include book chapters and articles on cultural diversity and evaluation of nutrition counseling education methods. Her applied individual and group nutrition counseling experiences extend to faith-based and wellness programs, fitness centers, hospitals, nursing homes, and private practice.

Doreen Liou, EdD, RDN, was director of the Didactic Program in Dietetics at Montclair State University for fourteen years and spearheaded the program into its initial accreditation. She teaches both undergraduate and graduate courses in nutrition education and social marketing. Her research interests encompass qualitative and quantitative methods in addressing chronic disease risk and the applications of social psychological theories in minority population groups. Her nutrition education experiences extend to a variety of academic, community, and clinical settings.

1 Preparing to Meet Your Clients

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Learning Objectives

1.1 Define nutrition counseling and nutrition education.

1.2 Identify and explain factors influencing food choices.

1.3 Describe characteristics of an effective counselor.

1.4 Identify factors affecting clients in a counseling relationship.

1.5 Evaluate oneself for strengths and weaknesses in building a counseling relationship.

1.6 Identify novice counselor issues.

> Not only is there an art in knowing something but also a certain art in teaching it.
>
> —CICERO

Nutrition counselors and educators provide guidance for helping individuals develop food practices consistent with the nutritional needs of their bodies. For clients, this may mean altering comfortable food patterns and longstanding beliefs and attitudes about food. Nutrition professionals work to increase knowledge, influence motivations, and guide development of skills required for dietary behavior change. This can be a challenging task. To be an effective change agent, nutrition counselors and educators need a solid understanding of the multitude of factors affecting food behaviors. We will begin this chapter by addressing these factors in order to enhance understanding of the forces influencing our clients. Then, we will explore the helping relationship and examine counselor and client concerns. Part of this examination will include cultural components. Nutrition professionals always need to be sensitive to the cultural context of their interventions from both their own cultural perspectives as well as their clients' perspectives. Some of the activities in this chapter will provide opportunities for you to explore the cultural lenses that influence your view of the world.

1.1 Foundation of Nutrition Counseling and Education

Nutrition education has been defined as the following: "Nutrition education is any combination of educational strategies, accompanied by environmental supports, designed to facilitate voluntary adoption of food choices and other food- and nutrition-related behaviors conducive to health and well-being."[1] The needs of a target community are the focus of the nutrition education process. Nutrition counselors have similar goals, but interventions are guided by the needs of individual clients. According to the Academy of Nutrition and Dietetics, **nutrition counseling** has been defined as "a supportive process, characterized by a collaborative counselor–patient/client relationship to establish food, nutrition and physical activity priorities, goals, and individualized action plans that acknowledge and foster responsibility for the process of guiding a client toward a healthy nutritional lifestyle by meeting nutritional needs and solving problems that are barriers to change."[2] Haney and Leibsohn[3] designed a **model** of counseling to enable guidance to be effective and provided the following definition:

> ***counseling can be defined as an interaction in which the counselor focuses on client experience, client feeling, client thought, and client behavior with intentional responses to acknowledge, to explore, or to challenge. (p. 5)***

Exercise 1.1 DOVE Activity: Broadening Our Perspective (Awareness)

D—defer judgment
O—offbeat
V—vast
E—expand on other ideas

Divide into groups of three. Your instructor will select an object, such as a cup, and give you one minute to record all of the possible uses of the object. Draw a line under your list. Take about three minutes to share each other's ideas, and write the new ideas below the line. Discuss other possibilities for using the object with your group and record these in your journal. Use the DOVE technique to guide your thinking and behavior during this activity. Do not pass judgment on thoughts that cross your mind or on the suggestions of others. Allow your mind to think of a vast number of possibilities that may even be offbeat. How many more ideas occurred with sharing? Did you see possibilities from another perspective? One of the goals of counseling is to help clients see things using different lenses. What does this mean? How does this activity relate to a counseling experience? Write your thoughts in your journal and share them with your colleagues.

Source: Dairy, Food, and Nutrition Council, *Facilitating Food Choices: Leaders Manual* (Cedar Knolls, NJ: 1984).

1.2 Fundamentals of Food Behavior

The heart of nutrition education and counseling is providing support and guidance for individuals to make appropriate food choices for their needs. Therefore, understanding the myriad influences affecting food choices is fundamental to designing an intervention. Influencing factors are often intertwined and may compete with each other, leaving individuals feeling frustrated and overwhelmed when change is needed. Before we journey through methodologies for making change feel achievable, we will explore aspects of environmental, psychological, social, and physical factors affecting food choices, as depicted in Figure 1.1.

- ***Sensory Appeal:*** Taste is generally accepted as the most important determinant of food choices.[4] Biological taste preferences evolve from childhood based on availability and societal norms, but research shows that preferences can be altered by experiences and age.[5] Generally, young children favor sweeter and saltier tastes than adults, and

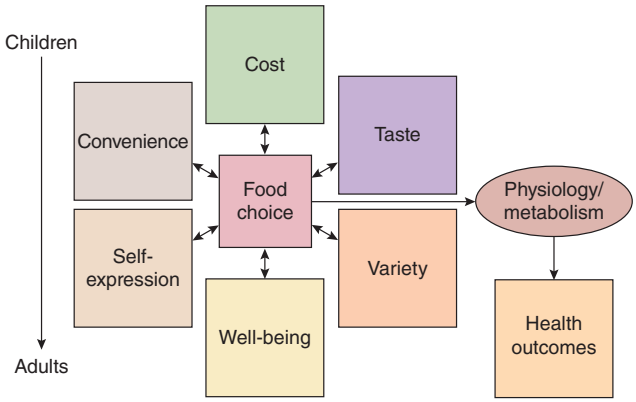

Figure 1.1 The Consumer Food Choice Model
Source: Adapted from A. Drewnowski, Taste, Genetics, and Food Choice. In *Food Selection: From Genes to Culture,* H. Anderson, J. Blundell, and M. Chiva, Eds. (Levallois–Perret, France: Danone Institute), 30. Copyright 2002.

relocating to a new environment will often change eating patterns and even favorite foods.[6] The fact that taste preferences can be modified should be reassuring for those who want to make dietary changes.[7] Illness may also modify food preference. Individuals going through chemotherapy may find some of their favorite foods do not taste the same, and they lose the desire to eat them.[8]

- ***Habit:*** Research indicates that consumers who use cues such as time of day/habit as a trigger to eat are more likely to seek healthful food choices as compared to individuals who choose to eat "whatever is there" and stop eating because the food is gone. This indicates that nutrition counselors and educators could help their clients who eat food simply because it is there to use preplanned cues to develop healthful habits.[4,9]
- ***Health Concerns:*** Health can be a driving force for food choice as illustrated by public campaigns to increase intake of fruits, vegetables, and whole grains. In a 2018 national survey, nearly half of the participants indicated they have eliminated soft drinks and candy to reduce sugar intake.[4] Consumers are more likely to respond to healthful food messages if the advice stresses the good taste of wholesome foods and convenient ways to include them in the diet. Health status of an individual, such as having loss of teeth or digestive disorders, can also affect the amount of food consumed and food choice.

Anecdote

A young man in his early twenties commenting about his food habits stated, "My friends do not say 'let's eat a salad together.' If you are a guy, it is a wussy thing to do. It is kind of looked down upon if you are a guy—weak. Eat the steak, eat the greasy stuff, be a man."*

- ***Nutrition Knowledge:*** Traditionally, educators and nutrition counselors perceived their roles as disseminating information. After research indicated that many clients were not responsive to simple didactic approaches, their roles expanded to include a variety of behavior change strategies. However, the value of increasing knowledge should not be devalued. Those who have higher levels of knowledge are more likely to have better quality diets and to lose more weight in weight loss programs.[10,11]
- ***Convenience and Time:*** Our fast-food culture has created a demand for easy-to-prepare and tasty food. In a research survey, about half of the women surveyed expressed that they spend less than five minutes for breakfast and lunch preparation and less than twenty minutes for dinner preparation.[12] Takeout, value-added (precut, prewashed), and ready-made foods have become a cultural standard. These time-saving choices are frequently more expensive and likely to be higher in calories, fat, and sodium than home-prepared foods.[13] Nutritional advice needs to take all these factors into consideration. Quick, easy-to-prepare, and healthful food options should be stressed.
- ***Culture and Religion:*** Food is an integral part of societal rituals influencing group identity. Ritual meals solidify group membership and reaffirm our relationships to others. For example, all-day eating at weekly family gatherings on Sundays or daily coffee breaks with sweet rolls are rituals that do much more than satisfy the appetite. If clients need to change participation in these rituals because of dietary restrictions, it is likely to create stress for clients, friends, and relatives. Culture also defines what is acceptable for consumption such as sweet red ants, scorpions, silk worms, or a glass of cow's milk. Culture also defines food patterns, and in the United States, snacking is common.[14] In addition, religions advocate food rituals, and may also define food taboos such as restrictions against pork for Muslims, beef for Hindus, and shellfish for Orthodox Jews. Since the 1970s the United States has been moving toward a cultural plurality, where no single racial or ethnic group is a majority. Minority groups are expected to climb to 56 percent of the total population by the

*First-person accounts from dietetic students or nutrition counselors working in the field are included throughout this book.

year 2060.[15] As a result, an array of ethnic foods is available in restaurants and grocery stores and has influenced the national palate. For example, in the past, ketchup was considered a household staple; however, recent national sales of salsa now compete with ketchup and at times have surpassed ketchup sales.

- ***Social Influences:*** Food is often an integral part of social experiences. Sharing a meal with friends after a football game or going out for ice cream to celebrate an academic achievement helps make special experiences festive. However, foods associated with sociability are often not the most nutritious. Social eating frequently encourages increased consumption of less-nutritious foods and overconsumption.[16,17] Eating with friends increases energy intake by 18 percent.[18] However, even though regular family meals have been shown to be correlated with positive health outcomes, an analysis of societal trends indicates that family meal frequency has declined for middle school students, Asians, and adolescents.[19]

> **Anecdote**
> A female college student stated: "The whole society does not emphasize eating healthy. When you are eating, you have to think hard about what are the healthy foods to eat."

- ***Media and Physical Environment:*** North Americans are surrounded by media messages, and most of them are encouraging consumption of high-calorie foods that are nutritionally challenged. Food distributors and manufacturers spend billions of dollars each year on advertising to persuade consumers.[20] Commercials can have powerful influences on the quantity and quality of food consumed.[21] Not only do we encounter food messages repeatedly throughout the day, but we also have access to a continuous supply of unhealthy food and large portion sizes. Almost anywhere you go—drug stores, gas stations, hardware stores, schools, for example—there are opportunities to purchase unhealthy food. Even laboratory animals put in this type of environment are likely to overeat the calorie-dense food and gain excessive weight.[22]
- ***Economics:*** An individual's residence and socioeconomic status can influence myriad factors, including accessibility to transportation, cooking facilities, refrigeration, grocery store options, and availability of healthful food choices. For those who are economically disadvantaged, meeting nutritional guidelines is a challenge.[23] Low-income households purchase significantly less fruits and vegetables than high-income households.[24] Low-income households with limited transportation options spend a greater share of their food budgets at convenience, dollar, and drugstores compared with households with easier access.[25]
- ***Availability and Variety:*** Individuals with increased numbers of food encounters, larger portion sizes, and variety of available choices tend to increase food intake.[26,27] Variety of food intake is important in meeting nutritional needs, but when the assortment is excessive, such as making food selections from a buffet, overconsumption is probable. However, this finding can be useful for those trying to increase fruit and vegetable intake. A dinner plate containing broccoli, carrots, and snap peas was shown to increase intake of vegetables more than if the plate contained only one of the items.[28]
- ***Psychological:*** Food behavior in response to stress varies among individuals. Some people increase consumption, whereas others claim they are feeling too stressed to eat. Certain foods have been associated with depression and mood alteration. Depressed individuals eat lower amounts of antioxidants, fruits, and vegetables and consume higher amounts of chocolate (up to 55 percent) than others.[29,30]

An understanding of how all these factors influence our food behaviors is essential for nutrition educators and counselors. Since we are advocating lifestyle change of comfortable food patterns, we need to understand the discomfort that our clients are likely to feel as they anticipate and attempt dietary alterations. Our role is to acknowledge the challenge for our clients and to find and establish new achievable patterns for a healthier lifestyle.

1.3 Understanding an Effective Counseling Relationship

No matter what theory or behavior change model is providing the greatest influence, the relationship between counselor and client is the guiding force for change.

Exercise 1.2 Explore Influences of Food Behavior

Interview three people and ask them to recall the last meal they consumed. Inquire about the factors that influenced them to make their selections. Record your findings in your journal. Compare your findings to the discussion of influences on food choices in this chapter.

Exercise 1.3 Helper Assessment

Think of a time someone helped you, such as a friend, family member, teacher, or counselor. In your journal, write down the behaviors or characteristics the person possessed that made the interaction so effective. After reading over the characteristics of effective counselors, compare their qualities to those identified by the leading authorities. Do they differ? Share your thoughts with your colleagues.

The effect of this relationship is most often cited as the reason for success or failure of a counseling interaction. Helm and Klawitter[31] report that successful clients identify their personal interaction with their therapist as the single most important part of treatment. To set the stage for understanding the basics of an effective counseling relationship, you will investigate the characteristics of effective nutrition counselors, explore your own personality and culture, examine the special needs and issues of a person seeking nutrition counseling, and review two phases of a helping relationship in the following sections.

