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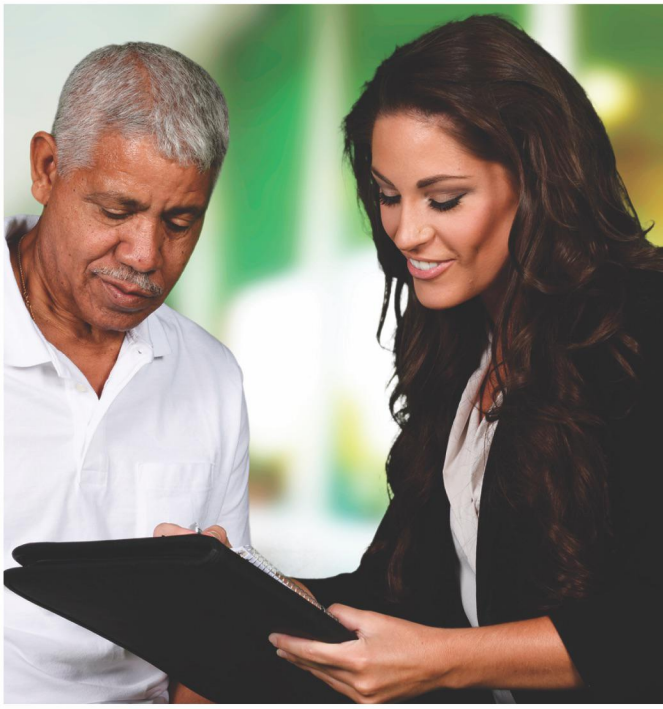
ENHANCED SEVENTH EDITION

Nutrition Counseling AND Education Skills

A GUIDE FOR PROFESSIONALS



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To our extended families, professional colleagues, and dedicated students who have contributed to our nutrition communication and education skills over the years.

BBH and JAB

Preface

Effective communication skills are essential for all nutrition professionals, whether working in clinical, community, management, research, or food service settings. A major challenge is to learn, develop, and apply the necessary knowledge and skills while practicing them in one's professional and personal life.

The scope of practice of nutrition professionals is rapidly expanding to wider and more diverse audiences. The Accreditation Council for Education in Nutrition and Dietetics (ACEND) standards remain grounded in the core communication, counseling, and education skills essential for professional practice, which are the focus of the book. These competencies are mirrored in international practice as well.

The Nutrition Care Process (NCP) is the basis for the Standards of Practice and Standards of Professional Performance. The Nutrition Care Process Terminology (eNCPT) provides a means to connect practice intervention with outcomes in the age of the electronic medical record.

Here are a few of the changes in the 7th edition:

- The Table of Contents is divided into three sections: Communication Skills, Counseling for Health Behavior Change, and Education Skills. Some chapters are reordered and renumbered.
- Case studies are reformatted as a Case Challenge found at the beginning of each chapter with Case Analysis questions interwoven throughout.
- Chapter 1 reflects the expanding scope of nutrition practice in the United States as well as globally.
- References are found at the back of the book grouped by chapter.
- Instructor and student support materials are expanded and available on Navigate 2 Advantage Access, the publisher's website.
- The standardized Nutrition Care Process Terminology (eNCPT) is no longer available in print, but electronically from the Academy of Nutrition and Dietetics (AND).

Effective nutrition interventions are based on evidence-based theories, models, and strategies; clinical nutrition principles; and the knowledge of a variety of behavioral science and educational approaches. There is evidence that interventions based on theories are more effective than those without a theoretical basis and that

health professionals need to customize (or individualize) the choice of theory or model to the client's specific situations. Interventions that are based on theories or models, such as the Health Belief Model, behavioral theory, social-cognitive theory, motivational interviewing, or the transtheoretical model of behavior change, are found in the chapters.

The dramatic increase in overweight and obesity among adults and children worldwide is a major threat to overall health. The purpose of our interventions is active behavior change in diet and physical activity to improve health and to prevent and/or control a chronic disease.

Acknowledgments

We thank Hope T. Bilyk, MS, RD, LDN, Assistant Professor, Department of Nutrition, College of Health Professions, Rosalind Franklin University of Medicine and Science, North Chicago, Illinois, for her review of the chapter on Communication and Cultural Competence. Diane Rigassio Radler, PhD, RD, Associate Professor, Department of Nutritional Sciences and Director, Institute of Nutrition Interventions, Rutgers University, New Jersey, continues as a chapter contributor on Counseling for Behavior Modification.

We thank John Larkin, Project Manager at our publisher, for his assistance throughout the preparation of the manuscript and ancillaries. Some photographs were obtained from the US Department of Agriculture and the CDCP Public Health Image Library.

Contents

SECTION 1

Communication Skills

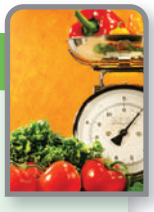
CHAPTER 1

Expanding Scope of Nutrition Practice

Objectives

- Discuss the origin of people's food habits or behaviors.
- Describe the use of the Scope of Practice Framework.
- Describe the four parts of the Nutrition Care Process.
- Explore evolving areas of practice in nutrition

CASE CHALLENGE 1



Karen, a 35-year-old married woman, made an appointment with a Registered Dietitian Nutritionist (RDN) in private practice to get counseling for weight loss and maintenance. Karen works full-time as a secretary at a bank, often going out to lunch with coworkers. Her husband is in computer sales. They have three children ranging in age from 6 to 10 years, and all are in school. Karen's mother comes to watch the children after school until she arrives home. Karen is 5'5" tall and weighs 170 lb. She weighed 135 lb when she was married 12 years ago.

Karen described her daily schedule. She gets up early to make breakfast and to help the children get ready for school. After work, she is tired and the children are hungry and clamoring for dinner, so she describes dinner as a "rush job" or something brought in. After cleaning up, she helps the children with homework, does laundry or other housework, attends evening activities at the school, runs errands, gets the children to bed, and then goes to bed herself. She describes herself as "exhausted."

Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.

—Margaret Meade

Introduction

Counseling, and education knowledge and skills have been recognized since the beginning of the nutrition profession as essential for successful clinical and management practice. These basic communication techniques are still required today in the United States by the Academy of Nutrition and Dietetics for the credential of Registered Dietitian Nutritionist (RDN) and Nutrition and Dietetic Technician, Registered (NDTR). Similar communication and counseling skills are required by the global community of nutrition professionals as well.[1–4]

The International Confederation of Dietetic Associations (ICDA) represents more than 41 international dietetics organizations comprising more than 160,000 members worldwide. The ICDA's definition of "a dietitian is a person with a qualification in nutrition and dietetics, recognized by national authority(s). The dietitian applies the science of nutrition to the feeding and education of individuals or groups in health and disease."[5]

Specific educational competencies vary between member groups, but counseling and education knowledge and skills are required universally. Practitioners may be called dietitians or nutritionists and may have country/area-specific licensure requirements.[6] Some of the dietetic associations that are members of the ICDA include The Academy of Nutrition and Dietetics, Dietitians Association of Australia, Dietitians of Canada, and the European Federation of the Association of Dietitians.[5]

Nutrition professionals have expanded their practice settings, particularly over the last decade to include hospitals, academic health science centers, long-term care facilities, corporate wellness programs, interdisciplinary practice in areas such as sports nutrition or weight loss, public health agencies, private practice, or corporate management. Most practitioners are responsible for assessing nutritional status, selecting diagnoses, intervening through counseling, and evaluating what clients and patients are doing successfully and what they may need to change. The goal is to help people change their eating behaviors for improving their health and reducing the risk of chronic diseases. Health behavior change holds the promise of reducing the risk of preventable diseases and improving the health of those with medical problems.

This chapter discusses the expanding scope of practice in nutrition. Government initiatives are reviewed that direct population-based public health knowledge and programs for health behavior change. The Academy of Nutrition and Dietetics' Scope of Practice framework forms the parameters of competent practice. The Nutrition Care Process (NCP) model uses the Nutrition Care Process Terminology (eNCPT) to drive the cycle of nutrition care. Finally, new areas of evolving practice are explored.

Origin of Food Habits or Behaviors

People's food habits, often described as food behaviors, originate beginning in childhood and evolve over time. Why do people eat the way they do? In physiologic response to hunger, of course, but food choices and eating are far more complex. Cultural, social, economic, environmental, and other factors are involved in food selection in addition to individual choice, patterns, and personal taste.[7] There are many cues to eating in our daily lives. The consumption of food eaten away from home at commercial food service establishments continues to increase.

Nutrition practitioners counsel people who need to make changes in their food habits, using intervention strategies to motivate and improve people's success at change. Food selection is a part of a complex behavioral system that is shaped by a vast array of variables. Food is essential to life, but the dietary patterns and choices people make can directly affect health. Food and lifestyle choices often change an individual's risk for many chronic diseases including heart disease, stroke, diabetes, and some cancers.[8] Successful nutrition counseling and education require an understanding of

why clients eat the way they do and then using this knowledge to develop appropriate interventions.

CASE ANALYSIS 1

What lifestyle factors may help or hinder Karen in adhering to different food choices?

Having positive rather than negative cognitions or thoughts helps a person to make changes. Cognitions may be influenced by attitudes, perceptions, and feelings. There is a big difference between "Nutrition is important and this is worth the effort for my health" and "It's too much trouble and I feel OK anyway." Attitudes are thought to influence peoples' decisions and actions. People may eat not only for physiologic reasons such as hunger but also for psychological reasons, such as anxiety, depression, loneliness, stress, and boredom, as well as due to positive emotional states, such as happiness and celebrations. Food may assuage guilt as well as lead to guilt feelings.[7]

SELF-ASSESSMENT 1

List three things that influence your choices of foods.

Knowledge of what to eat is certainly a first step in influencing healthful food choices, but it is probably overrated. There are individuals who know what to eat and yet do not do it. When people do not eat healthfully, some counselors redouble their efforts in educating as if the problem is lack of knowledge. The relationship between what people know about food and nutrition and what they eat is a very weak one. Other factors may be taking precedence and need to be explored. Knowledge helps only when people are ready and motivated to change. Thus, there are many influences on food choices, including cognitive, sociocultural, physical, and geographical factors. The nutrition counselor needs to explore all of them to understand the client, the client's motivation for change, and the appropriate intervention to use. Figure 1-1 summarizes some of the variables motivating changes in people's food choices and health behaviors. In subsequent chapters of this book, specific counseling strategies are provided to address areas such as cognitive and behavioral change along with an entire chapter discussing cultural components.

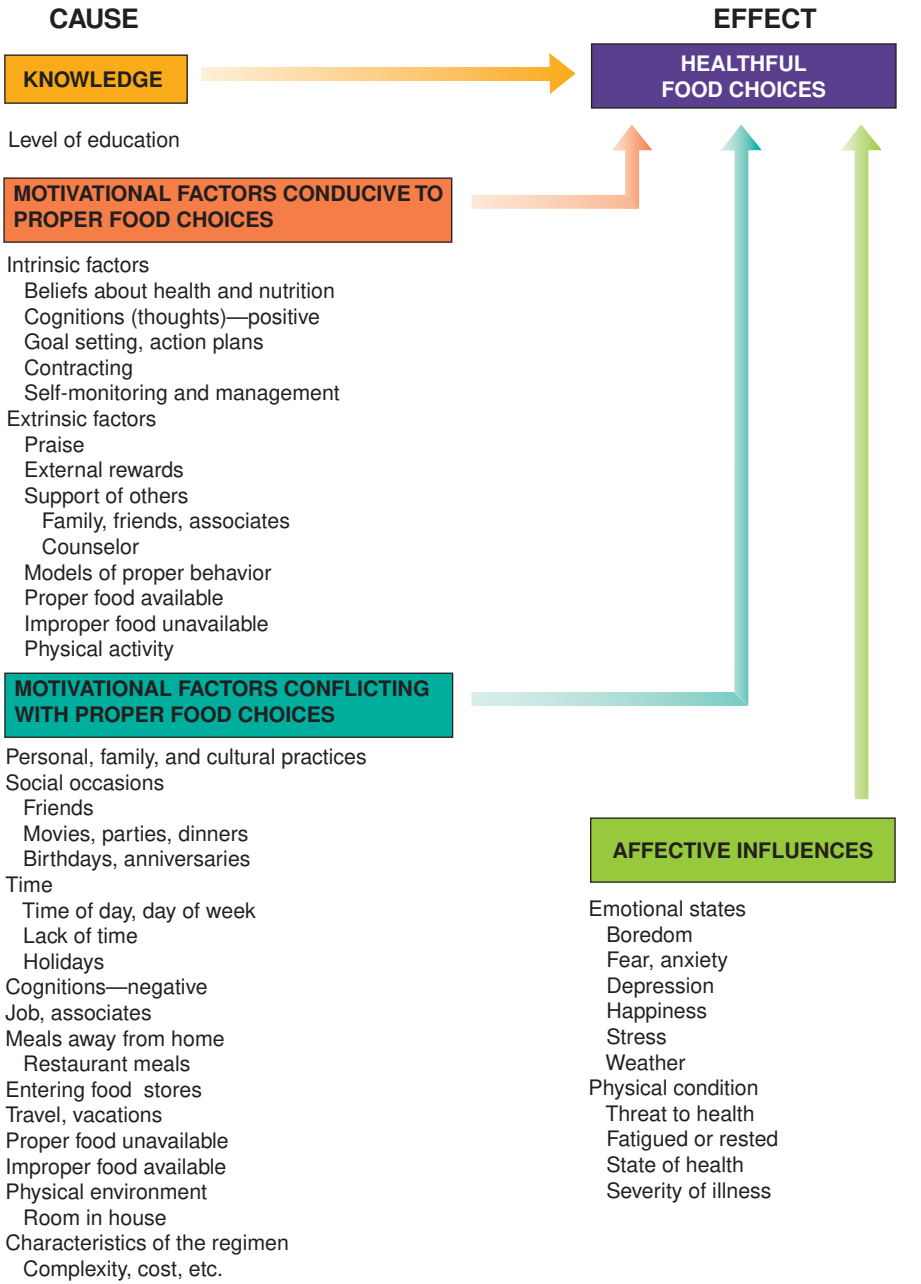


Figure 1-1 ■ Variables motivating change in food choices and health behavior.

Government Public Health Initiatives

Many government agencies have developed public health education initiatives to improve the health outcomes of populations. The United States Department of Agriculture, for example, has ongoing programs to evaluate the status of the American public and provide guidelines for improving health. The National Health and Nutrition Evaluation Survey (NHANES) is an ongoing, federally funded longitudinal program that provides data on a randomized set of children and adults of varying ages by collecting data on dietary intake and anthropometrics.[9] This dataset is often used by investigators to conduct research on health trends over time correlated to behavior changes.

ChooseMyPlate

The United States Department of Agriculture "ChooseMyPlate" gives a positive and visual message of how to select foods for each meal.[10] On the plate, fruits and vegetables should make up half of the diet, with more vegetables than fruits. The other half should include grains and protein, such as meat, poultry, and fish, with more grains than proteins. Dairy is shown on the side. Adaptations to the ChooseMyPlate program include application in school environments and in group settings, and electronic support with a website and accompanying interactive online resources (Figure 1-2).[11,12]

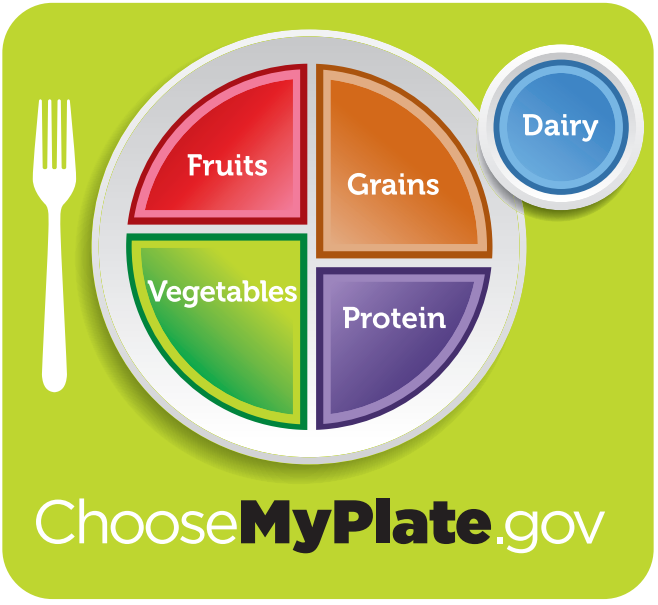


Figure 1-2 ■ http://ChooseMyPlate.gov.
Source: US Department of Agriculture.

Dietary Guidelines for Americans

The United States Department of Health and Human Services (HHS) sponsors updates to the Dietary Guidelines for Americans at regular intervals. The most current edition (2015–2020) summarizes a consensus of scientific, evidence-based nutrition recommendations for a healthy diet, which are revised every 5 years. The chairperson of the Dietary Guidelines Advisory Committee was Barbara Millen, DrPH, RDN from Boston.[13] The guidelines are the basis for nutrition counseling and education programs and federal food assistance programs. They are intended for healthy people and those at high risk for chronic diseases. Poor diet and physical inactivity are important factors contributing to the epidemic of overweight and obesity and are associated with major causes of morbidity and mortality in the United States. More than one-third of children and more than two-thirds of US adults are overweight or obese.[8]

Healthy People 2020

Healthy People 2020 is a set of national goals and objectives designed to guide health promotion and disease prevention efforts to improve people's health over a 10-year period. It is released by the US HHS each decade. More than forty health topics are found on the website. The challenge is to avoid preventable and chronic diseases from occurring. Heart disease, cancer, and diabetes mellitus are responsible for 7 out of 10 deaths among Americans annually. A healthy diet helps reduce the risk of overweight and obesity, heart disease, high blood pressure, type 2 diabetes, dyslipidemias (poor lipid profile), some cancers, and other conditions.[8,13]

CASE ANALYSIS 2

What suggestions or alternatives can you give Karen to overcome any problems using any of the public health initiatives described above? How could she use the ChooseMyPlate program in her family unit?

International Health Guidelines

Table 1-1 provides selected examples of international health guidelines that are applicable to country-specific or general world populations including the United States. The World Health Organization (WHO) maintains a global focus as well as an individualized focus by countries and regional areas of health and nutrition interest. The Food and Agriculture Organization (FAO) of the United Nations also monitors food-focused guidelines. The majority of health guidelines are updated regularly and are individualized to their intended audiences.[13-15]

Country	Health Guideline	Organization
Australia	Australia Guide to Health Eating www.eatforhealth.gov.au	Australian Government, National Health and Medical Research Council, Department of Health and Ageing
Canada	Canada's Food Guide www.hc-sc-gc.ca	Health Canada, Office of Nutrition Policy and Promotion
International	Global Targets/Country-specific guidelines who.int/nutrition/en fao.org/nutrition	World Health Organization, Food and Agriculture Organization of the United Nations
Philippines	Philippines Dietary Reference Intake (PDRI) 2015 fnri.dost.gov.ph	Food and Nutrition Research Institute, Department of Science and Technology
United States	ChooseMyPlate ChooseMyPlate.gov	United States Department of Agriculture, Food and Nutrition Services
United States	2015–2020 Dietary Guidelines health.gov/dietaryguidelines	United States Department of Health and Human Services, United States Department of Agriculture

Table 1-1 ■ List of Selected Government Population-Focused Health Guidelines

Food and Health Survey Results

How much do people already know about nutrition and health and how are food choices affected? In 2015, the International Food Information Council Foundation conducted the tenth Food & Health Survey about consumer attitudes toward food safety, nutrition, and health.

The survey found the following[16]:

- More than three-quarters (78%) say they would rather hear information about *what to eat* versus *what not to eat*. This was up 7% from 2014 for the strongly agree response category.
- About 84% (up from 76% in 2011) are trying to lose or maintain their weight. The two highest barriers were lack of willpower (37%) and lack of time (31%).
- About 76% are trying to cut calories by consuming more water and low- or no-calorie beverages.