Characteristics of Effective Nutrition Counselors

After thoroughly reviewing the literature in counseling, Okun[32] identified seven qualities of counselors considered to be the most influential in affecting the behaviors, attitudes, and feelings of clients: knowledge, self-awareness, ethical integrity, congruence, honesty, ability to communicate, and gender and culture awareness. The following list describes these characteristics as well as those thought to be effective by nutrition counseling authorities:

- ***They have a solid foundation of knowledge.*** Nutrition counselors need to be knowledgeable in a vast array of subjects in the biological and social sciences as well as have an ability to apply principles in the culinary arts. Because the science and art of nutrition is a dynamic field, the foundation of knowledge requires continuous updating. Clients particularly appreciate nutrition counselors who are experienced with the problems they face.
- ***Effective nutrition counselors are self-aware.*** They are aware of their own beliefs, respond from an internal set of values, and as a result have a clear sense of priorities. However, they are not afraid to reexamine their values and goals. This awareness aids counselors with being honest as to why they want to be a counselor and helps them avoid using the helping relationship to fulfill their own needs.
- ***They have ethical integrity.*** Effective counselors value the dignity and worth of all people. Such clinicians work toward eliminating ways of thinking, speaking, and acting that reflect racism, sexism, ableism, ageism, homophobia, religious discrimination, and other negative ideologies. Ethical integrity entails many facets that are addressed in the Academy of Nutrition and Dietetics' Code of Ethics (a discussion of this topic can be found in Chapter 13).[33]
- ***They have congruence.*** This means the counselor is unified. There are no contradictions between who the counselor is and what the counselor says, and there is consistency in verbal and nonverbal behaviors as well. (For example, if a client shared some unusual behavior, such as eating a whole cake covered with French dressing, the counselor's behavior would not be congruent if the nonverbal behavior indicated surprise but the verbal response did not.)
- ***They are honest and genuine.*** Such counselors appear authentic and sincere. They act human and do not live by pretenses, hiding behind phony masks, defenses, and sterile roles. Such counselors are honest and show spontaneity, congruence, openness, and willingness to disclose information about themselves when appropriate. Honest counselors are able to give effective feedback to their clients. They do not avoid difficult issues related to the client's problems and handle them tactfully.
- ***They can communicate clearly.*** Clinicians must be able to communicate factual information and appear to have a sincere regard for their clients. Effective nutrition counselors are able to make sensitive comments and communicate an understanding about fears concerning food and weight.
- ***They have a sense of gender and cultural awareness.*** This requires that counselors be aware of how their own gender and culture influence them. Effective counselors have a respect for a diversity of values that arise from their clients' cultural, social, and economic orientations.
- ***They have a sense of humor.*** Helping clients see the irony of their situation and laugh about their problems enriches counseling relationships. In addition, humor helps prevent clients from taking themselves and their problems too seriously.
- ***They are flexible.*** This means not being a perfectionist. Such counselors do not have unrealistic expectations and are willing to work at a pace their clients can handle.

- ***They are optimistic and hopeful.*** Clients want to believe that lifestyle changes are possible, and they appreciate reassurance that solutions will be found.
- ***They respect, value, care, and trust others.*** This enables counselors to show warmth and caring authentically through nonjudgmental verbal and nonverbal behavior, listening attentively, and behaving responsibly, such as returning phone calls and showing up on time. This behavior conveys the message that clients are valued and respected.
- ***They can accurately understand what people feel from their frame of reference (empathy).*** It is important for counselors to be aware of their own struggles and pain to have a frame of reference for identifying with others.

This list can appear daunting, leading one to wonder if becoming an ideal counselor is achievable. However, Egan and Reese[34] emphasize that there is no right way of mixing and matching the characteristics to meet client needs. They are a list of characteristics to work

Exercise 1.4 People Skills Inventory

- ❑ Do you expect the best from people? Do you assume that others will be conscientious, trustworthy, friendly, and easy to work with until they prove you wrong?
- ❑ Are you appreciative of other people's physical, mental, and emotional attributes—and do you point them out frequently?
- ❑ Are you approachable? Do you make an effort to be outgoing? Do you usually wear a pleasant expression on your face?
- ❑ Do you make the effort to remember people's names?
- ❑ Are you interested in other people—all kinds of people? Do you spend far less time talking about yourself than encouraging others to talk about themselves?
- ❑ Do you readily communicate to others your interest in their life stories?
- ❑ When someone is talking, do you give him or her 100 percent of your attention—without daydreaming, interrupting, or planning what you are going to say next?
- ❑ Are you accepting and nonjudgmental of others' choices, decisions, and behavior?
- ❑ Do you wholeheartedly rejoice in other people's good fortune as easily as you sympathize with their troubles?
- ❑ Do you refuse to become childish, temperamental, moody, inconsistent, hostile, condescending, or aggressive in your dealings with other people—even if they do?
- ❑ Are you humble? Not to be confused with false modesty, being humble is the opposite of being arrogant and egotistical.
- ❑ Do you make it a rule never to resort to put-downs, sexist or ethnic jokes, sexual innuendoes, or ridicule for the sake of a laugh?
- ❑ Are you dependable? If you make commitments, do you keep them—no matter what? If you are entrusted with a secret, do you keep it confidential—no matter what?
- ❑ Are you open-minded? Are you willing to listen to opposing points of view without becoming angry, impatient, or defensive?
- ❑ Are you able to hold onto the people and things in your life that cause you joy and let go of the people and things in your life that cause you sadness, anger, and resentment?
- ❑ Can you handle a reasonable amount of pressure and stress without losing control or falling apart?
- ❑ Are you reflective? Are you able to analyze your own feelings? If you make a mistake, are you willing to acknowledge and correct it without excuses or blaming others?
- ❑ Do you like and approve of yourself most of the time?

Affirmative answers indicate skills you possess that enhance your ability to relate to others.

Source: Adapted from Scott N, "Success Often Lies in Relating to Other People," *Dallas Morning News*, April 20, 1995, p. 14C.

toward that can be enhanced by engaging in professional self-improvement.

It is one of the most beautiful compensations of this life that no man can sincerely try to help another without helping himself.

—RALPH WALDO EMERSON

Understanding Yourself—Personality and Culture

Our personalities are one of the principal tools of the helping process. By taking an inventory of your personality characteristics, you can have a better understanding of the ones you wish to modify. Intertwined with a personality evaluation is self-examination of why you want to be a counselor. What you expect out of a counseling relationship, the way you view yourself, and the personal attitudes and values you possess can affect the direction of the counseling process. You should be aware that as a helper, your self-image is strengthened from the awareness that "I must be OK if I can help others in need." Also, because you are put into the perceptual world of others, you remove yourself from your own issues, diminishing concern for your own problems.

Sometimes counselors seek to fulfill their own needs through the counseling relationship. Practitioners who have a need to express power and influence over others tend to be dictatorial and are less likely to be open to listening to their clients. This type of counselor expects clients to obey suggestions without questions. A counselor who is particularly needy for approval and acceptance will fear rejection. Belkin[35] warns that sometimes counselors try too hard to communicate the message "I want you to like me," rather than a more effective "I am here to help you." As a result, such counselors may be anxious to please their clients by trying to do everything for them, perhaps even doing favors. The tendency will be to gloss over and hide difficult issues because the focus is on eliciting only positive feelings from their clients. Consequently, clients will not learn new management skills, and dietary changes will not take place.

Anecdote

My aunt died of high blood pressure. Her religious belief was that her illness was God's will and should not be interfered with by taking medicine or changing her diet.

Another important component to understanding yourself so as to become a culturally competent nutrition counselor and educator is to know what constitutes your **worldview** (cultural outlook). Each culture has a unique outlook on life, what people believe and value within their group. Our worldview provides basic assumptions about the nature of reality and has both conscious and unconscious influences. An understanding of this concept becomes clearer when we explore assumptions regarding supernatural forces, individual and nature, science and technology, and materialism. (See Table 1.1.) Kittler and Sucher[36] relate this unique outlook to its special meaning in the health community:

> ***. . . expectations about personal and public conduct, assumptions regarding social interaction, and assessments of individual behavior are determined by this cultural outlook, or worldview. This perspective influences perceptions about health and illness as well as the role of each within the structure of society. (p. 35)***

Majority American values, which are shared by most whites and to some extent other racial and ethnic groups, emphasize individuality, self-help, and control over fate. One study found 82 percent of American consumers believe they are directly responsible for their own health.[37] Throughout the world there are many who believe the primary influence on health and wellness are supernatural forces such as the will of God, astrological agents, or cosmic karma.

Your worldview is determined by your culture and life experiences. **Culture** is shared history, consisting of "the thoughts, communication, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or societal groups."[38] Possible societal groups include gender, age, sexual orientation, physical or mental ability, health, occupation, and socioeconomic status. Any individual will belong to several societal groups and acquire cultural characteristics and beliefs from each based on education and life experiences within those groups. Because each experience is unique, no two people acquire exactly the same cultural attributes. In addition,

Exercise 1.5 How Do You Rate?

Ask a close friend or family member who you supported at one time to describe what it was about your behavior that was helpful. Write these reactions down in your journal. Review the desirable characteristics for an effective counselor described in the previous section. Complete the personality inventory in Exercise 1.4, and then identify what characteristics you possess that will make you a good helper. What behaviors need improvement?

Write in your journal specific ways that you need to change to improve your helping skills.

Table 1.1 Worldview Assumptions

Category	Assumption
Supernatural Assumptions	Supernatural assumptions include beliefs regarding God, malevolent spirits, ancestors, fate, or luck being the cause of illness. The concept of soul loss causing depression or listlessness is prevalent in many societies. In order to alleviate supernatural problems, societies have devised ceremonies or rituals.
Individual and Nature	Not all societies make a clear distinction between human life and nature as in the United States. Some societies believe that we are subjugated by nature and need to show respect for natural forces and attempt to live in harmony with nature. The dominant culture in the United States sees human beings as having higher value than nature with a need to exploit or protect it.
Technology	The citizens of the United States put great fate in technology and the scientific method. Diseases are viewed as correctable mechanistic errors that can be fixed by manipulation. Americans tend to think science can help humanity—a view not as highly held in Europe.
Materialism	Many people around the world believe that materialism dominates the worldview of Americans, that is, the need to acquire the latest and best possessions. This may have contributed to the popularity of "supersize food portions."

Source: Jandt F. *An Introduction to Intercultural Communication: Identities in a Global Community*. 6th ed. Thousand Oaks, CA: Sage Publications, Inc.; 2009.

we are likely to migrate to and away from various cultures throughout our lives. For example, a change of job, religion, residence, or health status can alter cultural attributes. However, there are attributes that prevail and will affect the way we perceive ourselves and others.

We share a commonality with those who are most like us. For example, many North Americans appreciate a friendly, open health care professional. People from other cultures, however, may feel uncomfortable interacting with a professional on such terms and may even view this behavior as a sign of incompetence. Your food habits can also be an important component of your culture. For example, Hindus find eating beef to be abhorrent—much the way many Westerners feel about Asians consuming dog meat.

Understanding the role of **cultural values** in your life as well as in the lives of clients from cultures other than your own provides a foundation for developing cultural sensitivity. Our cultural values are the "principles or standards that members of a cultural group share in common."[39] For example, in the United States, great value is placed on money, freedom, individualism, independence, privacy, biomedical medicine, and physical appearance. Cultural values are the grounding forces that provide meaning, structure, and organization in our lives. (See Table 1.2.) Individuals may hold onto their values despite numerous obstacles or severe consequences. For example, Jung Chang describes in her family portrait, *Wild Swans: Three Daughters of China,* how her father actively supported Mao's Communist takeover of China and rose to be a prominent official in the party. His devotion to the party never wavered, even during the Cultural Revolution when he was denounced, publicly humiliated with a dunce hat, and sent to a rehabilitation camp.[40]

Table 1.2 Functions of Cultural Values

- Provide a set of rules by which to govern lives.
- Serve as a basis for attitudes, beliefs, and behaviors.
- Guide actions and decisions.
- Give direction to lives and help solve common problems.
- Influence how to perceive and react to others.
- Help determine basic attitudes regarding personal, social, and philosophical issues.
- Reflect a person's identity and provide a basis for self-evaluation.

Source: Adapted from Joan Luckmann, *Transcultural Communication in Nursing.* Belmont, CA: Delmar Cengage Learning, 1999.

Exercise 1.6 Why Do You Want to Be a Helper?

Describe in your journal what it means to be a helper and why you want to be a helper. How does it feel when you help someone? Is it possible that you have issues related to dominance or neediness that could overshadow interactions with your clients?

Exercise 1.7 What Is Your Worldview?

Indicate on the continuum the degree to which you share the following white North American cultural values; 1 indicates not at all, and 5 represents very much.

Not at All				Very Much	
1	2	3	4	5	Personal responsibility and self-help for preventing illness.
1	2	3	4	5	Promptness, schedules, and rapid response-time dominates.
1	2	3	4	5	Future-oriented—willing to make sacrifices to obtain future goals.
1	2	3	4	5	Task-oriented—desire direct participation in your own health care.
1	2	3	4	5	Direct, honest, open dialogue is essential to effective communication.
1	2	3	4	5	Informal communication is a sign of friendliness.
1	2	3	4	5	Technology is of foremost importance in conquering illness.
1	2	3	4	5	Body and soul are separate entities.
1	2	3	4	5	Client confidentiality is of utmost importance; health care is for individuals, not families.
1	2	3	4	5	All patients deserve equal access to health care.
1	2	3	4	5	Desire to be youthful, thin, and fit.
1	2	3	4	5	Competition and independence.
1	2	3	4	5	Materialism.

Can you think of a time when your values and beliefs were in conflict with a person you were trying to associate with? What were the circumstances and results of that conflict? Write your response in your journal, and share your stories with your colleagues.

Source: Adapted from Kittler P and Sucher K, *Food and Culture in America*, 2d ed. (Belmont, CA: West/Wadsworth; 1998); and Keenan, Debra P. In the face of diversity: Modifying nutrition education delivery to meet the needs of an increasingly multicultural consumer base, *J Nutr Ed.* 1996;28:86–91.

As nutrition counselors and educators advocate for change, there needs to be an appreciation of the high degree of importance placed on certain beliefs, values, and cultural practices. You can then empathize with individuals from non-Western cultures who are experiencing confusion and problems as they try to participate in the North American health care system. Also, awareness can help prevent your personal biases, values, or problems from interfering with your ability to work with clients who are culturally different from you.

Conscious and unconscious prejudices unrelated to cultural issues that a counselor may possess could also interfere with emotional objectivity in a counseling situation. Individuals could have exaggerated dislikes of personal characteristics such as being obese, bald, aggressive, or poorly dressed. Awareness of these prejudices can help build tolerances and a commitment not to let them interfere with the counseling process through facial expressions and other nonverbal behavior.

Exercise 1.8 Explore Your Biases

You can explore possible biases that you have by going to the Harvard Project Implicit website.

- ❏ Go to a quiet environment that will allow you to compete an implicit bias evaluation.
- ❏ Go to the following website: https://implicit.harvard.edu/implicit/takeatest.html.
- ❏ Select a category for evaluation.
- ❏ Take the quiz for the category you selected and answer the following questions in your journal:
  1. How did the evaluation compare to your beliefs about the category you chose?
  2. Our biases are often unconscious. Considering the evaluation you just completed, comment on this statement.
  3. Do you agree with the bias evaluation you received Explain?

Exercise 1.9 What Are Your Food Habits?

Record answers to the following questions in your journal; share them with your colleagues.

- ❑ Who purchases and prepares most of the food consumed in your household?
- ❑ What is your ethnic background and religious affiliation?
- ❑ Are there foods you avoid eating for religious reasons?
- ❑ List two foods you believe are high-status items.
- ❑ What major holidays do you celebrate with your family?
- ❑ List two rules you follow when eating a meal (for example, "Don't sing at the table").
- ❑ Are there food habits that you find morally or ethically repugnant?
- ❑ Are you aware of any of your own food habits that others would consider repugnant?

Source: Adapted from Kittler P and Sucher K, *Food and Culture,* 4th ed. (Belmont, CA: Wadsworth/Thomson; 2004), pp. 24–25.

Understanding your Client

Just like counselors, clients come into nutrition counseling with unique personalities, cultural orientations, health care problems, and issues related to the counseling process. Each person's personality should be recognized and appreciated. Clients have their own set of needs, expectations, concerns, and prejudices that will have an impact on the counseling relationship. In the rushed atmosphere of some institutional settings, health care workers can lose sight of the need to show respect, especially if clients have lost some of their physiological or mental functions due to illness.

From a cultural perspective, clients are diverse in many ways, belong to a number of societal groups, and have a set of unique life experiences contributing to a distinctive worldview. Getting a fresh perspective from a counselor is one of the advantages of counseling. However, the further away counselors are from their clients' cultural orientation, the more difficult it is to understand their worldview. If this is the case, then you will need to explore your clients' culture through books, newspapers, magazines, workshops, movies, and cultural encounters in markets, fairs, and restaurants. Learning your clients' beliefs about illness and the various functions and meanings of food are particularly important. While exploring **cultural groups**, you should remember that the characteristics of a group are simply generalities. You want to avoid stereotyping. Do not fall into the trap of believing that each characteristic applies to all people who appear to represent a particular group. Remember that the thoughts and behaviors of each individual develop over a lifetime and are shaped by membership in several cultural groups. For example, a homosexual male who grew up with a learning disability in Alabama with first-generation parents from Italy and lives in Chicago as an adult would have a number of social groups and life experiences influencing his communication style, view of the world, and expectations. People totally, partially, or not at all embrace the standards of a culture they appear to represent.

Anecdote

My client, a robust man in his youth, was a World War II veteran who took part in the invasion of Normandy. But at age seventy-five, he suffered a stroke and went into a veterans' hospital for treatment. During his hospital stay, he asked a health care worker to help him get into bed because he wanted to go to sleep. The worker told him he would be able to go to sleep after he finished his lunch. My client became very angry and threw his lunch tray at the health care worker.

The circumstances that bring clients to counseling can have a major impact on their readiness for nutrition counseling. Those who have been recently diagnosed with a serious illness may be experiencing shock or a great deal of physical discomfort to deal effectively with complex dietary guidelines—or any guidelines at all. They may display a tendency toward rebelliousness, a denial of the existence of the problems, anxiety, anger, or depression. When counseling an individual with a life-threatening illness, nutrition counselors need to take into account a client's position on the continuum of treatment and recovery.

An attitudinal investigation of young and well-educated patients with diabetes suggests a desire for a collaborative relationship with their health care providers helping them to explore options rather than simply being told what to do.[41] On the other hand, this same study identified a significant number of the elderly with diabetes who did not desire an independent self-care role. Promoting self-sufficiency is often a stated goal of nutrition counseling;[42] however, for some clients, that goal may need to be modified. This issue has also been addressed by the expert panel for the National Institutes of Health report, *Identification, Evaluation, and Treatment of Overweight and Obesity in Adults*,[43] which states that a weight maintenance program consisting of diet therapy, behavior therapy, and physical activity may need to be continued indefinitely for some individuals.

Exercise 1.10 Exploring Food Habits of Others

Interview someone from a culture different than your own. Ask that person the questions in Exercise 1.7, and record his or her answers in your journal. What did you learn from this activity? How can you personally avoid ethnocentric judgments regarding food habits?

Some clients may regard the counseling process itself as an issue. The act of seeking and receiving help can create feelings of vulnerability and incompetence. During counseling there is a presumed goal of doing something for the clients or changing them in some way. This implication of superiority can raise hostile feelings in the client because the act presumes that the helper is wiser, more competent, and more powerful than the client. This is illustrated in Helen Keller's account of her dreams about her teacher and lifelong friend, Annie Sullivan, who provided constant help for almost all aspects of Helen's existence:

> ***[T]here are some unaccountable contradictions in my dreams. For instance, although I have the strongest, deepest affection for my teacher, yet when she appears to me in my sleep, we quarrel and fling the wildest reproaches at each other. She seizes me by the hand and drags me by main force towards I can never decide what—an abyss, a perilous mountain pass or a rushing torrent, whatever in my terror I may imagine.***[44] ***(pp. 165–166)***

To help alleviate the negative impact of such issues on the counseling process, the motive for help and the nature of the helping task as perceived by the counselor should be made clear to the receiver.

Exercise 1.11 Starting a Relationship

Lilly is forty-two years old, has three children, and is about twenty pounds overweight. She sought the help of a fitness and nutrition counselor, Joe, because she wants to increase her energy level and endurance. She tires quickly and feels that exercise will help her stamina.

Joe Hello, Lilly. It's great you came a little early. Let's get you right on the scale. OK, at 163 pounds, it looks to me as if you need to shed about 20 pounds. You have a ways to go but worry not—we will get it off you. Everything will be fine.

Lilly I really…

Joe I am not kidding, Lilly—don't worry. We will start slowly. What you want to do is get your BMI down, your muscle tissue up, as well as get rid of the fat. If you follow me, I'll introduce you to everyone, sign you up for an aerobics class, and start you on your routine.

Lilly Well, you see I only want…

Joe Hey, Rick, this is Lilly. She is a newcomer.

Rick Welcome, Lilly. Don't forget to take home some of our power bars—they are great for beginners who may not know how to eat right.

Joe Yeah, and be sure to bring a sports drink in with you; you will get mighty thirsty. No pain, no gain!

In groups of three, brainstorm the concerns in this scenario. Why is this helping relationship off to a bad start? What questions or comments could Joe have made that may have been more helpful?

Relationship Between Helper and Client

The helping relationship is often divided into two phases: building a relationship and facilitating positive action. Building a relationship requires the development of rapport, an ability to show empathy, and the formation of a trusting relationship.[45] The goals of this phase are to learn about the nature of the problems from the client's viewpoint, explore strengths, and promote self-exploration.

The focus of the second phase of the counseling process is to help clients identify specific behaviors to alter and to design realistic behavior change strategies to facilitate positive action.[45] This means clients need to be open and honest about what they are willing and not willing to do. Lorenz et al.[46] state that in the successful Diabetes Control and Complications Trial, clients could better communicate their capabilities when health professionals articulated what problems could develop in attempting to improve blood glucose control. They found honesty more likely to occur in an environment in which clients do not feel they will be criticized when difficulties occur, but rather believe the caregivers will show understanding and work toward preparing for similar future circumstances. Nonjudgmental feedback was also an important component of the successful DASH (Dietary Approaches to Stop Hypertension) dietary trial for reducing hypertension.[47] Counselors must communicate their willingness to discover their clients' concerns and help them prioritize in a realistic manner.

In summary, it would be futile to start designing behavior change strategies when an effective relationship has not developed and you do not yet have a clear understanding of your clients' problems or an appreciation of their strengths. According to Laquatra and Danish:[45]

> ***Attending to the second part of the counseling process without the strong foundation afforded by the first part results in dealing with the problem as being separate from the client, or worse yet, providing solutions to the wrong problems. Behavior-change strategies designed under these circumstances are not likely to succeed. (p. 352)***

The scenario in Exercise 1.11 illustrates a common mistake helpers make—indicating that everything will be fine. Because it has no basis for reality, the comment belittles the client's feelings. If the client actually feels reassured by the comment, the benefit is temporary because no solution to the problem has been sought. Patronizing a client is self-defeating. It indicates superiority and can automatically create negative feelings. Effective counselors provide reassurance through clarifying their roles in the counseling process, identifying possible solutions, and explaining the counseling program.

Novice Counselor Issues

New counselors typically have concerns about their competency. A counselor who feels inadequate may be reluctant to handle controversial nutrition issues, sometimes giving only partial answers and ignoring critical questions. Confidence in your ability will increase with experience.

Client: ***Are high-protein diets a good way to lose weight?***

Counselor: ***Some people say they lose weight using them.***

In this example, the counselor is talking like a politician—not taking a stand, trying not to offend anyone. If you are not clear about an issue, you can tell your client that it is a topic you have not thoroughly investigated and that you will review the matter. If after investigating the issue, you still do not have a clear answer, you should provide your client with what you have found out regarding the positives and negatives of the topic. The Academy of Nutrition and Dietetics Code of Ethics[33] states, "The dietetics practitioner presents reliable and substantiated information and interprets controversial information without personal bias, recognizing that legitimate differences of opinion exist."

Another issue for novice nutrition counselors is assuming the role of expert or empathizer. Combining the two roles can contribute to an effective intervention, but a single approach is likely to hamper progress. An authority figure is impressive and appears to have all the answers. Clients blindly accept the direction of the "guru," but little work is done to determine how to make the lifestyle changes work for them. As a result, clients revert to old eating patterns. On the other hand, the empathizer puts so much effort into focusing on client problems that the client receives little direction or information. With experience and determination, the two roles can be effectively combined.

KEY TERMS

Cultural Groups: nonexclusive groups that have a set of values in common; an individual may be part of several cultural groups at the same time.

Culture: learned patterns of thinking, feeling, and behaving that are shared by a group of people.

Cultural Values: principles or standards of a cultural group.

Models: generalized descriptions used to analyze or explain something.

Nutrition Counseling: a supportive process guiding a client toward nutritional well-being.

Nutrition Education: learning experiences aimed to promote voluntary adoption of health-promoting dietary behaviors.

Worldview: perception of the world that is biased by culture and personal experience.

REVIEW QUESTIONS

1. Define nutrition counseling and nutrition education.
2. What is generally considered the most important determinant of food choices?
3. Name and explain the seven qualities of counselors considered to be the most influential by leading authorities as identified by Okun.
4. Explain how taking on the role of helper improves the self-image of the helpee.
5. Identify and explain how seeking to fulfill two basic needs of counselors through a counseling relationship can be detrimental to the relationship.
6. Why is it important for counselors to understand their worldviews to achieve cultural sensitivity?

7. Name and explain the two phases of the helping relationship.
8. Why is indicating to a client that everything will be fine unlikely to be productive? What is a more useful approach?
9. Identify three issues for novice counselors.

ASSIGNMENT Build a Collage

The purpose of this assignment is to reflect on the aspects of your culture that have had the greatest impact on you. Part of becoming a culturally competent nutrition counselor is to understand your own beliefs, attitudes, and the forces that influenced them. This activity can help in the process of understanding the factors that have framed your values, views, and thinking patterns.

Culture is defined as "the thoughts, communication, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or societal groups."[38] You are a member of several cultural groups. Select pictures from print media or use your own photographs that represent cultural forces that have influenced your worldview. Attach them to a poster board. Be prepared to discuss your collage with your colleagues. Discussions of your collages are likely to lead to an appreciation for the unique stories each person possesses.