- About 57% rate their health as very good to excellent, yet 55% of survey group was overweight or obese.
- Consumers are trying to eat more fruits and vegetables (82%).
- About 70% are trying to eat more foods with whole grains.
- About 69% are cutting back on foods that are higher in added sugar.
- About 68% are consuming smaller portions.
- More than half of Americans (51%) admit our food supply would be higher in cost if processed foods were eliminated and 45% state food would become less convenient.
- Lower income survey respondents are concerned about rising food costs and are more likely to spend extra money, if available, on food.
- Taste (83%), price (68%), and healthfulness (60%) continue to be top three drivers of food purchases.
- About 60% (compared to 70% in 2013) have confidence in the safety of the US food supply.
- Consumers use the food label to determine before they buy the product for expiration date (51%), nutrition facts panel (49%), ingredients (40%), serving sizes and amount per container (36%), and brand name (27%). Only 11% report not using the food label.
- The time reported to prepare dinner: 19% less than 15 minutes, 52% between 15 and 44 minutes, and 29% more than 45 minutes.

Access to technology continues to change healthcare for both professionals and their clients. In 1995, only 1 in 10 Americans had Internet access compared with about 80% of adults in 2015. The number of individuals with a smartphone only increased to 13% (up from 8% in 2013). The greatest increase in replacing home phone, cable, and internet service with only smartphone technology occurred in African-American and rural populations. Clients with access may arrive at appointments with medical and nutrition information.[17]

Scope of Practice Framework

The Scope of Practice Framework from the Academy of Nutrition and Dietetics provides guidance on what is within the practitioner's skill set or scope of practice. For RDNs and NDTRs, it delineates core responsibilities at the entry level of practice based on formal education, knowledge, skills, and training or foundation knowledge set by the Accreditation Council of Education in Nutrition and Dietetics (ACEND).[1,18,19] The first level of the Scope of Practice Framework uses the NCP as a framework for decision-making in nutrition care.[20] NCP is a required knowledge area in accredited education programs, in the credential examinations for RDN and NDTR conducted by the Commission on Dietetic Registration

(CDR), and has been incorporated into the Standards of Practice and of Professional Performance.[1,18–21]

The second level provides evaluation resources, such as Standards of Practice (SOPs) and Standards of Professional Performance (SOPPs), at the entry level and advanced levels of practice and includes the Academy Code of Ethics (Figure 1-3). Finally, there are decision aids or tools for those considering new roles or activities. As dietetics professionals refer to these materials, they guide practice, and the decision tree assists in personal assessment of competence. It is important to note that these standards are for scope of theoretical credential practice, but actual application of practice may be further defined by licensure. Licensure occurs typically on a state level, whereas credentials occur on a national level. For example, an RDN credential is attained by passing a national competency examination administered by the CDR. However, individual licensure must be obtained for practice within each state resulting in a licensed dietitian nutritionist (LDN) status which requires the RDN credential but also payment of an annual fee at the state level.

As part of the Scope of Practice, the Academy develops standards for evaluating the quality of practice and performance of RDNs and NDTRs. SOPs and SOPPs are tools for professionals to use in self-evaluation and to determine the education and skills necessary to advance from a generalist to specialty and advanced levels of dietetics practice. The SOPs are based

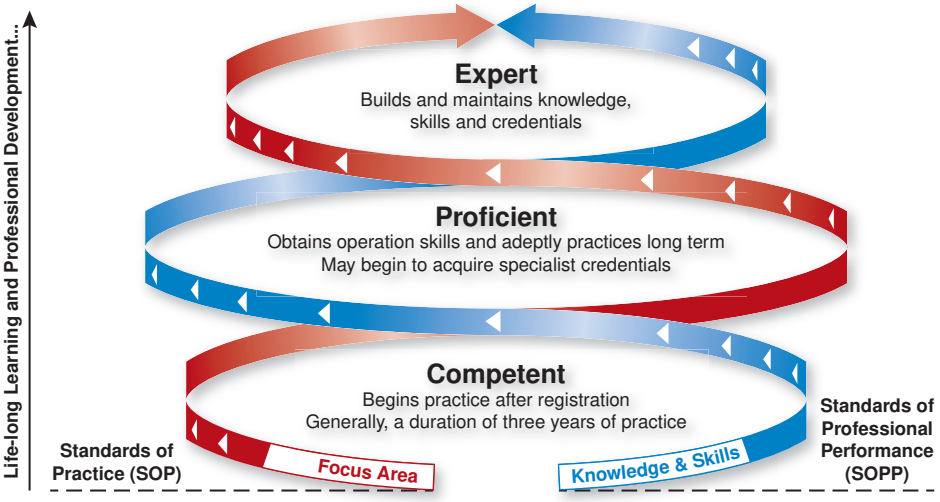


Figure 1-3 ■ Standards of practice and standards of professional performance for registered dietitian nutritionists (competent, proficient, and expert).

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on the four steps in the NCP of nutrition assessment, nutrition diagnosis, nutrition intervention, and nutrition monitoring and evaluation and are related to patient care.[20] The SOPPs contain six dimensions of professional performance, including the following: provision of services, application of research, communication and application of knowledge, utilization and management of resources, quality in practice, and competency and accountability.

Practice-specific SOPs and SOPPs have also been developed in areas such as disordered eating and eating disorders, integrative and functional medicine, extended care settings, diabetes care, oncology nutrition care, sports dietetics, and management of food and nutrition systems to name a few.[22] Many of these practice-specific SOPs and SOPPs form the basis of specialty credentials. For example, the Certified Specialist in Renal (CSR) documents competence in the defined standard of practice in nephrology care at the expert level.[23]

Nutrition Care Process

The NCP is a tool created to advance the profession of dietetics and to achieve "strategic goals of promoting the demand for nutrition professionals and to help them be more competitive in the marketplace."[20] An initial workgroup created the stepwise process to describing how nutrition professionals provide care to patients/clients. It was evident that a standardized taxonomy would assist in communicating the results of nutrition care and a standardized nutrition language would evolve. The NCP provides a method to address practice-related problems and make decisions about nutrition interventions. The nutrition professional obtains and interprets data about a possible nutrition-related problem and its causes. The framework aids thinking and decision making that RDNs use to guide professional practice.

The NCP uses the official international dietetics and nutrition terminology (eNCPT), a standardized set of terms which is only available electronically. These terms are also used for documentation in the medical record. Use in an electronic medical record, but not a paper record, requires permission from the Academy of Nutrition and Dietetics since the language is protected by copyright.[24] Adoption of a standardized eNCPT language will enable electronic medical records to be searched for NCP and outcomes. This, in turn, will provide evidence for health outcomes that can be attributed to nutrition intervention—and link to evidence-based reimbursement for RDN counseling and education.

NCP is used by nutrition professionals when delivering quality nutrition care to patients, clients, and other groups. There are four interrelated, sequential steps in a standardized process: (1) nutrition assessment, (2)

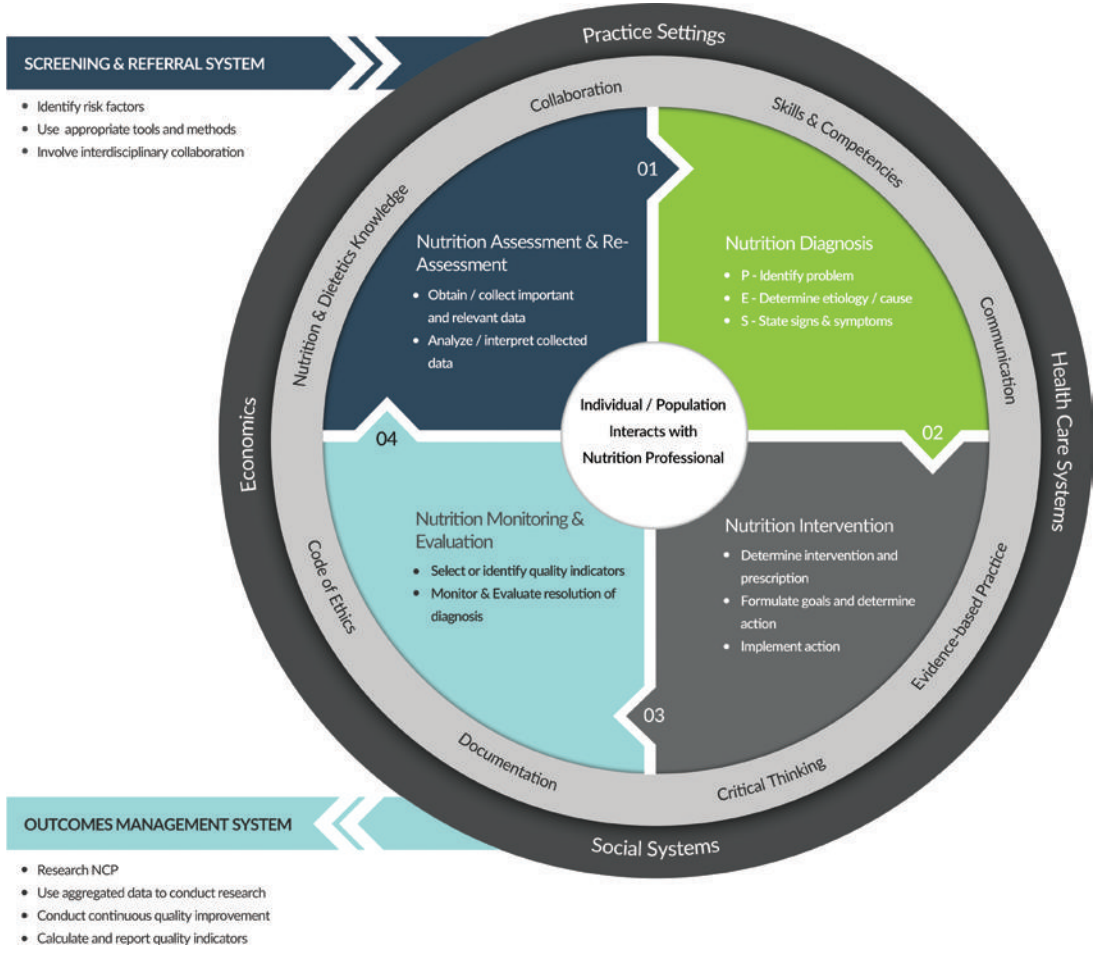

Figure 1-4 ■ The nutrition care process model.

Source: ©Academy of Nutrition and Dietetics. Reprinted with permission.

nutrition diagnosis, (3) nutrition intervention, and (4) nutrition monitoring and evaluation. Each step provides information for the following step. However, if new information is obtained and a reassessment is needed, previous steps may be revisited. NCP begins after the patient is referred by a health professional or identified at possible nutritional risk (Figure 1-4).[20]

Step 1: Nutrition Assessment

The purpose of nutrition assessment is "to obtain, verify, and interpret data needed to identify nutrition-related problems, their causes, and significance."[18] Nutrition-related data are obtained from patients/clients, the medical record, and other family members and health professionals. There are five categories of data to collect: (1) a food/nutrition-related history is often obtained by interviews; (2) anthropometric measurements, such as height, weight, and body mass index (BMI); (3) results of biochemical data, medical tests, and procedures in the medical record; (4) nutrition-focused physical findings, such as appetite and physical appearance; and (5) a client personal history, some of which is in the medical record. Data are compared with standards and interpreted.[20]

In the assessment step, the nutrition professional gathers in advance data or information about the patient or client that may have an impact on treatment. Information that is unavailable from the medical record may be obtained during an interview, such as a food and nutrition history. Factors that may have an impact on food and nutrient intake include the role in family, occupation, socioeconomic status, educational level, cultural and religious beliefs, physical activity, functional status, cognitive abilities, and housing situation. For example, the counselor may discover that the individual has been on a previously prescribed diet (eNCPT terminology code FH 2.1 representing Food/Nutrition-Related History main category, 2.1 Diet History assessment term).[20,24]

The counselor may collect data on current eating patterns or habits; on physical, social, and cognitive environments; and on previous attempts to make dietary changes. The physical environment includes where meals are eaten (at home or in restaurants and in which rooms of the home) and events that occur while eating (socializing, watching television, or reading). The social environment, which may or may not be supportive, includes family members, friends, social norms, and trends involved with eating behaviors (e.g., meeting friends for dinner, popular food items, and beverages when tailgating). The cognitive or mental environment involves the client's thoughts and feelings about food and his or her self-image and self-confidence. It concerns what clients say to themselves about their food habits and life, since personal thoughts may or may not promote successful change. Positive thoughts, such as "I love a steak and baked potato" or "My favorite snacks are potato chips and beer," may support continued eating.

There may be negative and self-defeating thoughts or thoughts of failure, boredom, stress, and hunger. Examples include "It's too difficult," "It's not worth it," "I can't do it," "I've been on diets before, always failed, and regained all of the weight I lost," or "I'm happy the way I am and don't want to change." These may also support continued eating.

Since behavior is influenced by beliefs and attitudes, the counselor may need to explore these in relation to the medical condition, nutrition, food choices, and health. The client's literacy level and any language barriers should also be noted.

If a problem is identified, the assessment of nutritional status provides baseline information from which to determine the nutrition diagnosis and establish interventions that are realistic. Once all of the data for the assessment are collected, the counselor must integrate and assimilate what she or he has read, heard, and observed to distinguish relevant from irrelevant data, identify discrepancies and gaps in the data, and finally organize the data in a meaningful way and document the assessment.[20]

CASE ANALYSIS 3

What would be a potential nutrition assessment for Karen? How would you express the potential nutrition assessment using the eNCPT?

Step 2: Nutrition Diagnosis

The purpose of the nutrition diagnosis is "to identify and describe a specific nutrition problem that can be resolved or improved through treatment/nutrition intervention by a nutrition professional."[20] The nutrition diagnosis is what the RDN is treating independently and differs from the medical diagnosis identified by the physician.

The data from the nutrition assessment are used to label the nutrition diagnosis. The nutrition diagnosis is organized into three categories: (1) intake (NI), such as amount of food or nutrients consumed compared with needs; (2) clinical (NC), such as problems related to medical or physical conditions; and (3) behavioral–environmental (NB), such as attitudes, beliefs, and the person's physical environment. For example, the medical diagnosis for a dialysis patient may be "kidney failure" but the nutrition diagnosis terminology using the eNCPT may be "NI-5.10.2 excessive potassium intake" or "NB-1.1 food- and nutrition-related knowledge deficit."[20,24]

The nutrition diagnosis, selected from the list of diagnoses from the eNCPT terminology, is written in a PES statement describing the problem (P), its etiology (E) or cause, and signs and symptoms (S) or evidence data.[20] The format of the PES statement is "nutrition problem label related

Problem (P)	Etiology (E)	Signs and Symptoms (S)
Specific nutrition diagnosis	Related to etiology	As evidenced by signs and symptoms
Overweight (NC-3.3)	Related to excessive energy intake (NI-1.5)	As evidenced by significant fast-food consumption and weight gain up to 10 lb in 3 mo (FH-1.2.2.3)

Table 1-2 ■ Example of the PES System Integrating Nutrition Care Process Terminology Codes

Nutrition Diagnostic: NC, Clinical; NI, Nutrition Intake; Nutrition Assessment and Monitoring and Evaluation: FH, Food/Nutrition-Related History.

to ____ as evidenced by _____." The problem (P) *related to* etiology (E) *as evidenced by* signs/symptoms (S). The problem (P) or nutrition diagnosis label describes alterations in the person's nutritional status. It is followed by etiology (E), the potential cause or contributing factors, and is linked to the diagnosis by the words "related to." The signs/symptoms (S) are the data used by the nutrition practitioner to determine that the person has the specified nutrition diagnosis and is linked to the etiology by the words "as evidenced by."[20] Table 1-2 is an example of the PES.

Documentation is essential throughout the NCP and is a process that supports all four steps.[20] After selecting the most essential diagnoses to work on, the system of charting may be reoriented to capture, in one to two sentences, the diagnosis based on the assessment. The recommendation is to document the diagnosis in the three-step PES. The PES could be entered into the notes section of an electronic medical record or remain as a written chart note in other documentation systems.

CASE ANALYSIS 4

What would be a potential nutrition diagnosis for Karen? How would you express the potential nutrition assessment using the eNCPT? Write a PES statement for Karen.

Step 3: Nutrition Intervention

Nutrition intervention is defined as "purposefully planned actions intended to positively change a nutrition-related behavior, environmental condition, or aspect of health status for an individual (and his or her family or caregiver), target group, or the community at large."[18] The purpose is "to resolve or improve the identified nutrition problem by planning and

implementing appropriate nutrition interventions that are tailored to the patient/client's needs."[18] The intervention is directed by the etiology or causes of the nutrition problem described in the PES statement.

There are four general categories of eNCPT interventions: (1) food and/or nutrient delivery (ND), such as meals, supplements, or alternative feeding methods; (2) nutrition education (E), such as providing information and skills to modify eating behaviors to improve health; (3) nutrition counseling (C) to create individualized nutrition plans to improve health; and (4) coordinated nutrition care (RC), such as coordination with or referral to other healthcare providers. There are two interrelated components: a planning stage and the implementation stage. For example, the intervention strategy might be motivational interviewing, C-2.1 followed by E-2.2 skill development.[20,24]

The nutrition intervention incorporates the client's goals. The goals suggest the information, knowledge, and skills the client needs to make dietary changes. The counselor judges what information to provide, how much information can be absorbed at each session, at what educational or literacy level, and what handouts and media to use as supplements. The amount of information to provide and the best method of doing so must be individualized and matched to the client's cultural influences.

The intervention may include nutrition education or counseling, for example, about the following topics and activities: reading food labels, adapting recipes, menu planning, restaurant or carry-out meals, principles of healthful eating, food safety, nutrients in selected foods, nutritional supplements, nutrition misinformation, fat, carbohydrate, sodium, or calorie counting, nutrient–drug interactions, managing appetite, and the relationship of nutrition to the health problem. In addition, the client needs to know about physical activity, self-monitoring of diet and activity, and self-management. Problem-solving interventions for meal planning, food preparation, and food purchasing may be needed. Culturally sensitive interventions are important in meeting the needs, desires, and lifestyles of ethnic clients.

The counselor may suggest others with whom the client can discuss the goals, since a public commitment may make it more likely for goals to be accomplished. Self-monitoring records of food intakes and environments should be brought to the next appointment as a way for clients and the counselor to learn about factors affecting eating behaviors and as

CASE ANALYSIS 5

What would be a potential nutrition intervention for Karen? How would you express the potential nutrition assessment using the eNCPT?

a demonstration of the commitment to change. Clients' personal records, observations, and analyses of their environment contribute to the personal awareness and understanding.

Step 4: Nutrition Monitoring and Evaluation

The purpose of nutrition monitoring and evaluation is to "determine the amount of progress made and whether goals/expected outcomes are met."[18] The nutrition professional identifies patient/client outcomes relevant to the nutrition diagnosis, intervention plans, and goals. To determine progress, the practitioner identifies changes in behaviors, goals, or standards of care that are desired as the result of the nutrition care. This involves monitoring, measuring, and evaluating any changes in nutrition care indicators, the patient/client's previous status, reference standards, and the differences between assessment and reassessment.[18]

Monitoring is the follow-up step while evaluation is the comparison step, whether it is comparison to the last visit or comparison to a standard. After ascertaining progress, one may need to modify recommendations to promote progress to the goals. The determination of what the intervention should be as well as the evaluation mechanisms are individualized, but the Academy Evidence Analysis Library provides the framework for basing the NCP on available evidence of best practices.[25] An outcome, for example, is the measured result of the client's changes due to the counseling and education process. There are four categories of outcomes organized in nutrition monitoring and evaluation: (1) food/nutrition-related history outcomes, such as changes in dietary intake, physical activity, or knowledge and behaviors; (2) anthropometric measurement outcomes, such as weight, height, and BMI; (3) biochemical data, medical tests, and procedure outcomes including lab data and tests; (4) nutrition-focused physical finding outcomes, such as physical appearance and appetite.[20,24]

Outcome data identify the benefits of medical nutrition therapy in patient and client care. In using these systems of quality control, nutrition counselors may wish to evaluate several things: (1) the success of the client in following the goals set and in implementing new eating behaviors; (2) the degree of success of the nutrition intervention, including its strengths and weaknesses; and (3) their own personal skills as counselors.

CASE ANALYSIS 6

What would be a potential nutrition monitoring and evaluation plan for Karen? How would you express this using the eNCPT?

Having the right food available is helpful.