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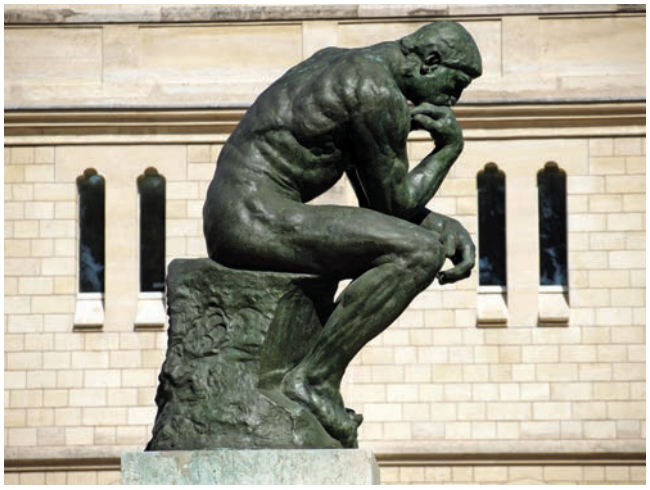
2 Frameworks for Understanding and Attaining Behavior Change



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Learning Objectives

2.1 Explain the importance of behavior change models and theories for a nutrition practitioner.

2.2 Describe and apply major concepts of selected behavior change theories and models.

2.3 Describe major components of selected theoretical approaches to counseling.

2.4 Differentiate counseling approaches for various durations of brief interventions.

Change and growth take place when a person has risked himself and dares to become involved with experimenting with his own life.

—HERBERT OTTO

2.1 Introduction

Historically, nutrition counselors and educators overlooked many fundamental factors affecting food behavior and attempted to change food choices by simply dispensing facts and diets. The results were often disappointing. Eventually, nutrition professionals recognized a need for a new procedure and turned to established psychotherapy counseling approaches and theoretical models stemming from food-related research and social psychology to guide nutrition interventions. During the 1980s, the focus was on behavior modification, giving way to goal setting and client-centered counseling in the 1990s. More recently, the Transtheoretical Model and Motivational Interviewing have provided guides for instituting behavior change in the health arena. An array of counseling philosophies, theories, behavior change models, and counseling approaches are currently available to deal with the complex process of changing health behaviors. Table 2.1 summarizes the usefulness of using theories and models for formulating an intervention.

The following discussion summarizes the approaches most often identified as useful for designing interventions and guiding and appraising changes in dietary behavior. Note that some of the concepts overlap among the behavior change theories, therapies, models, and approaches. We will start by discussing self-efficacy, which is a construct of several behavior change theories and is incorporated into some counseling approaches. Next, we will look at three theories that primarily focus on individual factors, such as knowledge, attitudes, beliefs, and prior experience. These include the Health Belief Model (HBM), the Transtheoretical Model (TTM), and the Theory of Planned Behavior (TPB).

Table 2.1 Benefits of Theoretical Behavior Change Theories and Models

- Present a road map for understanding health behaviors
- Highlight variables (for example, knowledge, skills) to target in an intervention
- Supply rationale for designing nutrition interventions that will influence knowledge, attitudes, and behavior
- Guide process for eliciting behavior change
- Provide tools and strategies to facilitate behavior change
- Provide outcome measures to assess effectiveness of interventions

Source: Adapted from Academy of Nutrition and Dietetics. Nutrition Counseling Evidence Analysis Project. http:// andeal.org.

The last theory to be addressed is the Social Cognitive Theory (SCT), which does not look solely at individual traits for understanding behavior but incorporates a person's relationship with social groups and the environment. We will then turn our attention to counseling approaches frequently used to assist clients with making health behavior changes. Because Client-Centered Counseling provides guidance for establishing an effective counseling relationship, many practitioners utilize basic aspects of this approach. Then we will explore Solution-Focused Therapy. This commonly used counseling approach has not received much attention for changing dietary behavior, but it offers some intriguing useful strategies in nutrition counseling. Next, we will review Cognitive Behavioral Therapy (CBT), which has repeatedly been shown to be effective for changing health behaviors, and finally Motivational Interviewing (MI), which is widely used, especially with clients who are in the early stages of behavior change. You will observe a great deal of interplay among the theories, models, and counseling approaches.

2.2 Self-Efficacy

The concept of self-efficacy as a basic component of behavior change was developed by Albert Bandura.[1] Although sometimes considered a separate model, self-efficacy has been widely accepted and incorporated into numerous behavior change models. Bandura[2] defines self-efficacy as "the confidence to perform a specific behavior," such as a belief in ability to change food patterns. Attainment of health behavior changes has been found to correlate solidly with a strong self-efficacy,[3] probably because self-perception of efficacy affects individual choices, the amount of effort put into a task, views of barriers, and willingness to pursue goals when faced with obstacles. As a result, a person's confidence in his or her ability to accomplish a behavior change may be more important than actual skill.[1]

After the importance of change is acknowledged, counselors and educators can help clients to feel that there is a "way out of this situation." Clients need to believe that there are workable options that make change possible. If individuals perceive there is no solution, their discomfort may shift to defensive thinking: denial ("not really so bad"), rationalization ("didn't want to anyway"), or projection ("not my problem, but theirs").[4] The counselor's responsibility is to give clients hope by increasing awareness of options and assisting in setting achievable goals. Successful experiences build confidence that more complex goals can be attained. Self-efficacy can also be strengthened by pointing out

strengths, relating success stories, and expressing optimism for the future.

2.3 Health Belief Model

The Health Belief Model (HBM) proposes that cognitive factors influence an individual's decision to make and maintain a specific health behavior change.[5] As depicted in Figure 2.1, central to making this decision, a person would need to (a) perceive personal susceptibility to a disease or condition; (b) perceive the disease or condition as having some degree of severity, such as physical or social consequences; (c) believe that there are particular benefits in taking actions that would effectively prevent or cure the disease or condition; (d) perceive no major barriers that would impede the health action; (e) be exposed to a cue to take action; and (f) have confidence in personal ability to perform the specific behavior (self-efficacy).[6] See Table 2.2 for examples.

These beliefs interact with each other to determine a client's willingness to take action. For example, a woman who loves to eat sweets may believe that she is susceptible to getting dental cavities, but if she perceives the adverse effect (severity) on her life to be minimal, then she will not have an impetus to change. Studies have shown that a person with few overt symptoms has lower dietary adherence.[7] Similarly, a man may believe that eating a plant-based diet will reduce his cholesterol level (benefits), but he may feel it is too inconvenient to change his food pattern (too many barriers) or feel incapable of taking the necessary steps to make the change (low self-efficacy). Cues to action to participate in a program or seek counseling can come from a number of sources, including physical symptoms, observation of another person taking action, a media report, or advice of a physician. Counselors and clients can brainstorm together to design workable prompts to provide reminders to cue action, such as a note on the refrigerator.

Application of Health Belief Model

Using the HBM, a nutrition intervention in a community congregate food program was able to successfully increase consumption of whole grains, improve knowledge regarding whole grains, and strengthen the belief that intake of whole-grain foods would reduce risk of disease.[8] The following is an example of the application of the HBM constructs for changing whole grain behavior in this study:

- **Perceived susceptibility and severity:** Personal risk was addressed by emphasizing increased risk for heart disease, cancer, type 2 diabetes, and constipation.

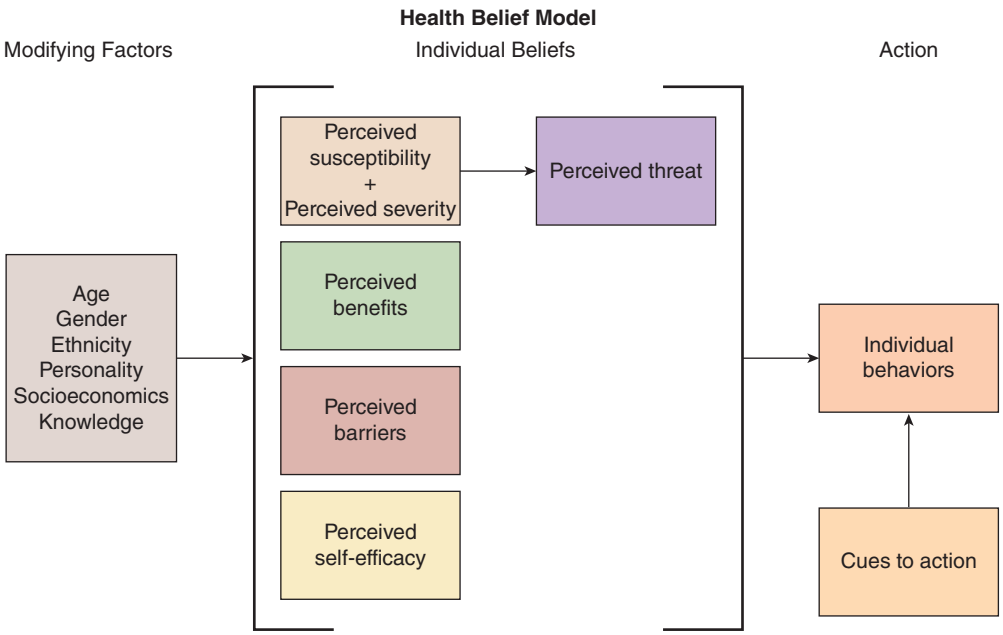

Figure 2.1 Health Belief Model Diagram
Source: Adapted from Figure 5.1, page 79, *Health Behavior and Health Education Theory, Research, and Practice,* 5th ed., Karen Glanz, Barbara K. Rimer, and K. Viswanath, Eds., San Francisco, CA: Jossey-Bass, 2015.

Table 2.2 Examples of Health Belief Model Constructs

Health Belief Construct	Sample Client Statements	Intervention Possibilities
Perceived susceptibility	"I worry about my chances of developing high blood pressure."	Educate on disease risk and link to diet, compare to an established standard. Example: "The American Heart Association recommends keeping blood pressure below 120/80 mm Hg. Your blood pressure is 148/110."
Perceived severity	"Well, I have high blood pressure, but I feel fine."	Discuss disease impact on client's physical, economic, social, and family life. Show graphs and give statistics. Clarify consequences. Example: "High blood pressure increases risk of developing a stroke."
Perceived benefits	"Eating more salads would be good for my health."	Provide role models and testimonials. Imagine the future. Specify action and benefits of the action. Example: "Eating more plant foods can be good for lowering your blood pressure."
Perceived barriers	"The foods I need to eat to lower my blood pressure are tasteless."	Explore strategies to overcome barriers such as inconvenience, cost, and unpleasant feelings. Offer incentives, assistance, and reassurance; correct misinformation and misperceptions; provide taste tests. Example: "There are good recipes to try using various herbs and salt substitutes."
Cues to action	"My roommate always has savory snacks and potato chips on the kitchen counter."	Link current symptoms to health problem, discuss media to promote health action, encourage social support, use reminder systems (sticky notes, automated cell phone messages, mailings). Example: "You could place additional snacks and nuts on the kitchen counter that are low in sodium."
Self-efficacy	"I am confident that I can prepare low sodium pasta dishes."	Provide skill training and demonstrate behaviors step-by-step. Encourage goal setting and positive reinforcement. Example: "Yes, you are on the right track."

- **Perceived benefits:** To encourage beliefs regarding benefits, lessons highlighted nutritional superiority of whole grains over refined grains.
- **Perceived barriers:** To overcome obstacles, lessons provided taste tests and education regarding labeling of whole grains.
- **Self-efficacy:** To increase confidence, lessons included demonstrations and opportunities to practice reading labels.
- **Cues to action:** Participants were given recipes, tip sheets, and educational materials to foster cues to action at home.

Exercise 2.1 Health Belief Model Activity

Match the following descriptions with the appropriate Health Belief Model construct.

____ **1.** Perceived Benefits	**a.** Reading a blog about gut microbiota prompts action in eating fiber-rich foods
____ **2.** Perceived Susceptibility	**b.** Perception that a leaky gut can negatively affect a person's work productivity
____ **3.** Perceived Barriers	**c.** Individual's confidence in ability to prepare a meal with whole grains
____ **4.** Perceived Severity	**d.** Perception that eating fruits and vegetables may lower risk of inflammation
____ **5.** Self-Efficacy	**e.** Perception that eating healthfully will be costly and inconvenient
____ **6.** Cues to Action	**f.** Personal belief in the chances of developing irritable bowel disease

2.4 The Transtheoretical Model (Stages of Change)

This model, developed by Prochaska and DiClemente, is referred to as transtheoretical because it crosses over many psychotherapy and counseling theories. This model has been used as a guide for explaining how behavior change occurs, supplying effective intervention designs and strategies, and evaluating dietary change interventions.[9–11] The core constructs of this model include stages of change, processes of change, decisional balance, and self-efficacy.