Nutrition Care Process Chains

It has been challenging to track the effect of nutrition intervention on changes in health patterns. With the NCP, the concept of "chains" has been formulated as a method to document RDNs are using evidence-based guidelines in their counseling content by linking health outcome data with RDN intervention and client change through electronic medical record searches. By tracking these changes over time, data can be collected that provides evidence that reimbursement for RDN services will result in cost-effective improvements in health outcomes. RDN reimbursement has already been approved by the Center for Medicare Services (CMS) for selected clients with diabetes and chronic kidney disease. RDNs must obtain a CMS provider number to bill and receive reimbursement directly. Internationally, reimbursement policies for nutrition services vary.[26]

The counselor should document using electronic records of the client's issues and goals, the factors influencing them, and the intervention for future measurement of client change. Examples of outcomes are changes in weight, glycemic control, blood pressure, lipid and other laboratory values; patient acceptance; progress at self-management; and improvement in knowledge, skills, dietary changes, and lifestyle changes. These indicate the impact of the intervention and can be used to evaluate the effectiveness of the treatment. The counselor and client should engage in evaluation jointly

Enthusiasm for change may decline during the first week and even more during the second week as obstacles develop. Therefore, frequent follow-up

CASE ANALYSIS 7

Write a potential nutrition care process "chain" plan for your work with Karen? How would you evaluate your effectiveness of treatment and document the cost-effectiveness of your professional time for future reimbursement?

appointments should be scheduled if possible. Acute care settings may not provide the opportunity for follow-up. Referrals to nutrition professionals in outpatient settings or in private practice may be necessary, since one session with a client is insufficient to promote long-term change in health practices. Communication is fundamental to each step in the process. Based on the nutrition assessment, clear documentation of the nutrition problem (diagnosis) and the treatment intervention will link measured outcomes to nutrition practice.

Evolving Scope of Practice in Nutrition

New areas of practice are continually evolving in the field of nutrition. A few will be highlighted here, but these examples only illustrate a small portion of the new and exciting areas of practice that are yet to be defined. The Subjective Global Assessment tool and nutrition physical examination examines patients for changes in oral mucosa, skin integrity, and nutrient deficiencies to formulate nutrition diagnoses and corresponding nutrition interventions.[27,28] Some practitioners are exploring advanced clinical skills examination principles that may one day be tested using standardized patients such as is currently done in medicine, osteopathic medicine, and podiatry.[29] An advanced practice audit conducted in 2013 funded by the CDR provided initial practice patterns that could eventually be used to develop an advanced practice credential examination.[30]

The concept of nutrition assessment using narrative medicine is also being explored. This technique builds upon motivational interviewing skills. It provides the ability to include subjective and detailed narrative prose in addition to the NCP. An example of narrative medicine documentation:

> The patient sat in the room with a lifeless expression, not wanting to make eye contact. He had just learned that his kidneys were failing and dialysis would soon be required. What to eat or not to eat was the last thing on his mind. Mr. Smith was instead focused on how he could continue to work and support his family.[31]

Finally, new practice settings are being explored. The area of emerging nutrition practice within integrated healthcare teams is evolving in patient-centered "whole-person" philosophy medical "homes" and accountable care organizations. These systems are shifting from a traditional fee-for-service model to a more comprehensive "total" care viewpoint. These integrated systems are rewarded for financially for improving health and wellness outcomes. The RDN has an integral basis in determining

Support sustainable farming practices and ecologic agriculture innovation
Encourage international food security and public policy collaboration
Promote farm-to-fork and fork-to-table global education initiatives
Advocate for safe and nutrition-conscious food processing
Partner with retailers to market healthy food options and programs
Educate consumers on evidence-based food preparation and storage methods
Raise awareness for comprehensive reduction of food waste/wasted food

Table 1-3 ■ Professional Initiatives to Link Agriculture, Nutrition, and Health

Adapted from Volgiano C, Steiber A, Brown K. Linking agriculture, nutrition, and health: The role of the Registered Dietitian Nutritionist. J Acad Nutr Diet. *2015;115:1710–1714; and Volgiano C, Brown K, Miller AM, et al. Plentiful, nutrient-dense food for the world: A guide for Registered Dietitian Nutritionists.* J Acad Nutr Diet. *2015;115:2014–2018.*

nutrition diagnosis, delivering appropriate nutrition interventions, and taking credit for client change in health risk reduction.[32]

Globally, groups have met to consider health economics of medical nutrition therapy in disease-related malnutrition and food insecurity.[15] Evidence-based nutrition guidelines have begun to evolve to advance research and practice. Ongoing monitoring and evaluation will be needed to direct public health policy and standards. An area of rising interest is the direct linking of agriculture, nutrition, and health (Table 1-3). Internationally, more than 30% of the food grown for human use is wasted or never available for use. Some nutrition professionals have already begun to move their area of influence to the role of farmer and direct food producer.[33,34] Future areas of practice are evolving rapidly in new and exciting directions.

SELF-ASSESSMENT 2

What is an area of nutrition practice that you would like to explore or envision as developing in the future?

Summary

The current and expanding scope of the nutrition professional roles rely on communication, counseling, and education skills. Translating the science of nutrition and government health initiatives into practical application is fundamental to nutrition whether applied to communities, groups, families, or individuals in diverse areas such a food preparation, purchase, or intake. The art of communication is also essential in manager and leadership roles. All practitioners need the ability to communicate and work effectively with their employees, with coworkers and team members on their same level, with superiors who are in authority, and with customers, patients, and clients. The Scope of Practice Framework assists us in considering present and future boundaries of practice and providing quality, safe care to those we serve. The use of the NCP standardized language and eNCP terminology improves our communication in providing effective and quality nutrition care linked to positive health outcomes.

Review and Discussion Questions

1. List five influences on people's food habits or behaviors.
2. What are the major three components of the Standards of Practice Framework?
3. What are the four steps in the Nutrition Care Process (NCP)?
4. What does the nutrition professional do at each of the four steps in the NCP?

Suggested Activities

1. With someone trying to make changes in food choices, discuss the changes and the factors influencing the changes, including any opportunities, challenges, or barriers. What are the factors influencing the person?
2. Select a dietary regimen, such as increased fiber, restricted sodium, reduced calorie, or reduced fat and cholesterol, and follow it yourself for 7 days. Keep a daily record of all foods eaten. How easy or difficult was it to comply with the dietary change for a week? What factors helped or hindered your adherence?
3. Watch 2 hours of television or examine two current magazines. What food products are advertised? What are the messages? How do these ads influence food choices? Compare with peers.

CHAPTER 2

Communication

Objectives

- List the components of the communication model.
- Discuss ways to make verbal communication supportive and effective.
- Explain the use of paraphrasing.
- Explain examples of nonverbal behaviors.
- Discuss the impact of diversity on communication.
- Relate ways to improve listening skills.
- Identify common communication barriers and how to overcome them.

CASE CHALLENGE 1

Joan Stivers, Nutritionist, noted on the medical record that her patient, John Jones, age 63, was 5'11" tall and weighed 250 lb. A retiree, he was just diagnosed with type 2 diabetes mellitus. Joan stopped by his hospital room, introduced herself, and told him that the purpose of her visit was to discuss his current food intake. During the conversation, Mr. Jones and his roommate were watching a baseball game on television, and periodically commented briefly on the plays and players. Finally, Mr. Jones said, "You need to talk with my wife, not me. She does the cooking." Just then, the physician entered the room.

You only have one chance to make a good first impression.

—Gary Dessler

Introduction

Today's technology makes communicating easier. We are connected by texting, email, smart phones, instant messaging, Twitter, and Facebook. But for health professionals, relating to others in person is necessary. Face-to-face skills need to be developed for communicating with individuals, groups, and the public. The Academy of Nutrition and Dietetics recognizes "expertise in verbal communication," as core competencies for communicating effectively with patients, clients, customers, and other professionals.[1,2] Providing "accurate and truthful information in communicating with the public" is required by the Code of Ethics.[3]

Communication skills are the foundation for interviewing, counseling, and educating patients, clients, and the public, as well as for efforts to assist people in changing their dietary and health behaviors. Nutrition counselors and health professionals deliver nutrition care and education in a collaborative partnership with patients, clients, and caregivers. Patient- and client-centered counseling as part of an intervention, for example, requires competent communication, counseling, and education skills.[1]

Well-developed communication skills increase the likelihood of the professional's success with clients and staff. Communication with other members of the healthcare team is important in identifying those in need of nutrition care and then in communicating with patients and clients about nutrition-related issues. Those in food service management and positions coordinating human resources communicate with staff and

others regularly. As professionals advance to higher levels of authority in management, communication skills are essential in working effectively with people.

This chapter introduces the interpersonal communication process, including verbal and nonverbal communication, and listening skills. A model of the communication process is presented and discussed, followed by an explanation of the implications of the process for verbal, nonverbal, and listening behaviors. The impact of diversity on communication is addressed.

Communication Defined

A simple definition is that communication is "the process of acting on information" and about transmitting verbal and nonverbal messages in which "meaning is co-created simultaneously among people."[4] A professional needs the ability to use language that is appropriate to the client's or staff's level of understanding, the ability to develop a relationship with clients or staff, the ability to talk in a way that relieves anxiety, the ability to communicate in a way that ensures being able to recall information, and the ability to provide people with feedback.

Effective communication requires that the message is understood clearly as intended by the speaker; it achieves the intended effect; and it is ethical and truthful.[4] Differences in culture, gender, age, education, background, and other factors can be sources of misunderstanding. Effective and ethical communication requires listening carefully, understanding the person's story, and maintaining confidentiality.[5]

Among the focus areas in the government's Healthy People 2020 initiative is to bring better health to all citizens. Communication contributes to health promotion as well as disease prevention efforts. The plan is to use health communication and health information technology (IT) to improve population health outcomes and healthcare quality in order to achieve health equity.[6] Among the objectives are new opportunities to reach the culturally diverse and those with limited literacy skills who may face disparities in access to health information.[6,7]

Health literacy has been defined as "a constellation of skills that contribute to the ability to perform basic reading and numerical tasks for functioning in the health care environment and acting on health care information."[8] Low literacy is associated with poor understanding of written or spoken medical advice affecting health and is prevalent in certain groups, such as the less educated, those of lower cognitive ability, persons of certain social and ethnic groups, and the elderly.[7]

Communication skills are learned. One's speaking, listening, and the ability to understand verbal and nonverbal messages need to continue developing. Putting the principles into practice requires conscious efforts, repeated attempts, and many trials. With practice, in a relatively short time,

you will notice a difference in the way others respond to you. Honing the skills, however, is an ongoing process and begins with an understanding of the many elements included in the interpersonal communication exchange.

Interpersonal Communication Model

Complicated processes are easier to grasp when they can be visualized in a model. The model is a graphic illustration to aid one's understanding. Studying the communication model to understand the role of each component is essential for professionals who are intent on expanding and improving their own communication repertoire.

Components of the Communication Model

The elements included in the communication model are the following: sender, receiver, the message itself, both verbal and nonverbal, feedback, and barriers. They are depicted graphically in Figure 2-1.

Sender

Senders of the message originate the thought or emotion, encode it into words, and speak first.

Receiver

Receivers or listeners attempt to decode or make sense of the message and usually interpret and transmit simultaneously. They may be listening to what is being said, filtering the message through their past experiences,

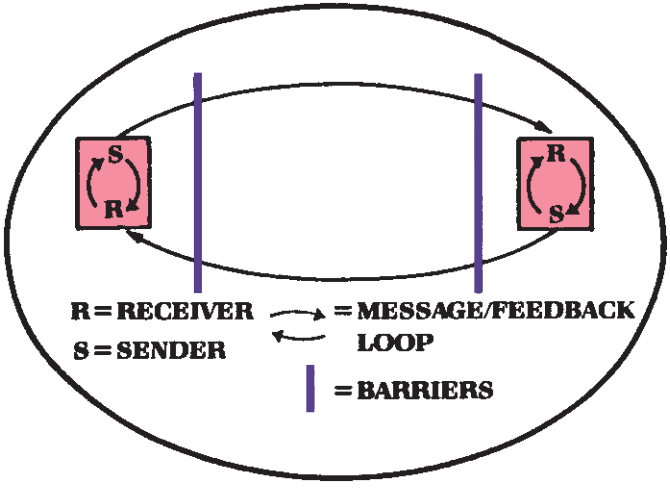

Figure 2-1 ■ Communication model.

values, or biases, while thinking about what they are going to say when the sender stops talking. Even when silent, it is impossible for receivers in a two-way communication transaction not to communicate. They may be reacting nonverbally with a flushed face or bored look, for example, depending on their inferences from the message. Senders interpret the receivers' appearance and demeanor and adjust subsequent communication accordingly. Thus, the two parties are sending and receiving simultaneously.

Message

The message is the information that is communicated to another. The receiver interprets two messages, the actual verbal message and the nonverbal message inferred from the sender and the environment. Nonverbal inferences arise from the perceived emotional tone of the sender's voice, facial expression, dress, gestures, tone of voice, choice of words, diction, and pronunciation, as well as from the communication environment.

Feedback

Since the communication process can be fraught with error, misunderstanding, or misinterpreted by the recipient, feedback is helpful. The term "feedback" refers to both verbal and nonverbal responses to messages. It insures that the message is understood and that the communication is successful. In face-to-face communication, the sender is talking while looking at the other person. The other person's verbal and nonverbal reactions to the sender's message, whether agreement, surprise, boredom, or hostility, are examples of feedback.

After the first few seconds, face-to-face communication becomes a simultaneous two-way sending-and-receiving process. While senders are talking, they are receiving nonverbal reactions from receivers. Based on these reactions, they may change their tone, speak louder, use simpler language, or in some other way adjust their communication. One can expect that feedback will vary with a person's experience, education, gender, and cultural group.[4] In many non-Western cultures, it can be subtle and circuitous, while the sender may prefer a more direct acknowledgment.

In written communication, writers cannot clarify the content for readers because they do not see them. Even when writers carefully select words for the benefit of their intended readers, written communication is generally less effective than one-on-one verbal communication because of the inability to adjust written language in response to the feedback from readers.

Barriers

Barriers, sometimes called noise or interference, can distort communication, and interfere with the understanding of the message. These factors include the unique attributes inherent in senders and receivers, such as the physiologic state of each communicator at the moment. Other factors

include the room size, shape, color, temperature, and furniture arrangement. Interference can result from a ringing telephone or a television set.

No two people are exactly alike. Feelings of anxiety, fear, or apprehension may distort the message.[9] Because no one has shared in the exact life experiences of another, no two people understand language in precisely the same way. The sophisticated communicator needs to understand these dynamics and compensate or safeguard accordingly, so that the intended message is the one received.

Bear in mind that individuals have a limited capacity for processing information. When it exceeds our ability, the result is information overload. People may select, ignore, or forget, resulting in less effective communication.[9] Words mean different things to different people, and misinterpretation of the message may result. Meanings are in people, not in words.

Today's clients and employees, more than ever, originate from a wide variety of cultural and ethnic backgrounds. People from a different group increase the likelihood of a miscommunication in a verbal exchange. Words imply different things in different languages and people have different values, experiences, perceptions, and frames of reference.[9] Distortions can stem from psychological interference as well, including bias, prejudice, and closed-mindedness.

Psychological interference in healthcare patients may be due to fear of illness and its consequences. The job of senders is to generate in receivers those meanings for language that are closest to the sender's own. Because meanings are not universal, they can be affected by both external and internal influences. The communication environment, cultural differences, the distance between speakers, lighting, temperature, and colors are a few of the variables that can affect meanings ascribed to a message. These variables can be barriers and account for the difficulty in generating in others the meanings a person intends.

Interpersonal Communication

When focused on relationship-centered care, effective interpersonal communication should lead to better health outcomes for patients and clients. Improving patient knowledge and understanding, responding to emotions, and encouraging patient self-management are helpful. Communication outcomes may be affected by many factors, such as health literacy, provider communication, personal preferences, level of education, income, employment, occupation, neighborhood, culture, and urban or rural location. These shape interpersonal communication and health. How a person deals with illness influences health behavior change.[10]

While behavior change theories focus on actual behavioral change, interpersonal communication theories are based on the relationship between patient and provider. This may include family members and friends who can influence a person's health and illness may be included.[10] Relationships can affect goals and tasks associated with health behavior

change. A relationship with trust and rapport promotes disclosure and openness in communication and affects how health behavior change is negotiated by the parties.

The patient or client is an expert on his or her own life, health, experiences, and relationships. Shared decision-making, negotiated dialog with the patient, development of empathy, and respect and removal of judgments allow for trust and openness.[10]

Relationship-centered care assumes that the provider and patient have a relationship characterized by respect, mutual trust, and engagement.[10] After the patient's feelings are understood and satisfied, one commits to goals and plans for treatment.

Patient–provider communication is important in affecting health outcomes. Interpersonal communication develops in a relationship between the provider and the patient or client in influencing health behavior change. Healing relationships respond to the person as well as the task of exchanging health information and providing patient self-management information. Helping and supporting people in managing their own health promotes self-management.

CASE ANALYSIS 1

What are the barriers to communication in the case challenge?

Verbal and Nonverbal Communication

We use two languages daily, our verbal language and our nonverbal or body language. Although both verbal and nonverbal communication occur simultaneously during interactions, they are discussed separately here in the context of their influence on the communication process.

Verbal Communication

To keep the communication channel open between the client or employee and the professional, one needs to know how to create a supportive climate. A supportive climate is one in which as one person speaks, the other listens, attending to the message rather than to his or her own internal thoughts and feelings. This creates a climate of trust, caring, and acceptance. A defensive climate, which occurs when the other person is feeling threatened or upset, creates the opposite effect, with the listener "shutting down." When this happens, there is little point in continuing the interaction because the message is no longer penetrating. Maintaining a supportive climate becomes especially crucial when the professional is attempting either to

discuss a topic viewed differently, or to resolve conflict and defuse anger.

The verbal guidelines for creating a supportive communication climate are (1) to be aware of one's choice of words and discuss problems descriptively rather than evaluatively; (2) describe situations with a problem orientation in interpreting messages rather than in a manipulative way; (3) offer alternatives provisionally rather than dogmatically; (4) treat people as equals listening thoughtfully; and (5) be empathic rather than neutral or self-centered responding sensitively.[4]

Families communicate at meal time.

Source: Pillitteri A. Maternal & Child Health Nursing, *4th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2003.*

Descriptive Rather Than Evaluative

Ordinarily, when approaching topics that tend to provoke defensiveness in clients, such as weight gain, professionals should think through the discussion before engaging the client, so that the problem area is exposed descriptively rather than evaluatively. Whenever people feel as if others are judging their attitudes, behavior, or the quality of their work, they show an increased tendency to become defensive. Such comments as "You don't seem to be trying," or "You don't care about cooperating," are based on inferences rather than facts. So when the other's response is "I do care," or "I am too trying," the framework for an argument is set, with no way of proving who is right or wrong.

Instead of making judgments regarding another's behavior or attitudes, the safest and least offensive way of dealing with a touchy issue is to describe the facts as objectively as possible. For example, when the professional tells a client that his or her continuing to eat ice cream and potato chips several times each day is discouraging to her as the client's counselor, she is confronting the problem without being evaluative. The client can then address the topic rather than argue about the professional's evaluation of poor adherence.

In a work-related situation, accusing an employee who has arrived late several mornings of being "irresponsible" and "uncaring" is likely to provoke a hostile response or cold silence. The employee may believe that being late does not warrant a reprimand. There may, in fact, be a reasonable explanation about which the manager should inquire. Describing how being late is causing problems for coworkers and causing work to back up is honest and descriptive and allows for nondefensive dialogue.

Problem-Oriented Rather Than Manipulative

Orienting people to a problem rather than manipulating them promotes a supportive communication climate. Frequently, when people want others to appreciate their point of view, they lead them through a series of questions until the other reaches the "appropriate" insight. This is a form of manipulation and provokes defensiveness as soon as respondents realize they are being channeled to share the other's vision.

> **EXAMPLE** "Several weeks ago, you agreed that you were going to stop eating ice cream and potato chips; however, each week you acknowledge eating them. About a month ago, you agreed to switch to fresh fruit as a snack, but that has not occurred."

A discussion with the client would be more productive if the counselor took a direct problem-oriented approach.

> **EXAMPLE** "In the past 6 weeks, you have gained 3 lb. With the dietary changes we planned, we anticipated a 4-to-5-lb weight loss. There seems to be a discrepancy here. Let's discuss what might explain the weight gain."

Employees and clients respect the professional when they believe the individual is being straightforward.