Motivational Stages

The Transtheoretical Model (TTM), as depicted in Figure 2.2, describes behavior change as a process of passing through a sequence of distinct motivational stages (that is, levels of readiness to take action). Implicit in this model is that behavior change is a process that occurs over time. For an intended behavior change, an individual can begin at any one of the motivational levels or stages:

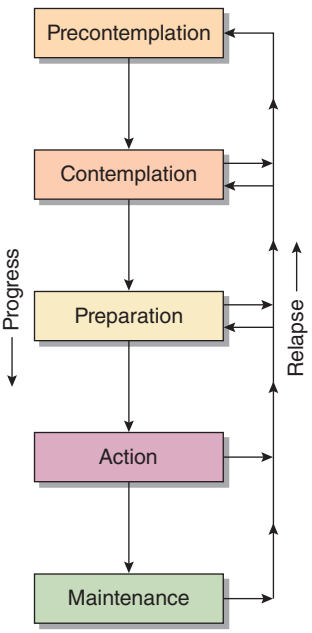

Figure 2.2 The Transtheoretical Stages of Change Model
Source: From BOYLE. *Community Nutrition in Action,* 7e. © 2017 Cengage Learning, Inc. Reproduced by permission. www.cengage.com/permissions

1. **Precontemplation:** A person in this stage has no intention of changing within the next six months and in fact resists any efforts to modify the problem behavior. The reasons for this include no awareness that a problem exists, denial of a problem, blame others for the problem, awareness of the problem but unwillingness to change, or feelings of hopelessness after attempting to change.
2. **Contemplation:** Contemplators recognize a need to change but are in a state of ambivalence, alternating between reasons to change and reasons not to change. During an interview, a client may appear to be saying contradicting statements. For example, "I eat only good foods. I really enjoy the desserts in the lunch room at work." There is concern that the long-term health benefits of the change do not compensate for the short-term real or perceived costs.[11] Perceived barriers such as unacceptable tastes, economic constraints, or inconvenience are major obstacles. People can be stuck in this stage for years waiting for absolute certainty, the magic moment, or just wishing for different consequences without changing behavior. If asked, contemplators are likely to say they intend to change their undesired behavior in the next six months.
3. **Preparation:** Preparers have identified a strong motivator, believe the advantages outweigh the disadvantages of changing, and are committed to take action in the near future (within the next thirty days). They may have taken small steps to prepare for a change, such as making an appointment with a nutrition counselor or inquiring about a walking club. A person in this stage would be willing to

Exercise 2.2 Determine Your Stage Using the Transtheoretical Model

The following is a list of health behaviors commonly accepted as desirable. Review the stages of change, and circle the corresponding number that indicates your stage.
1 = Precontemplation, 2 = Contemplation, 3 = Preparation, 4 = Action, 5 = Maintenance

❑ Floss teeth at least once a day.	1	2	3	4	5
❑ Exercise at least 90 minutes a week.	1	2	3	4	5
❑ Go to the dentist at least once a year.	1	2	3	4	5
❑ Eat at least 5 servings of fruits and vegetables a day.	1	2	3	4	5
❑ Always use a seat belt when driving.	1	2	3	4	5
❑ Refrain from smoking.	1	2	3	4	5
❑ Consume at least 1,000 milligrams of calcium every day.	1	2	3	4	5
❑ Eat at least 3 servings of whole grains every day.	1	2	3	4	5
❑ Consistently use sunscreens.	1	2	3	4	5

In your journal, write what you learned about yourself. Describe what you learned about the stages of change construct.

Source: This activity was adapted from one developed by Mary Finckenor, Adjunct Professor, Montclair State University, Montclair, New Jersey. Used with permission.

problem solve, explore goals, and take some practical steps such as trying a new recipe or tasting some new foods.

4. **Action:** Clients are considered to be in this stage if they have altered the target behavior to an acceptable degree for one day or up to six months and continue to work at it. Although changes have been continuous in this stage, the new behaviors should not be viewed as permanent. The most common time for relapse to occur is between three and six months in the action stage.[12]
5. **Maintenance:** A person in this stage has been engaging in the new behavior for more than six months and is consolidating the gains attained during previous stages.[13] The new behavior has become a habit, and the client is confident that the behavior will persist. Prochaska and Norcross[14] explain, "Perhaps most important is the sense that one is becoming more of the kind of person one wants to be." However, the individual needs to work actively to modify the environment to maintain the changed behavior and prevent a relapse.
6. **Termination:** Individuals in this stage are not tempted to relapse and are 100 percent confident that the behavior will continue. Prochaska et al.[11] suggest that the ultimate goal for many new nutrition and exercise behaviors may be a lifetime of maintenance, not termination, because "relapse temptations are so strong and prevalent."

Anecdote

I walked into the hospital room of an obese teenage boy to give a discharge calorie-controlled, weight reduction diet. As soon as I introduced myself and explained the purpose of my visit, the boy said he didn't want another diet. He said he tried them all before, and none of them worked. He said he was fat, his whole family was fat, and that is the way it would always be. Although I was sympathetic to his plight, I proceeded to explain the diet. During the whole explanation, he rolled his eyes, and the rest of his body language indicated that he was annoyed with me. Even at the time I knew that the encounter was not productive. I just transmitted a bunch of facts, even though he obviously was not listening. I felt it was my responsibility to go over the diet with him and chart in his record that the diet order was accomplished. Now that I have had a counseling course, I believe I would have spent the limited time I had with him dealing with his frustration and would have told him to come see me as an outpatient after discharge if he had a change of heart. Now I wouldn't even attempt to go over the diet.*

A review of the various stages indicates that behavior change occurs in a linear order in which people "graduate" from one stage to the next. However, it is normal for individuals to slip back one or more stages, or even to have a relapse and then start to move forward again, progressing toward maintenance. (See Lifestyle Management Form 7.5 in Appendix C.) Figure 2.2 depicts the concept that although individuals move through a sequence of stages, there is forward and backward movement in the various stages. Smoking research, for example, has shown that people commonly recycle four times

*Numerous first-person accounts from dietetic students or nutrition counselors working in the field are included throughout this book.

through various stages before achieving long-term maintenance.[4] The fact that change is not perfectly maintained should not be viewed in a negative light. By knowing from the outset that perfection is not realistic and lapses are to be expected, an intervention can be planned accordingly. Hopefully, by understanding that relapses are a normal occurrence in the change process, clients and counselors can maintain a realistic perspective and not become demoralized when they occur. In addition, individuals may be in different stages of change for various behaviors affecting a health outcome. For example, a person who would like to reduce cholesterol may be in an action stage for eating an ounce of nuts each day but may be only in the contemplation stage for decreasing intake of high-fat cold cuts.

Processes of Change

TTM serves as a guide to identify potentially effective messages and intervention strategies to facilitate movement through the stages to reach and remain at the maintenance stage or even the termination stage. Because the strategies clients find useful at each stage differ,[15] the treatment intervention needs to be tailored to a client's stage of change. Traditionally, nutrition interventions have not taken readiness into consideration and have treated all people as if they were actively searching for ways to make behavior changes (by giving information, offering advice, and developing a diet plan). This approach has been counterproductive because most individuals with dietary problems are in a pre-action stage: precontemplation, contemplation, or preparation. In fact, giving advice to individuals who do not believe they have a problem could make them feel beleaguered and defensive, making change even less likely to occur. In some cases, nutrition counselors may have erroneously assumed that an individual enrolled in a program is ready to take action.[13] The person may in fact have decided to participate because of pressure from a loved one, or serious consideration may have been given to the problem, but the person is not actually ready to make a behavior change. In general, cognitive (thinking-related) and affective (feeling-related) strategies are more effective in the early stages, whereas behavioral (action-oriented) strategies in the latter stages are more likely to meet client needs.[13] (See Table 2.3.) As individuals move through stages, intervention strategies need to be adjusted; therefore, counselors need to reassess their clients' stage periodically. Prochaska and Norcross[14] have identified ten effective intervention strategies to assist clients' progress from one stage to another. These include the following:

Cognitive and Affective Experiential Processes

- Consciousness Raising (Learn the facts): By increasing awareness of the causes, consequences, and available treatments regarding a problem, individuals are better able to formulate a decision to make a behavior change. Increase understanding through nutrition education, observations, and personal feedback about the behavior.
- Dramatic Relief (Experiencing and expressing feelings): Either positive or negative emotional arousal can influence a decision to make a behavior change.

Table 2.3 Transtheoretical Model Summary

Stage	Key Intervention Objectives	Intervention Strategies
Precontemplation		
"I won't" "I can't" No intention of changing within the next six months	Increase information and awareness, emotional acceptance.	• Show respect, empathy, use reflection • Assess knowledge, attitudes, and beliefs • Clarify: Decision is yours • For "I won't": "I hear you saying you are not ready to make a decision to change right now. What would you like to address with me?" • For "I can't": "Do I understand you correctly that you do not think a change will work? Can you tell me more about that?" • Do not threaten the client, "You will have a heart attack." • Ask when and how the food problem conflicts with the client's values • Provide personalized benefits of changing and possible ways changes could be made, offer nutrition information including handouts and websites

(continued)

Table 2.3 Transtheoretical Model Summary *(continued)*

Stage	Key Intervention Objectives	Intervention Strategies
Contemplation		
"I may" Aware of problem, thinking about changing behavior within the next six months	Encourage self-reevaluation, help develop a vision for change, increase confidence in ability to adopt recommended behaviors.	• Validate lack of readiness • Clarify: Decision is yours • Recall an emotional reaction to a food problem. For example: "Can you recall a time when your eating issue caused a problem?" "What good things could happen if you changed your food habits?" • Explore availability of support networks • Ask how life would be different for the client and family • Explore small achievable steps to make a change • "What will happen if you do not make any changes in the way you eat?" • Give positive feedback about client's abilities • Imagine the future: "If you decided to change your food habits, what changes would you make?"
Preparation		
"I will" Intends to change within the next thirty days, may have made small changes	Resolution of ambivalence, firm commitment, and development of a specific action plan	• Discuss and resolve barriers to change • Help client to set achievable goals • Remove cues for undesirable behavior • Reinforce small changes that client may have already achieved. State that small goals lead to success. • Encourage participation in support groups • Encourage client to make public the intended change
Action		
"I am" Actively engaged in behavior change for less than six months	Collaborative, tailored plans, behavioral skills training, and social support.	• Develop or refer to education program to include self-management skills • Cultivate social support • Reinforce self-confidence • Consider reward possibilities • Remove cues for undesirable behaviors and add cues for desirable ones • Explore cognitive restructuring
Maintenance		
"I still am" Engaged in the new behavior for at least six months	Collaborative, tailored revisions, problem-solving skills, and social and environmental support.	• Identify and plan for potential difficulties (for example, maintaining dietary changes on vacation) • Collect information about local resources (for example, support groups, shopping guides) • Encourage client to "recycle" if a lapse or relapse occurs • Recommend more challenging dietary changes if client is motivated

Sources: Journal of the Academy of Nutrition and Dietetics, 99:683, Kristal A.R., Glanz K., Curry S.J., Patterson R.E., How can stages of change be best used in dietary interventions?; International Food Information Council Foundation. 2014 Food & Health Survey: Behavior Change Consumer Profiles. https://www.foodinsight.org/

Personal testimonials, media campaigns and stories, and role playing can move people emotionally.
- Environmental Reevaluation (Notice effect on others): Realization regarding the impact of an unhealthy behavior on others can encourage change. For example, a parent's recognition that a harmful eating practice is a bad role model for a child could stimulate a commitment to change. Empathy training, documentaries, or testimonials can encourage reevaluation of an unhealthy behavior.
- Self-Reevaluation (Create a new self-image): Emotional (feeling) and cognitive (reasoning) self-appraisal of how a healthy behavior fits into an individual's self-image. Values clarification activities, healthy role models, or imagery can encourage reassessment of a desired image.
- Social Liberation (Notice public support): Awareness of social support or advocacy for healthy opportunities encourage adopting a new behavior. Social support could include salad bars, calorie data on menus, or neighborhood walking paths.

Behavioral Processes

- Self-Liberation (Make a commitment): Individuals believe a new behavior can be attained and make a firm commitment to change. New Year's resolutions, public testimonies, writing a plan, and making a choice among several options can increase commitment to change.
- Counter Conditioning (Use substitutes): Replace unhealthy behaviors with healthier alternatives. Relaxation techniques can offset stress, advocacy can counter peer pressure, and positive self-statements can replace demoralizing self-talk.
- Helping Relationships (Get support): Counselors as well as a positive social network can give emotional support during attempts to change a problem behavior. Phone calls, emails, text messages, online support groups, group counseling, and a buddy system can be beneficial.
- Reinforcement Management (Use rewards): Rewards from self or others can be an incentive to change an unhealthy behavior. Contingency contracts, group recognition, and positive self-talk can provide positive reinforcement.
- Stimulus Control (Manage your environment): Change the environment to alter the prompts that encourage the unhealthy behavior and add reminders to engage in the healthy behavior. Possible strategies include removing unhealthy food from sight or possibly the home, providing easily seen tasty and healthy options, and participation in self-help groups.

Decisional Balance

In the TTM, part of the decision to move from stage to stage is based on a client's view of the pros and cons of making a behavior change. Pros are considered an individual's beliefs about the anticipated benefits of changing (for example, eating vegetables will decrease cancer risk). Cons are the costs of behavior change, which can include undesirable taste; inconvenience; and monetary, physical, or psychological costs. A shift in the balance of the two will contribute to advancing or backsliding.[14,16] In the precontemplation stage, cons clearly outweigh pros, resulting in a decision to not change an unhealthy food habit. For individuals in this stage, pros need to increase twice as much as the cons for an individual to move to the next stage. In the contemplation stage, pros and cons tend to balance each other, reflecting the ambivalence and confusion individuals experience at this stage. As individuals progress from preparation through maintenance, the pros increase and the cons decrease.