After the professional plans opening remarks descriptively rather than evaluatively, one should allow for collaborative problem solving without preplanned solutions. Creative, superior, and long-lasting solutions are more likely to occur when each person hears out the other fully, is heard in return, and when the client initiates the solution.

In the previous examples, the counselor's subsequent remarks depend on how the person responds to the directive to explain the problem. The professional needs to give the person time to think; this often means waiting for an answer. The practitioner needs to learn the discipline of sitting through the tension of silence supportively until the client or employee responds.

Frequently, the first explanations are those that people believe will not upset or shock the counselor. The "real" reasons, however, may not be revealed until the client or staff member feels secure enough to risk shocking the professional without fear of being humiliated or embarrassed. In other words, after the first explanations are offered, professionals would do best simply to repeat in their own words or paraphrase what they have understood. Only when the clients or employees are comfortable enough will they be able to express their authentic reactions, questions, or answers.

Provisional Rather Than Dogmatic

When offering advice to clients or helping them to solve problems, counselors should give advice provisionally rather than dogmatically. "Provisionally" implies the possibility of the practitioner changing the options, provided that additional facts emerge. It keeps the door open for clients to add information. A dogmatic prescription might be, "I know this is the way to solve your problem." A provisional prescription might be, "Here are several alternatives you might consider," or "There may be other ways of handling this problem; perhaps you have some ideas too, but here are things you might consider."

Equal Rather Than Superior

In discussing issues, the two parties should regard each other as equals and work collaboratively. Whenever the possibility of defensiveness exists, even between persons of equal rank, any verbal or nonverbal behavior that the other interprets as superiority generates a defensive response.

In the relationship between professionals and clients, or managers and employees, the professional's tendencies to emphasize status or rank may arise unconsciously from a desire to convince the other to accept his or her recommendations. Comments such as the following may cause the other to feel inferior or angry: "As a consumer, you may find this difficult to understand. Just do what I recommend; I've been doing this for 10 years." Certainly, there is nothing wrong with professionals letting clients know that they are educated and competent. However, the manner in which it is done is crucial. A more effective and subtle way is to make it clear that you don't have all the answers and to say, "I have studied this problem and dealt with other clients who have similar situations. I am interested, however, in incorporating your own thoughts and plans into the solution. You must be satisfied and willing to try new eating habits."

An employee making a recommendation to a manager that the manager had tried unsuccessfully in the past might be told, "If I were in your shoes, I would think the same thing. Someday when you are more experienced, you'll know why it won't work." The subtle underscoring of the inferior relative status of the subordinate could be enough to cause a defensive battle. The professional could have succeeded with a comment, such as "I can understand why you say that. I have thought the same myself, but when I tried, it was not successful." Showing respect for the client's and employee's intelligence and life experiences and recognizing their human dignity facilitates cooperation.

In conflict resolution, problem solving, and the discussion of any issues that may be threatening to the other person, collaboration is far more effective than trying to persuade the person to act according to the professional's recommendations. Collaboration has other virtues as well. People feel more of an obligation to uphold solutions that they themselves have participated in designing. If clients are trying the professional's solution, they may feel

little satisfaction in proving that he or she was right; however, if the solution is one that was arrived at through collaboration, there is genuine satisfaction in proving its validity. Two people sharing insights, knowledge, experience, and feelings can generate creative thought processes in each other, which in turn generates other ideas that otherwise would not have emerged.

Empathic Rather Than "Neutral"

Empathy is "an emotional reaction that is similar to the reaction being experienced by another person."[4] We feel what the other person feels. Ask yourself: "Am I able to understand the other person's experiences as if I were experiencing them?" The skill of empathy is especially important when there is bias in healthcare, such as may occur with obese people.

Empathy is mentioned frequently in the skill of listening and is discussed later in the chapter. Empathy conveys that the professional is fully present and actively engaged in the interaction. Lacking empathy may leave patients, clients, and staff feeling misunderstood.[9]

To be effective in working with clients and employees, professionals must be able to demonstrate in some way their desire to understand the other's feelings. This "demonstration" might be an empathic response to comments, where the listener tells the other that he or she is attempting to understand both the speaker's content and feelings. For example, a client might say, "For my entire life I have eaten salty foods; they are a part of my culture. I don't know what my life will be like without them." The professional might then respond, "You seem to be worried that the quality of your life will change because of the dietary recommendations."

If the professional is accurate in the empathic remarks, the client will acknowledge it and probably go on talking, assured that the person listens. If the professional is wrong, however, the client will clarify the judgment and continue to talk. Thus, the counselor need not be accurate in inferring the other's feelings as long as he or she is trying to understand them. In addition, empathic responses allow the professional to respond without giving advice, focusing instead on the individual's need to talk and to express concerns. Before clients or staff can listen to the professional, they must express their concerns; otherwise, while the practitioner is talking, the clients or staff are thinking about what they will say when the individual stops talking.

An employee who has asked to be released from work on a busy weekend to attend a family gathering might receive the following neutral response: "No offense, but a rule is a rule. If I make an exception for you, others will expect it too." The employee would still feel sad about working, but would feel less antagonistic toward the supervisor, with the following empathic response: "I realize how badly you feel about not being able to attend the family party. I feel sorry myself having to refuse your request, but I can't afford to let you have the day off." The supervisor, by letting the subordinate know that he or she understands the subordinate's underlying feelings and is sympathetic, uses the most effective means of defusing the person's disappointment.

CASE ANALYSIS 2

How should the professional respond to Mr. Jones? What should be the next steps?

Paraphrasing, a Critical Skill

Paraphrasing is restating in your own words what the other person has said and it is often done with empathy.[4] Most people have not incorporated the skill of paraphrasing into their communication repertoire. Even after people realize how vital this step is and begin to practice it in interactions, they may feel uncomfortable, self-conscious, or fear others may think they are "showing off." A hint for the professional feeling awkward about asking clients and staff to paraphrase would be to ask for the paraphrase by acknowledging one's own need to verify that what was heard is what the other intended. For example: "To be sure I understand your concern, you seem to be saying . . ."

EXAMPLE "I know that I don't always explain as well as I should, and that frequently, people have questions. Just to be sure I clearly covered the information, would you mind explaining in your own words how you will plan your meals?

Of course, it takes less time to ask, "Do you understand?" However, asking this question is less effective. Because of the perceived status distinction between the helper and the person being helped, the latter may be ashamed to admit that he or she does not understand. When persons of perceived higher status ask others if they "understand," almost always the answer is, "yes." This phenomenon is likely when working with some ethnic clients.

Another possibility is that the client or staff member honestly believes that he or she understands, and for that reason answered, "yes." The understanding, however, may include some alteration of the original message, in the form of substitution, distortion, or addition. The skill of paraphrasing needs to become second nature and automatic for professionals to verify important instructions, feelings, and significant client or staff disclosures.

Because of the anxiety attached to being in the presence of another of perceived higher status, the client or staff member may be less articulate than usual when describing symptoms or explaining a problem. The professional should paraphrase to verify that he or she understands the message as the "sender" intends. One should try to avoid sounding too

clinical with such comments as "What I hear you saying is. . ." Instead, keep the language clear, simple, and natural. A comment such as "I want to make sure I understand this; let me repeat what you are saying in my own words" is more natural.

Two points need to be emphasized regarding paraphrasing: (1) Not everything the other person says needs paraphrasing. It would become a distraction. Paraphrasing is essential only when the discussion is centered on critical information that must be understood. (2) Paraphrasing often leads to additional disclosure and therefore provides further information.

People are so accustomed to being with others who do not really listen that when they are with someone who proves that he or she has been paying attention by repeating the content of what has been said, they usually want to talk more. For the professional, this additional information can be valuable. Another benefit is that after the client or staff member has expressed all questions and concerns and has cleared his or her mental agenda, he or she is psychologically ready to sit back and listen or to solve problems.

By talking too much or too soon, the professional may not be able to convey all of the message to the other, who may be using the difference in time between how fast the professional speaks and how fast the client's own mind processes information to rehearse what he is going to say next.[4] The human mind operates 4 to 10 times faster than human speech.

CASE ANALYSIS 3

What did Mr. Jones' verbal statements tell you about his attitudes toward his health problem?

SELF-ASSESSMENT 1

Directions: Paraphrase the following:

1. Client: "I've been overweight most of my life. I've tried many different diets: I lose a few pounds, and gain it all back."
2. Employee: "I don't know why you want to keep changing things around here. Our old manager was satisfied with our procedures."

Nonverbal Communication and Image Management

Be aware of the person's nonverbal behaviors.

Source: Springhouse. Lippincott's Visual Encyclopedia of Clinical Skills. Philadelphia, PA: Wolters Kluwer Health; 2009.

Communication that creates meaning for people, but is not verbal or written, is called "nonverbal."[4] Of the two messages received simultaneously by receivers, verbal and nonverbal, the nonverbal is the larger component and more influential and believable. As receivers of messages, people learn to trust their interpretations of nonverbal behaviors more than the word choices consciously selected by the sender. Intuitively, they know that control of nonverbal behavior is generally unconscious, whereas control of verbal messages is usually planned and deliberate.

Nonverbal messages communicate our feelings toward others and are critical to relationships. However, it is important to develop awareness in using nonverbals in interactions as well as to recognize them in others.[4] Our nonverbal messages are more believable than our verbal ones.

"A picture is worth a thousand words." What is your picture like? Even before we speak, we may be judged by our clothing and appearance.[11,12] Dress and appearance are consciously selected and are nonverbal communication vehicles. Makeup, hairstyle, clothing, and accessories represent who you are and your self-image. Professional image is difficult to define, but it is an impression one creates at the first meeting and most people recognize it. Personal appearance, including clothing, hairstyle, and accessories, are among the most important elements of the image.

Simple well-tailored clothes in neutral colors, such as a skirt or slacks with a blouse or sweater are examples for women. A shirt, tie, slacks, and dress shoes are examples for men as the goal is to look professional and conservative.[4] One should avoid clothes that are too tight, short, or trendy, piercings, flip flops, sweats, excessive jewelry, chipped nail polish, and uncovered body art. Clients who are unable to relate to your appearance may have trouble relating to your message and question your competence.[4,11]

In meeting new people, we begin making judgments immediately, based on nonverbals, such as noticing eye contact, appearance, and whether or not the handshake is strong or limp.[4] Chief nonverbal vehicles inherent in speakers are facial expression, tone of voice, eye contact, gestures, posture, and touch, with meanings varying among cultures.[4] The receivers of communication notice nonverbal behavior in clusters.

If the professional is listening to a client, for example, but shifting papers and looking at a computer screen with a bored look, the client will not believe the person is interested. Ordinarily, people do not notice posture, eye contact, or facial expression isolated from the other nonverbal channels. For this reason, professionals need to monitor all nonverbal communication vehicles so that together the clusters are congruent with one another as well as with the verbal messages.

Nonverbal behaviors vary widely among different groups with each having its own body language. Although similarities exist, the meanings of behaviors differ among groups, as the way people behave is learned early in life. Our own history influences our ideas of what a person "is" or "should be." These variations may require professionals to adapt their nonverbal behaviors. If the client shows any sign of resisting or objecting to the professional's eye contact or touch, for example, the professional should cease immediately. Communication competence requires "the ability to adapt one's behavior towards another person in ways that are appropriate to the other person's culture or ethnic group."[4]

CASE ANALYSIS 4

What do you notice about Mr. Jones's nonverbal behaviors?

Facial expression is usually the first nonverbal trait noticed. "Smile and the world smiles with you." What do you look like when you are happy? Or when you are bored or worried? A relaxed face with pleasant smile indicates a friendly, approachable climate and makes a good first impression.[12] A supportive tone of voice is one that is calm, controlled, energetic, and enthusiastic.

Eye contact includes gazing in a way that allows the communicator to encounter the other visually—to the extent of being able to notice the other's facial and bodily messages. Besides being an excellent vehicle for feedback, eye contact makes the person feel visible and ensures the other person of the professional's interest and desire to communicate. Posture is best when leaning somewhat toward, rather than away from, the person. Large expansive gestures may be interpreted as a show of power and generally should be avoided.

Touch is a vehicle for feedback that can work positively. Through a gentle touch, a pat, or a squeeze of the hand, one can communicate instantly a desire to solve a problem without offending. Touch can communicate affection, concern, and interest faster than these messages can be generated verbally. Although an individual may look calm, controlled, and totally at ease, a touch may reveal nervousness and insecurity.

Professionals Must Be Alert to Nonverbal Signals from Others

Besides the professional's concerns with the environment and his or her own verbal and nonverbal behavior in creating a trusting climate, one must also be sensitive to nonverbal cues in others. Even though the practitioner is being open, caring, and attending to his or her own behavior, the internal anxiety, confusion, nervousness, or fear in people may be causing them to misunderstand. Two requirements for effective interpersonal communication are to observe the nonverbal cues in others and then respond to them in an affirming way.[11]

If the client or employee is nodding the head to suggest understanding, for example, but looks puzzled, the professional needs to verify understanding by having the person paraphrase or summarize important instructions or dietary recommendations. If the client is flushed, has trembling hands, or tears rolling down the cheeks, the professional may need to deal directly with relieving anxiety. Until the individual is relaxed enough to concentrate, optimal two-way communication is unlikely.

After talking with one another for only a few minutes, both the professional and the client can sense the "warmness" or "coldness" of the other, as well as the degree of the other's concern. If the speaker has a pleasant expression, and looks directly into the eyes of the listener while talking, he or she might be generating inferences in the listener of being a caring person. After the initial positive impression has been created, the impression tends to spread into other areas not directly related to the behavior originally observed.

The process can work in reverse as well. If the professional does not look at the client while talking or touches the client too firmly and has an unpleasant facial expression, the inferences being created may be negative—arrogance, lack of concern, indifference, and "coldness." Even though these initial reactions, both positive and negative, may be inaccurate, faulty first impressions are common. The professional might not be given a second chance to win the client's trust and cooperation.

Positive Affect Must Be Consistent

Seeing clients or employees regularly gives practitioners and managers an opportunity to reinforce or alter the perceptions the other person has of them. A person who is cold, aloof, and uncaring on a daily basis, and suddenly, because it is time to conduct a meeting, acts differently, the individual will not be believed. Practitioners need to be consistent in adding positive inferences to the impressions of their staff and clients.

Not only is it important to generate concern through your own nonverbal behavior and disposition, it is also essential to control, whenever possible, the communication environment so that it, too, leads to positive inferences while eliminating barriers. Attractive offices, pastel-colored rooms, soft lighting, comfortable and private space for counseling, and

comfortable furniture all can add to the client's or staff member's collective perception. Piles of papers on a desk, a ringing mobile phone, and constant interruptions must be replaced with privacy and quiet.[11] Because so much counseling takes place in a clinical setting, more attention must be given to creating an inviting atmosphere.

Among the requirements for effective and successful interpersonal communication is the need for the professional to send verbal and nonverbal messages that are congruent with one another. A client may hear a practitioner say, "I want to help you; I'm concerned about your health and the possible recurrence of your heart problem as a result of your food choices." But if the client sees the practitioner taking notes and checking a watch rather than looking at the client, the contradictory second message of impatience will be more intense than the stated message of concern. The professional may have said all the "right" words, but is judged as insincere. Helping professionals and managers who do not genuinely like working with people are ultimately destined to fail.

Diversity

In recent years, the US population has become more racially and ethnically diverse.[13,14] With the increasing diversity, professionals need knowledge and skills related to cultural competence in communication. The United States is becoming a multi-racial country due to shifts in demographic makeup resulting from immigration and fertility rates with the number of babies born here increasing. In 2011, more minority babies were born than White babies.[13] More children are members of minorities, that is, Black, Hispanic, Asian, and other non-White races.

As the baby boomers grow older and there is a lack of White immigration, the White population is expected to decline. Population projections based on the 2010 census show that White people will become a minority in the 2040s. It is predicted that there will be no racial majority in the United States after 2046.[13]

Communicating health and nutrition education is affected by cultural influences. People from other cultures have their own communication style, languages, practices, beliefs, values, customs, and foods. Cultural understanding and competence are needed to communicate effectively with racial, ethnic, cultural, and linguistically diverse groups.[14] Developing these abilities takes time.

Cultural practices, health beliefs, dealing with illness, and literacy may be influential. Interactions with people who are culturally and linguistically different from oneself should be based on mutual respect, trust, empathy, tolerance, genuine interest, and nonjudgmental responses. Responding to the person as well as exchanging information with simple words about dietary practices in a supportive environment enhances the communication relationship.

One needs to be aware of one's own cultural values, assumptions, and beliefs, but have the ability to function with people from diverse ethnic and cultural backgrounds.[15] Printed materials in the person's culture and other resources are available on the Internet.

Blacks were the largest minority until 2000. Currently, Hispanics are the largest minority group followed by Asians. Overall, Hispanics are less educated than the total population and rank lower on English language usage.[13] As the country becomes more racially diverse, this is affecting educational, medical, and other institutions.

Because there is a risk in self-disclosure, ethnic groups vary in how much they disclose and to whom. Women tend to disclose more than men. Americans may disclose a wider range of information including personal information than Japanese, Chinese, and Asians. People in collectivist cultures, such as China and Japan, follow cultural norms, disclose less, and work for the good of the group. Self-disclosure is affected by competence, involvement, and perceived similarity to oneself. In collectivist cultures, sentences are rarely begun with "I" and people avoid calling attention to themselves, while Americans are more direct.[13]

Nonverbal behaviors should reflect openness, respect, concern, and interest by listening actively and moderating cultural variables, such as touch, eye contact, facial expression, physical space, and use of gestures. Do you make eye contact as you meet someone? Levels of personal space are determined by one's cultural background. Preferences for spatial distance vary, for example, and some stand closer when talking. Vocal qualities, such as pitch, volume, rate, tone, and resonance will differ. Our verbal behaviors should indicate respect, empathy, and nonjudgmental concern, invite questions, and integrate the person's ethnic values and beliefs.

A patient-centered approach to communication competency may consist of assessing cross-cultural issues; exploring the meaning of the illness; inquiring about the social context of living; and engaging in collaborative negotiation. In the healthcare industry, as many as 20 different languages may be encountered among patients and staff. It is impossible to learn all of them, but we should learn those used most often.

Listening Skills

Listening to someone is probably the most ancient of healthcare skills. Listening is "the process of receiving, constructing meaning from, and responding to verbal and nonverbal messages."[4] Most of us are egocentric or focused on ourselves and may have difficulty focusing on communication from others that does not relate directly to us. Well-developed listening skills are a foundation for effective interpersonal relationships and quality care of healthcare providers. Whether working with individuals or groups, more than anything else, people want to be listened to and lack of listening leads to dissatisfaction.[4]

Listening is an essential skill.
Source: CDC/Amanda Mills.

An individual with average intelligence can process information mentally at speeds that are faster than human speech. Most people speak 125 words per minute, while some people can listen up to 600 to 800 words per minute.[4] As a result, people have time to be thinking about other things simultaneously. Two days later, most of us remember only 25% to 50% of what we heard. This is true of both clients and employees. Thus, while nutrition practitioners are listening to their clients or staff members talk, they have time to be thinking about other things. Clients, patients, and staff must believe that they are heard and understood and that the listener is genuinely interested in the message. A person-centered attitude based on empathy, congruence, and unconditional positive regard is helpful.

Everyone has had the experience of listening to a speaker and letting the mind wander to other topics. From the speaker's clothes, shoes, jewelry, diction, and speech patterns, people may tend to fill in details and develop an elaborate scenario while listening. The process of good listening involves learning to harness your attention so that you are able to concentrate totally on the speaker's message, both verbal and nonverbal. Development of these skills is not difficult, but it does require a conscious effort and perseverance.

Listening ability can be enriched only when the person desires such enrichment and is willing to follow the training with practice. The following is a list of five of the most common issues and barriers related to poor listening[4]:

1. Most people have a limited and undeveloped attention span.
2. People tend to stop listening when they have decided that the material is uninteresting and tend to pay attention only to material they "like" or see an immediate benefit in knowing.
3. Listeners tend to trust their intuition regarding the speaker's credibility, basing their judgments more on the speaker's nonverbal behavior than on the content of the message.
4. Listeners tend to attach too much credibility to messages heard on electronic media, such as the internet, television, movies, and so forth.
5. Communication is inhibited by judging, bias, prejudice, giving advice, providing solutions, and ignoring the concerns of the person.