Self-Efficacy

Research indicates that self-efficacy tends to decrease between the precontemplation and contemplation stages, most likely due to an optimistic bias possessed by individuals in the precontemplation stage. Individuals in the contemplation stage may begin to realize the challenges of adopting a new behavior, which may be seen as daunting. As individuals progress through the action and maintenance stages, self-efficacy gradually increases.[17]

2.5 Using the Transtheoretical Model for Research and to Measure Outcomes

The TTM has been used by researchers to design dietary behavior investigations[18] and outcomes of interventions.[19] By tracking movement through various stages, the TTM has given nutrition counselors a tool for measuring outcomes. For example, counselors should consider their intervention successful if a client has moved from "I do not need to make a change" to "Maybe I should give some thought to a change." This measure of success may provide encouragement to health professionals who become discouraged with the slow pace of change.[20]

Application of the Transtheoretical Model

The Diabetes Stages of Change (DiSC) was a program administered in Canada using the Transtheoretical Model as a guide to design and implement a twelve-month intervention to improve self-care and improve diabetes control in 1,029 individuals with type 1 or type 2 diabetes.[21] Participants were in one of three levels of pre-action motivation groups: precontemplation, contemplation, or

preparation for self-monitoring of blood glucose, healthy eating, or smoking cessation. Participants were given usual care or a tailored intervention based on their stage of change called Pathways to Change, which included personalized assessment reports, self-help manuals, newsletters, and individual phone conversations using stage-appropriate counseling strategies. Participants who received the Pathways to Change intervention as compared to usual care showed significant movement to action or maintenance stage for improving their diets by decreasing fat intake and increasing fruits and vegetables. They also had better control of their diabetes as indicated by blood glucose measures.

Exercise 2.3 Match Intervention Strategy with Stage of Change

You are hired by the corporate wellness director to design a nutrition intervention promoting intake of calcium-rich foods with the goal of consuming at least 1000 mg of calcium per day. A needs assessment of middle-aged female employees found they were in precontemplation, contemplation, and action stages. Review the following behavior change strategies below and indicate which approach best meets the needs for individuals in each stage.

1. Provide coupons, recipes, cooking demonstrations.
2. Offer a self-assessment quiz to compare individual frequency of consumption of calcium-rich foods against a standard. Supply free samples of non-dairy sources of calcium.
3. Display vivid posters and distribute flyers about the importance of calcium to reduce the risk of developing osteoporosis.

2.6 Theory of Planned Behavior

In the Theory of Planned Behavior (TPB), originally known as the Theory of Reasoned Action,[22,23] an individual's health behavior is directly influenced by intention to engage in that behavior ("In the upcoming week, I intend to read labels for sodium content."). As indicated in Figure 2.3, three factors affecting behavioral intention include attitude, subjective norm, and perceived behavioral control.

- *Attitudes* are favorable or unfavorable evaluations about a given behavior. They are strongly influenced by our beliefs about the outcomes of our actions (outcome beliefs) and how important these outcomes are to the client (evaluations of outcomes). For example, "eating whole grain foods will increase my energy levels" and "having high energy levels is extremely important to me."
- *Subjective norm* or perceived social pressure reflects beliefs about whether significant others approve or disapprove of the behavior. Subjective norms are determined by two factors: normative beliefs and motivation to comply. Normative beliefs are the strength of our beliefs that significant people approve or disapprove of the behavior. For example, significant family members may want a client to eat less salt. Motivation to comply is the strength of our desire to comply with the opinion of significant others. For example, how much does the client want to comply with family members' recommendation to eat less salt?
- *Perceived behavioral control* is an overall measure of an individual's perceived control over the behavior, such as, "What is your overall perception of control in purchasing healthy food?" Control beliefs are influenced by presence or absence of resources

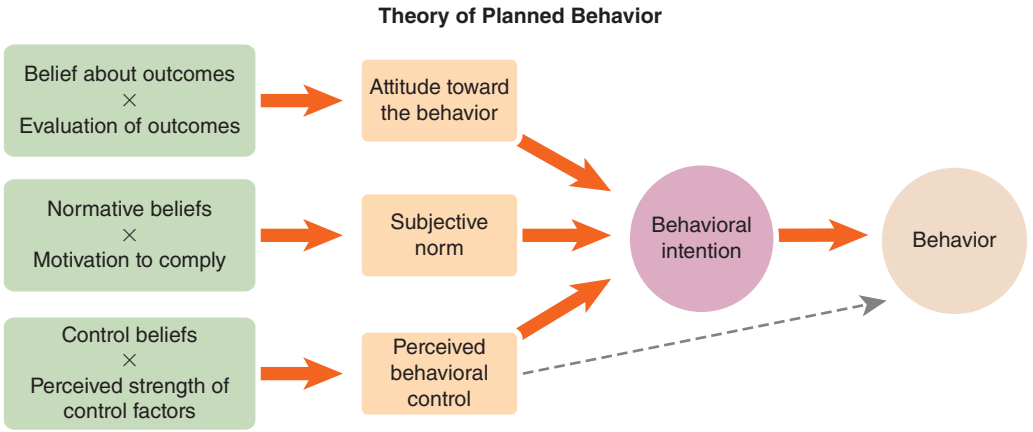

Figure 2.3 Theory of Planned Behavior Diagram
Source: Adapted from Figure 6.1, page 98, *Health Behavior and Health EducationTheory, Research, and Practice*, 5th ed. Karen Glanz, Barbara K. Rimer, and K. Viswanath, Eds., San Francisco, CA: Jossey-Bass; 2015.

supporting or impeding behavioral performance. For example, a supportive resource may include family members ("My wife always cooks without salt.") and barriers may include social or physical environmental factors ("My company provides lunch free of charge. If I want a low sodium lunch, I will not be able to eat most of the meals."). Control factors can be internal factors, such as skills and abilities, or external factors, such as social or physical environmental factors. The impact of each resource to facilitate or impede the desired behavior is referred to as perceived power of the variable.

Application of the Theory of Planned Behavior

The TPB was used in a study to investigate the intention of dietitians to promote whole-grain foods.[24] Intention was measured assessing likelihood of encouraging consumption of whole-grain foods in the next month. Attitude was evaluated by the likelihood that intake of whole-grain foods would result in health benefits for clients. Subjective normative beliefs were based on the belief that other health professionals thought they should promote whole-grain foods and their motivation to comply with health professionals' opinions. Perceived behavioral control was evaluated by measuring barriers to promotion and assessing knowledge and self-efficacy for promotion of whole-grain foods. Results indicated that attitude for promotion of whole-grain foods was high, as well as the belief that other health professionals wanted them to promote these foods and a majority of study participants wanted to comply with this subjective normative belief. Perceived control (self-efficacy and barriers, including knowledge) was low, indicating a need for continuing education for dietitians regarding promotion of whole-grain foods.

Exercise 2.4 Evaluation of a Desired Behavior Change Using the Theory of Planned Behavior

Think of a behavior you are trying to change and analyze it according to the Theory of Planned Behavior constructs. Describe the behavior you wish to change.
Circle your responses to the questionnaire and answer the following questions in your journal.

1. What is your attitude toward the behavior?
2. How do significant others feel about your possible change?
3. Do people in your social circles approve or disapprove of your adoption of the behavior?
4. What factors could help you perform the new behavior?
5. Describe the internal and/or external barriers to adopting the new behavior.
6. Evaluate the three components affecting behavioral intention (attitude, subjective norm, and perceived behavioral control) for your intended behavior change. Choose one of the three that is the most influential and explain why.

Intention: Indicate your level of intention (motivation) to change the behavior in the upcoming week.	Very unlikely	Unlikely	Unsure	Likely	Very likely
Attitude: What is your attitude toward the behavior change?	Extreme dislike	Dislike	Neutral	Enjoyable	Very enjoyable
Attitude: What do you feel about the outcomes of the new behavior?	Extreme dislike	Dislike	Neutral	Enjoyable	Very enjoyable
Normative Beliefs: Do significant others think you should change the behavior?	Highly unlikely	Unlikely	Unsure	Likely	Highly likely
Motivation to Comply: How likely are you to comply with significant others' opinions?	Highly unlikely	Unlikely	Unsure	Likely	Highly likely
Perceived Behavioral Control: What is your overall perception of control over the behavior?	Totally not under my control	Not under my control	Unsure	Under my control	Totally under my control

2.7 Social Cognitive Theory

The Social Cognitive Theory (SCT),[2] formerly known as the Social Learning Theory, provides a basis for understanding and predicting behavior, explaining the process of learning, and designing behavior change interventions. See Figure 2.4 and Table 2.4 for a summary of the components of this theory. In this theory, there is a dynamic interaction of personal factors, behavior, and the environment with a change in one capable of influencing the others (known as reciprocal determinism). For example, a change in the environment (husband develops high blood pressure) produces a change in the individual (motivation to learn about food choices to help husband) and a change in behavior (increase intake of fruits and vegetables). Key personal factors can include values and beliefs regarding outcomes of a behavior change and self-efficacy. Behavior change may occur by observing and modeling

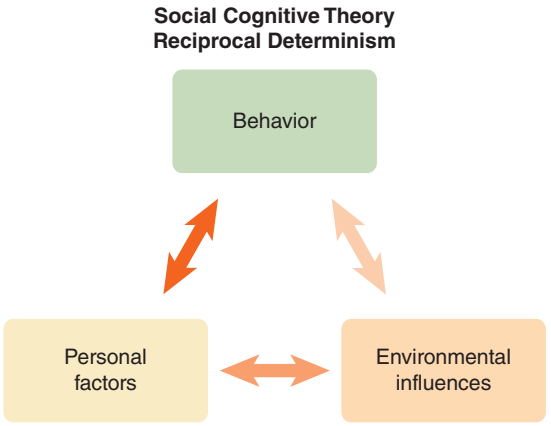

Figure 2.4 Reciprocal Determinism, Social Cognitive Theory

Source: Adapted from Pajares (2002). *Self-efficacy beliefs in academic contexts: An outline.* Retrieved April 20, 2019, from http://des.emory.edu/mfp/efftalk.html

Table 2.4 Social Cognitive Theory Concepts and Intervention Strategies

Concept	Definition	Implications for Interventions
Reciprocal determinism	Dynamic interaction of the person, behavior, and the environment	• Consider multiple behavior change strategies • Motivational interviewing • Social support • Behavioral therapy (for example, self-monitoring, stimulus control) • Change environment
Outcome expectations	Beliefs about the likelihood and value of the consequences of behavioral choices	• Provide taste tests • Educate about health implications of food behavior
Self-regulation (control)	Personal regulation of goal-directed behavior or performance	• Provide opportunities for decision-making, self-monitoring, goal setting, problem solving, and self-reward • Stimulus control
Behavioral capacity	Knowledge and skill to perform a given behavior	• Provide comprehensive education, such as cooking classes • Show clients how to properly shop to meet their personal nutritional goals
Expectations	A person's beliefs about the likely outcomes of a behavior	• Motivational interviewing • Model positive outcomes of diet and exercise
Self-efficacy	Beliefs about personal ability to perform behaviors that lead to desired outcomes	• Skill development training and demonstrations • Small, incremental goals and behavioral contracting • Social modeling • Verbal persuasion, encouragement • Improving physical and emotional states

(continued)

Table 2.4 Social Cognitive Theory Concepts and Intervention Strategies *(continued)*

Concept	Definition	Implications for Interventions
Observational learning	Behavior acquisition that occurs by watching the actions and outcomes of others' behavior, and media influences	• Demonstrations • Provide credible role models, such as teen celebrities who practice good health behaviors • Group problem-solving session
Reinforcement	Responses to a person's behavior that increase the likelihood of its recurrence	• Affirm accomplishments • Encourage self-initiated rewards and incentives • Offer gift certificates or coupons
Facilitation	Providing tools, resources, or environmental changes that make new behaviors easier to perform	• Alter environment • Provide food, equipment, and transportation

Source: Adapted from Baranowski T., Parcel G.S. *How Individuals, Environments, and Health Behavior Interact: Social Learning Theory, in Health Behavior and Health Education-Theory, Research, and Practice*, 3rd ed. K. Glanz, F. M. Lewis, and B. K. Rimer, eds. (San Francisco: Jossey-Bass; 2002) Copyright 2002 by Jossey-Bass, Inc., Publishers. Used with permission.

behaviors and using self-regulating behavior change techniques such as journaling or goal setting. Environmental changes may include buying new cooking equipment or altering types of food available in the home.

Application of the Social Cognitive Theory (SCT)

A guided goal-setting intervention called EatFit using computer technology with middle school adolescents in various school and community settings used constructs of the SCT to improve eating and fitness choices.[25,26] This program was developed by the Expanded Food and Nutrition Education Program administered by the University of California, Davis, and received a Dannon Institute Award of Excellence in Community Nutrition. This intervention started with students selecting one of six possible dietary goals and one of four physical activity options. These goals were reinforced through nine experiential lessons that focused on a variety of healthy behaviors. Many of the SCT constructs were used in the intervention, but the three guiding constructs included the following:

- Self-efficacy was enhanced by many skill-building activities, such as reading food labels, verbal encouragement, and utilization of social modeling by interviewing their parents about goal-setting experiences.
- Self-regulation was implemented by self-assessments.
- Outcome expectancies were addressed by matching goals with adolescent desired outcomes predetermined by focus group sessions with adolescents before the onset of the intervention. These outcome expectancies included improved appearance, increased energy, and increased independence.

Exercise 2.5 Using Social Cognitive Constructs

Interview an individual in your social circle regarding an experience with goal setting. How did the process work out for your friend or relative? What barriers and hurdles needed to be overcome? Write your answers in your journal.

2.8 Cognitive-Behavioral Therapy

Cognitive-behavioral therapy (CBT) incorporates components of cognitive therapies and behavior therapy and includes a wide range of treatment approaches.[27] Both are based on the assumption that behavior is learned, and by altering the environment or internal factors, new behavior patterns develop. Many therapists use a combination of the two therapies and refer to themselves as cognitive-behavioral therapists, even if they rely more on one than on the other. An Academy of Nutrition and Dietetics expert panel analysis of the usefulness of nutrition counseling theoretical approaches for changing health and food behavior gave CBT high marks.[28] The following provides a discussion of each approach.

Cognitive Therapies

Leaders in this field include Albert Ellis, who developed *rational emotive behavior therapy* (REBT)[29,30]; Aaron T. Beck, who developed *cognitive therapy* (CT)[31,32]; and Donald Meichenbaum,[33] who developed *cognitive-behavior modification*. The premise of this approach is that negative

self-talk and irrational ideas are self-defeating learned behaviors and the most frequent source of people's emotional problems. Clients learn to distinguish between thoughts and feelings, become aware of ways in which their thoughts influence feelings, critically analyze the validity of their thoughts, and develop skills to interrupt and change harmful thinking.[34] Clients are taught that harmful self-monologues should be identified, eliminated, and replaced with productive self-talk. By influencing a person's pattern of thinking, the person's feelings and actions are modified. An example of an individual with a high cholesterol level using negative self-talk and creating an emotional turmoil for herself would be, "I am a fool for eating that cheesecake. I have no self-control. I'll just die of a heart attack." This could be changed into better coping self-talk: "I am learning how to handle these situations. Next time I will ask for a small taste. I am on the road to a healthier lifestyle."

Cognitive therapists have developed a number of techniques to improve positive feelings and help problem-solving ability. These include relaxation training and therapy, mental imagery, thought stopping, meditation, biofeedback, stress management, social support, cognitive restructuring, and systematic desensitization. See Chapter 6 for elaboration on several of the strategies.

Anecdote

In the cardiac rehabilitation center where I worked, there was a client whose quality of life was severely affected by his weight. He was working as a security guard and had difficulty climbing steps or walking any reasonable distance because of his weight and his need to lug an oxygen tank. After several months of trying a variety of intervention strategies, I asked him whether he had ever been on a diet that worked. He said the only time he lost weight was when he cut bread out of his diet. We set "no more bread" as a goal, and that was the beginning of a successful weight loss program that allowed grains in other forms, such as cereal, pasta, and rice.

Behavioral Therapy

Behavioral counseling evolved from behavioral theories developed by Ivan Pavlov, B. F. Skinner, Joseph Wolpe, Edward Thorndike, and Albert Bandura.[35,36] The premise of this type of counseling is that many behaviors are learned, so it is possible to learn new ones. The focus is not on maintaining willpower but on creating an environment conducive to acquiring new behaviors. Three approaches to learning form the basis for behavior modification:

1. **Classical conditioning** focuses on antecedents (stimuli, cues) that affect food behavior. For example, seeing or smelling food, watching television, studying, or experiencing boredom may be a stimulus to eat. In nutrition counseling, clients may be encouraged to identify and eliminate cues, such as removing the cookie jar from the kitchen counter.
2. **Operant conditioning** is based on the law of effect, which states that behaviors can be changed by their positive or negative effect. In nutrition counseling, generally a positive approach to conditioning is applied, such as a reward for obtaining a goal. The change in diet itself can be the reward, as in the alleviation of constipation by an increased intake of fluids and fiber.
3. **Modeling** is observational learning, such as learning by watching a video or demonstration, observing an associate, or hearing a success story.

Counseling strategies that incorporate several of these approaches include goal setting, self-monitoring, and relapse prevention. See Chapter 6 for explanations and implementations of these strategies.

Application of Cognitive-Behavioral Therapy

Cognitive-behavior (CB) strategies were used in a twelve-week study to help seventy-nine subjects who had metabolic syndrome to follow a Mediterranean diet.[37] The CB strategies included anger management, problem solving, stimulus control, impulsivity control, cognitive restructuring, stress management, and social support. As compared to the control group, the intervention group decreased waist circumference, improved triglyceride levels, and adhered to a Mediterranean diet.

2.9 Solution-Focused Therapy

Insoo Kim Berg developed solution-focused therapy, and Steve de Shazer[38] brought the topic to international attention. Solution-focused therapists work with their clients to concentrate on solutions that have worked for them in the past and identify strengths to be expanded on and used as resources. Focus of sessions is not on discovering and solving problems but may well be an exception to the normal course of action—that is, the one time the client was able to positively cope. By investigating the accomplishment, no matter how small, adaptive strategies are likely to emerge. For example, a middle-aged executive who complains that business lunches and dinners are a frequent difficulty would be asked to think of an occasion when healthy food was consumed at one of these meals. After identifying the skills the executive used to make the meal a healthy experience, the

Exercise 2.6 Focus on Continuing

Think about what occurs in your life (such as relationships, habits, and activities) that you would like to continue to happen. Record two of these in your journal and identify what skills you have that facilitate these situations to exist.

Source: de Shazer S., *Keys to Solution in Brief Therapy* (New York: Norton; 1985).

nutrition counselor would focus on helping to replicate and expand those skills. The aim is for clients to use solution-oriented language—to speak about what they can do differently, what resources they possess, and what they have done in the past that worked. Language (solution-talk) provides the guide in solution-focused therapy. Examples of questions a solution-focused counselor may ask include the following:

- What can I do that would be helpful to you?
- Was there a time when you ate a whole-grain food?
- When was the last time you ate fruit?
- Has a family member or friend ever encouraged you to eat low-sodium foods?

2.10 Client-Centered Counseling

Carl Rogers was the founder of client-centered counseling, also referred to as "nondirective" or "person-centered."[39] The basic assumption in this theory of counseling is that humans are basically rational, socialized, and realistic, and that there is an inherent tendency to strive toward growth, self-actualization, and self-direction. Clients actively participate in clarifying needs and exploring potential solutions.[40] They realize their potential for growth in an environment of unconditional positive self-regard. Counselors help develop this environment by totally accepting clients without passing judgments on their thoughts, behavior, or physique. This approach includes respecting clients, regardless of whether they have followed medical and counseling advice.

Total acceptance needs to be communicated both verbally and nonverbally for a level of trust to develop in which clients feel comfortable to express their thoughts freely. This portion of the theory has special meaning for nutrition counselors. A study of nutrition professionals' perceptions and attitudes toward overweight clients indicates a need for training in sensitivity and empathy.[41] Another important component of this approach for a nutrition counselor is the underlying assumption that simply listening to information cannot help a client. In client-centered therapy, clients discover within themselves the capacity to use the relationship to change and grow, thereby promoting wellness and independence. Listening to a client's story has been compared to the role of a pharmacologic agent, meaning there is great value in developing an open and trusting relationship with a client.[42] Nutrition counselors should not lose sight of the fact that the educational component of dietary therapy has been shown to be extremely valuable.[43] However, person-centered theory of counseling can help guide nutrition counselors by stressing the importance of respect and acceptance for developing a counseling relationship.

Anecdote

When I started working for the WIC Program, I worried that I might have trouble totally accepting an unmarried client who was pregnant or had a baby. I enjoyed working with my WIC clients and they taught me to move past my biases.

2.11 Motivational Interviewing

A major factor for backsliding on the readiness continuum is lack of motivation (that is, eagerness to change). Motivational interviewing (MI) is an approach to counseling that integrates client-centered counseling and complements the Transtheoretical Model (TTM) because it entails a focus on strategies to help motivate clients to build commitment to make a behavior change and move toward the action stage. Miller and Rollnick,[4] founders of MI, provide the following definition: "a collaborative conversation style for strengthening a person's own motivation and commitment to change" (p. 12). As compared to client-centered counseling, MI is more focused and goal directed. As compared to the TTM, MI is not a comprehensive theory of change.

In MI, motivation is not viewed as a personality trait or a defense mechanism but is considered a state of readiness to change that can alter and be influenced by others. Since counselors can impact motivation, to do so is considered an inherent part of their intervention responsibility. MI is particularly useful in the early stages of behavior change when there is a great deal of ambivalence about making a decision to change.[44] If a client has clearly indicated a desire to change behavior, spending precious counseling time exploring ambivalence would probably be frustrating and as a result counterproductive.

MI works to cultivate a client's natural motivation for change (intrinsic).[4] Motivation can come from coerced external forces ("Lose weight or you can't be in my wedding.") or intrinsic (internal) due to specific values ("I want to be able to be a good role model for

Table 2.5 Overview of What Is Motivational

1. Knowledge of consequences
2. Self-efficacy
3. A perception that a course of action has been chosen freely
4. Self-analysis (giving arguments for change)
5. Recognition of a discrepancy between present condition and desirable state of being
6. Social support
7. Feelings accepted

my children.").[45] Even if perceived self-efficacy and competence are the same, if motivation originates from internal beliefs and values, there will be enhanced performance, persistence, and creativity to accomplish the task. An overview of factors usually found to be motivational can be found in Table 2.5.

Spirit of Motivational Interviewing

The communication style of the counselor greatly influences the outcomes of a counseling session. In the third edition of Millner and Rollnick's book, *Motivational Interviewing*, less emphasis was placed on techniques and more attention was put on the underlying spirit of MI. Inherent in the spirit is the need for counselors to resist the righting reflex. Counselors may want to make things right because of a desire to help others lead healthier lives. If a client is ambivalent about change, he or she has a good argument for both changing and not changing. Your natural reaction may be to "right off the bat" set things straight and provide all the reasons for changing an established food pattern. For example, a counselor may tell an ambivalent client, "You should eat breakfast. You will have more energy throughout the day, be more focused in your work and have better control of your appetite all day. Successful dieters typically eat breakfast." This is good advice, and when and how to give advice will be reviewed in Chapter 3. However, an ambivalent client is likely to respond with all the reasons the good advice will not work. This scenario is not likely to produce a good outcome. If your client is giving arguments for not changing, your interaction is building commitment to *not* change. More arguments for change on your part will likely interfere with the counseling relationship. You and your client will feel as if you are wrestling. Addressing the interrelated elements of the spirit of MI will help you achieve the type of interaction with clients that encourages behavior change. These include partnership, acceptance, compassion, and evocation.[46]

- *Partnership:* A collaborative approach in the search for ways to achieve behavior change is essential for the motivational interviewing process. The counseling experience is described as a dance rather than a wrestling match. The expertise of both the counselor and the client is respected. The counselor brings a wealth of knowledge and experience, and the client is the expert on past experiences, influencing pressures, and personal beliefs and values. The counselor appears curious during interactions with a client while exploring various angles of behavior change.
- *Acceptance:* Components of acceptance include absolute worth, affirmation, autonomy, and accurate empathy. Absolute worth refers to understanding that everyone's dignity is the same, thereby creating a counseling relationship in which clients are more likely to be open and honest regarding their issues. Affirmation is pointing out specific skills a client already possesses, giving a confidence boost that behavior change is possible. Autonomy recognizes that decisions to change always need to come from the client. The counselor creates an atmosphere where clients understand that they are not reacting to the force of any other person (such as counselor, parent, or doctor) but have chosen to make changes based on their own beliefs and values. Counselors demonstrate accurate empathy by taking an active interest in their clients and attempting to understand their perspective. The underlying assumption of expressing empathy is acceptance, and acceptance facilitates change. This does not mean that a counselor has the same perspective or would have made similar choices. However, basic acceptance ("You are OK") creates an environment for change.[4] A message of "You are *not* OK" creates resistance to change. In MI, clients are invited to explore conflicts. Unless a counselor communicates with empathy, clients are not likely to feel safe revealing discrepancies between their behavior and their beliefs and values. Empathy responses are further explored in Chapter 3.
- *Compassion:* This component of the spirit of MI involves genuine concern for the suffering of others. Clients feel worthy when counselors value their well-being. If a counselor is focusing on self-gain such as feeling the need to have a client sign up for additional sessions, the counselor is not likely to appear genuine.

Table 2.6 Possible Affirmations to Use With Clients

Accepting	Committed	Flexible	Persevering	Stubborn
Active	Competent	Focused	Persistent	Thankful
Adaptable	Concerned	Forgiving	Positive	Thorough
Adventuresome	Confident	Forward-looking	Powerful	Thoughtful
Affectionate	Considerate	Free	Prayerful	Tough
Affirmative	Courageous	Happy	Quick	Trusting
Alert	Creative	Healthy	Reasonable	Trustworthy
Alive	Decisive	Hopeful	Receptive	Truthful
Ambitious	Dedicated	Imaginative	Relaxed	Understanding
Anchored	Determined	Ingenious	Reliable	Unique
Assertive	Die-hard	Intelligent	Resourceful	Unstoppable
Assured	Diligent	Knowledgeable	Responsible	Vigorous
Attentive	Doer	Loving	Sensible	Visionary
Bold	Eager	Mature	Skillful	Whole
Brave	Earnest	Open	Solid	Willing
Bright	Effective	Optimistic	Spiritual	Winning
Capable	Energetic	Orderly	Stable	Wise
Careful	Experienced	Organized	Steady	Worthy
Cheerful	Faithful	Patient	Straight	Zealous
Clever	Fearless	Perceptive	Strong	Zestful

"Some Characterestics of Successful Changes" is in the public domain and may be reproduced and adapted without further permission. This list, complied by Shelby Steem, is from Miller, W.R. (Ed.). (2004). Combined behavioral intervention: A clinical research guide for therapists treating individuals with alcohol abuse and dependence (COMBINE Mocograph Serber, Vol. 1). Bethesda, MD: National Institute on Alchohol Abuse and Alcoholism.

- *Evocation:* In MI there is a basic assumption that individuals have an intrinsic desire to do what is truly important to them, and the counselor's responsibility is to facilitate clients to evoke that motivation (evocation) and to bring about change. Spending counseling time trying to convince a client to change or too much time educating a client will not likely lead to clients talking themselves into changing.

Exercise 2.7 Practice Formulating an Affirmation

Review the characteristics of successful changers in Table 2.6. Work with a colleague. Ask the partner to tell you a story about a time when he or she was successful. As the counselor your body language and tone of voice should indicate interest and curiosity. When your colleague has finished the story, you should voice an affirmation. The affirmation should begin with *you*, not *I*. For example, "You are someone who is…" or "You value…"

In your journal, describe your experience with formulating an affirmation.

Source: Adapted from an exercise described in *Building Motivational Interviewing Skills*, 2nd ed., 2018, by David B. Rosengren.

Core Counseling Skills of Motivational Interviewing: OARS

MI relies on basic counseling skills, such as those found in Table 2.7, to encourage clients to make a decision to change. Four skills are found to be the most useful for MI and can be remembered with the acronym OARS: open-ended questions, affirmations, reflective listening, and summaries.

- **Open-ended questions:** Open-ended questions are used to explore and gather information from the client's perspective, usually begin with the words *what*, *how*, or *tell me*, and tend to elicit change talk. They are questions that are not likely to be answered with a yes or no or a few words. To use these effectively, your approach must communicate curiosity, concern, and respect. You should not appear to be conducting an inquisition to gather information against your client. These types of questions are covered in more detail in Chapter 3, but the following have been found to be particularly useful for MI:
  - ❏ Ask about the pros and the cons of the client's present eating pattern and the contemplated change.
  - ❏ Ask about extremes related to the problem. For example, "What worries you the most?"
  - ❏ Ask the client to envision the future after the change has been accomplished. "How would life be different after this change?"
  - ❏ Ask about priorities in life (that is, what is most important to the client). Then ask how the contemplated behavior change fits into the hierarchy.
- **Affirmations:** Affirmations recognize client efforts and strengths and provide another source of motivation. Pointing out a job well done or persistence in the face of numerous obstacles reminds clients that they possess inner qualities that make behavior change possible. Rosengren[47] suggests that affirmations should focus on specific behaviors, avoid use of the word I, and highlight nonproblem areas. For example, "You are providing a healthy food environment in your home," rather than, "I am happy you decided not to buy soda anymore." See Table 2.6 for words listing characteristics of people who are successful changers and can assist you in formulating an affirmation. Also, affirmations can come from your clients by asking them to describe their strengths, past successes, and best efforts.
- **Reflective listening:** Reflective listening is a key skill in MI and entails using basic listening skills, interpreting the heart of your client's message, and reflecting the interpretation back to your client. By acting as a mirror and reflecting back your understanding of the intent or your interpretation of the underlying meaning, clients are encouraged to keep talking. This show of interest is an expression of empathy, creating an environment for self-exploration about the challenges of making a behavior change. You also have the opportunity to select what you would like to reinforce. The following dialogue illustrates a nutrition counselor listening reflectively and attempting to identify the underlying meaning of a client's statements:
- **Summaries:** Summaries are done periodically throughout an MI session to help organize thoughts, reinforce change talk, clarify discrepancies, provide links during the session, or transition to a new topic. The technique will be covered at greater length in Chapter 3.

Client: ***Everyone is getting on my back about my cholesterol level—my wife, my doctor, my brother. I guess I have to do something about my diet.***

Counselor: ***You're feeling harassed that other people are pushing you to change the way you eat.***

Table 2.7 General Motivational Interviewing Counseling Strategies

- Encourage clients to make their own appraisals of the benefits and losses of an intended change.
- Do not rush clients into decision-making.
- Describe what other clients have done in similar situations.
- Give well-timed advice emphasizing that the client is the best judge of what can work.
- Provide information in a neutral, non-personal manner.
- Do not tell clients how they should feel about a medical or dietary assessment.
- Present choices.
- Clarify goals.
- Failure to reach a decision to change is not a failed consultation.
- Make sure clients understand that resolutions to change break down.
- Expect commitment to change to fluctuate, and empathize with the client's predicament.

Client: ***I suppose they're right, but I feel fine.***

Counselor: ***You're worried about the future.***

Client: ***Yeah. I have a lot of responsibilities. I have two children, and I want to be around to take care of them, see them grow up, and get married. But it doesn't thrill me to give up meatballs and pizza.***

Counselor: ***You're wondering about what food habits you are willing to change.***

Client: ***You know, I wouldn't mind eating more fish. I've heard that is a good food to eat to lower cholesterol levels. What do you think about oatmeal?***

Note that the formulation of a response is an active process. You must decide what to reflect and what to ignore. In this dialogue example, the counselor chose to respond to the client's statement "I suppose they're right" rather than "I feel fine." The counselor guessed that if the client thought all those others were right, then he must be worried about his health. If the counselor had chosen to reflect on the feeling-fine part of the client's second statement, what would have happened? We can only guess, but it doesn't seem likely that a client-initiated discussion of diet changes would have occurred so quickly. To respond reflectively is particularly useful after asking an open-ended question when you are trying to better understand your client's story. Reflective responses are also reviewed in Chapter 3.

The development of reflective listening skills can be a complex task for novice counselors.[48] If this is a skill you decide to develop, explore the motivational interviewing resources at the end of this chapter and consider attending motivational interviewing workshops.

Processes in Motivational Interviewing

In the past Miller and Rollnick provided phases and guiding principles to help practitioners to implement motivational interviewing. In their third edition of *Motivational Interviewing*, they describe four broad processes: engaging, focusing, evoking, and planning to provide structure for using MI. Although these steps appear to be linear, they are not distinct processes. An adept counselor will move back or forward as needed.

- **Engaging:** Miller and Rollnick[4] define engaging as "the process of establishing a mutually trusting and respectful helping relationship" (p. 40). This is accomplished by showing warmth, appearing curious, and using nonthreatening, open-ended questions. The counselor listens carefully to understand the client's story and uses reflective listening to demonstrate that what the client has to say is important to the counselor. During the engaging process, the reason for the client's visit should be established, the counselor should provide an overview of what to expect, and the counselor should ask permission to explore the client's thoughts and feelings about a possible change, such as, "Is it OK if we talk about possible food changes to help lower your high cholesterol levels today?"[46]
- **Focusing:** In the second process, the goal is to develop a clear direction that allows development of achievable goals. The counselor invites the client to focus on a topic for the session. For a new diagnosis, the client may have no idea where to begin, and in that case the counselor should offer several options. The following questions can help select a focus:

  "Which of the options would you like to work on first?"

  "You have mentioned several concerns this afternoon, which one would you like to cover today?"

- **Evoking:** Once there is a focus on a particular change, the counselor elicits the client's ideas and feelings about why and how the change can occur. Counselors assess readiness to change, explore ambivalence if there is not a clear commitment to change, and evoke language from the client about change. When exploring ambivalence, client responses usually fall into two categories: *change talk* or *sustain talk*. "Change talk is any self-expressed language that is an argument for change"[4] (p. 159). Early stages of change talk often fall into the category of preparatory and can be remembered with the acronym DARN, referring to desire, ability, reasons, and need statements. These statements indicate the client is thinking about a change but is not making a solid commitment. See Table 2.8. Mobilizing change talk statements clearly expresses or implies action to change behavior. These statements indicate that the client is resolving ambivalence and can be remembered with the acronym CATS, referring to commitment, activation, and taking steps. Research has shown that the type and amount of change talk a client engages in predicts whether a client will make the behavior change. Furthermore, research also shows that counselor behavior influences change talk.[47]

  Sustain talk is about talking ourselves into continuing the current behavior, and change is unlikely to occur. Sustain talk parallels change talk as when a client expresses a desire, ability, reason, or

Table 2.8 Categories of Change Talk

Preparatory Change Talk (DARN): Client expresses motivations for change without stating or implying specific intent or commitment to make a change.
Desire: Statements regarding preference for change. • I **want** to lose weight. • I **would like** to lose weight. • I **wish** I could lose weight. • I **hope** to lose weight.
Ability: Statements about self-perceived ability. • I **might be able to** drink less soda. • I **could** drink less soda. • I **didn't always** drink soda.
Reasons: Statements about the benefits of change. Describes a specific if–then motive for change. • If my blood sugars were better controlled, then I would feel better. • Eating more vegetables **would be better** for my health.
Need: Statements expressing an imperative for change without specifying a particular reason. • I **need to** eat more fruit. • I **ought to** eat whole grains. • I **have to** start keeping food records.
Mobilizing Change Talk (CAT): Client expresses or implies action to change.
Commitment: Statements reflect a clear intention to change. • I am **going to** start exercising. • I **will** use a meditation tape tonight. • I **plan** to eat a salad at lunch or dinner every day.
Activation: Statements signal a movement toward change. • **I am ready** to change my eating behavior. • **I am willing** to try whole grains.
Taking Steps: Statements describe an action already taken toward change. • This week **I started** keeping food records. • **I am not** eating after 8:00 p.m.

need to keep performing the undesirable behavior. For example, "I don't want to eat vegetables. I do not think there is any way to make vegetables taste good. Eating vegetables makes me nauseous. I need to drink cola throughout the day." These statements indicate a need to continue the status quo. If these comments are mixed with change talk statements, the fact that the client is ambivalent will be clear. Also a client may be making statements indicating behavior change is possible, but their body language may indicate something different. In that case, the counselor will need to inquire regarding degree of importance, confidence, or readiness to make a change. See the next session, Evoking Change Talk.

- **Planning:** This process includes both developing commitment to change and formulating a plan of action. Planning for behavior change is covered in Chapter 5.

Exercise 2.8 Practice Identifying Change Talk and Sustain Talk

Work with a partner. Each of you should choose a behavior you are considering to change, such as drinking more water, drinking less coffee, eating more fruit, etc. Take turns being the counselor and the client and explore the desired behavior change. Record your session. When you are the counselor, help your client to explore their ambivalence. When you are the counselor, consider using the following questions:

"Most people considering a behavior change have reasons not to change and reasons to change. What are the reasons you have for considering change?"
"Have you ever tried to make this behavior change in the past? If so, what did you learn?"
"Rate on a scale of zero to ten (with ten being the highest) the importance of the behavior change."
"Why did you choose the number four and not two?"
"If you were to change, what would it be like?"
"Rate on a scale of zero to ten (with ten being the highest) how confident you are of making the behavior change."
"What would have to happen for you to choose the number six and not five?"
"If you decide to change, what would be your options?"
Be sure to include an affirmation. You may wish to have Table 2.6 in front of you.

After each has taken a turn, listen to the recording and jot down the change and sustain talk statements made by each of the participants. Discuss your findings with your partner.

Evoking Change Talk

Use Table 2.8 to identify the specific category of the change talk statements. The objective of change talk is to resolve ambivalence by providing opportunities and encouragement for the client, rather than the counselor, to make arguments for change. You guide the counseling session to allow your clients to explore perceptions and see a discrepancy regarding their current behavior compared with their values, beliefs, and concerns. The guiding encourages clarifying important goals, vocalizing change talk, and exploring the potential consequences of their present behavior. When the discrepancy overwhelms the need to keep the present behavior, there is likely to be a decision to start taking action to change. In doing so, the balance of indecision begins to shift toward taking action. As change talk strengthens, commitment increases as well as the likelihood of behavior change.[49]

1. **Ask Evocative Questions:** As clients speak aloud their thoughts and feelings about changing a behavior, clients are analyzing their commitment to change. Counselors are gaining a better understanding of what is important to their clients.[46] The following are some examples of useful questions for clients who are making DARN statements:

   "What are you hoping our work together will accomplish?"

   "What ideas do you have for getting your A1c levels below 7?"

   "What are the problems for how your diet is now?"

   "Most people considering a behavior change have reasons not to change and reasons to change. What are the reasons you have for considering change?"

   Counselors can reinforce and amplify motivational statements by using nonverbal attentive behavior such as a head nod. Verbal reinforcement can come from making reflection responses, requesting clarification (for example, how much, how many, and give an instance), and including change talk statements in summaries.

2. **Evaluate Importance and Confidence:** This technique usually involves two questions. First, clients are asked to rate on a scale of zero to ten (with ten being the highest) the importance of the behavior change (for example, increase intake of fruits and vegetables). Next they are asked to rate again on the same scale their confidence in making a change. Follow-up questions explore choices. For example, "Why did you choose the number four and not two?" "What would you need to get to the number seven instead of four?" An individual may feel that a change is worthwhile and may even elicit change talk indicating the importance of change, but if that person has little confidence in the ability to make the change, then implementation of action strategies is not likely to be successful. For example, a woman may feel confident in her ability to increase her calcium intake, but if she does not consider the issue important enough, her degree of readiness to change is reduced. Likewise, a woman who