

PERSPECTIVES IN PRACTICE

Facilitating dietary change: The patient-centered counseling model

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ABSTRACT

Recent data indicate that the patient-centered counseling model enhances long-term dietary adherence. This model facilitates change by assessing patient needs and subsequently tailoring the intervention to the patient's stage in the process of change, personal goals, and unique challenges. This article describes this model, including its theoretical foundations, a 4-step counseling process, and applications. This behavioral counseling model can help nutrition professionals enhance patient adherence to nutrition care plans and dietary guidelines. *J Am Diet Assoc.* 2001;101:332-338,341.

As with most training programs for health professionals (1,2), formal education in dietetics devotes relatively little time to training in behavior modification and behavioral counseling skills. While levels of these skills vary among dietitians, the paucity of formal training and the nature of patient encounters in the clinical setting (few repeat visits under sometimes severe time constraints) provide little opportunity to develop an understanding of the principles and practice of behavioral medicine.

To facilitate patient adherence to dietary guidelines in the context of prescribed nutrition care plans and public health initiatives, nutritionists need to increase their knowledge of and comfort level with practical intervention strategies based on cognitive behavioral theory (3-7). As demonstrated in previous investigations (8,9), the patient-centered counseling model provides an effective approach for intervening with patients to promote dietary change and long-term adherence.

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Questions for Assessing Stage of Change and Motivation

How do you feel about your current diet?
 What problems have you had because of your diet?
 Have you (ever) thought about making changes in your diet?
 What would you like to change about your diet now?
 Why would you like to change your diet now?
 What concerns do you have about changing your diet now?
 What reasons might you have to want to maintain your current diet?
 What would motivate you to maintain your current diet?

Questions for Assessing Past Experiences with Dietary Change

Have you ever made changes in your diet?
 Have you maintained these changes? If so, for how long?
 If not, how long did you maintain the change?
 How did you make changes in your diet? What helped?
 What difficulties did you encounter? How did you handle them?

Questions about Anticipated Challenges or Barriers to Change

What could get in your way of attaining your goal?
 What situations will make it hardest for you to achieve your goal?
 What other situations might make it difficult for you to maintain your change?

Questions about Strategies to Cope with Challenges or Barriers to Change

What could you do when you face this challenge?
 What else could you do in the face of this challenge or barrier?
 Who could help you cope with this challenge? How?
 What has been helpful in the past to deal with this barrier?

Questions for Goal Setting

What are you willing to change in your diet now?
 When? How often will you do this?
 Where will you do it?
 What will you have to do in advance to ensure that you are able to make and maintain this change?
 How confident are you of your ability to make and maintain this change?

Questions for Follow-Up

How did you do with your plan?
 What helped you stay on target?
 What difficulties did you encounter?

Questions for Assessing Lapse and Relapse

What made it difficult for you to stay with your plan?
 How did you feel after that?
 What else could you have done to stay on track?
 What would you like to do now?

FIG 1. A Model for Open-ended Questioning.

Incorporating constructs of current state-of-the-art theories, this model is tailored to specific stages of change, goals, and challenges of individual patients (3-7). The shared responsibility of nutritionist and patient in achieving dietary change is emphasized (7). This article describes the theoretical principles underlying patient-centered counseling, practical issues to consider in implementing this model to promote dietary change, and training and practice applications. The term *patients* will be used to refer to patients, clients, or study participants.

THEORETICAL FOUNDATION OF PATIENT-CENTERED COUNSELING

The model for patient-centered counseling reflects principles from several research-supported theories and models: Consumer Information Processing Theory, the Health Belief Model, the Stages of Change Model, Social Cognitive Theory, and Behavioral Self-Management Principles, each of which are briefly described below.

Consumer Information Processing Theory (CIP) postulates that information must not only be available but also wanted or believed to be useful to the consumer, and the consumer must have the time, energy, and level of compre-

hension to process the information (10). Thus, the information must be presented at times when the patient is most receptive, and at a level that he or she can comprehend. The more the provider is able to relate the patient's health concerns to his or her diet and is confident that the patient understands and is able to use this information, the greater the likelihood that the patient will be motivated to make and maintain dietary changes.

The Health Belief Model (11,12) asserts that cognitive factors influence a patient's decision to change or modify a specific behavior. Accordingly, an individual will change a specific health-related behavior if he or she believes that: the behavior makes him or her vulnerable to (or at risk for worsening) disease; changing the behavior will decrease risk; there will be serious consequences if the behavior is not modified; he or she is capable of taking action to change the behavior; and the potential costs of taking action are outweighed by the benefits.

The Stages of Change Model (13,14) of behavior suggests that individuals change problem behaviors by moving through a series of stages representing several levels of readiness to change. These levels reflect a process of change moving from not considering change (pre-contemplation), to motivation to

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Nutritionist (N): What concerns do you have about your diet? (OPEN-ENDED QUESTION)

Patient (PT): I seem to be losing motivation to eat a low-fat diet, and have skipped a couple of appointments because of time pressures at work.

N: Tell me about your work. (OPEN-ENDED QUESTION)

PT: I'm a lawyer with a large company. There is a lot of pressure to produce and bring in new clients.

N: It sounds like your work is quite stressful. (REFLECTIVE STATEMENT)

PT: Yes, but it is quite challenging, pays well, and I like going to court to try cases.

N: So, even though your work is stressful, you find it rewarding. (REFLECTIVE STATEMENT)

PT: Well, most of the time, but lately I wonder where it is all going. It's really affecting my motivation and energy to keep appointments and follow a low-fat diet.

N: What other concerns do you have about your diet? (OPEN-ENDED QUESTION)

PT: That's a good question. Actually, I used to keep a food diary that was very helpful, but I don't seem to have the motivation to continue to write things down all the time.

N: I know it is hard to think about keeping food diaries when you are feeling so much stress at work. (VALIDATING STATEMENT)

What kinds of things have you done in the past to keep a food diary? (OPEN-ENDED QUESTION)

PT: I used to keep it with me at all times, but lately I'm too tired to even think about it.

N: What other kinds of things helped you keep a food diary? (OPEN-ENDED QUESTION)

PT: Reminding myself that I eat much healthier meals when I monitor what I eat.

N: What other things have been helpful to you to keep a food diary? (OPEN-ENDED QUESTION)

PT: Going over the entire food diary at the end of the day. I used to take pride in how much I learned about nutrition and how much I had been able to improve my diet.

N: You mentioned a number of things about your work and the stress you are experiencing at work. You also spoke about having little energy or motivation to attend appointments and keep food diaries. (SUMMARY STATEMENT)

I'm optimistic about your ability to work toward your goal of staying on a low-fat diet and would like to help you attain your goal. (SUPPORTIVE STATEMENT)

What do you think might help you, little by little, to get back on track with things you used to do? (OPEN-ENDED QUESTION)

FIG 2. Example of Patient-centered Counseling.

change (contemplation) prior to making a commitment to change, and making the change (action). This model emphasizes that, to be effective, interventions should be tailored to the specific stage at which the patient is. It emphasizes that traditional interventions are action oriented (focused on immediate behavior change) and thus do not address issues faced by patients who are not yet ready to make a change. For example, counseling for a pre-contemplator or contemplator requires the provision of information and materials stressing the benefits of specific dietary changes and feedback on the patient's current diet-related risk; counseling a patient in the preparation or action stages warrants development of an action plan with specifically stated goals, and discussion of relapse prevention strategies.

Social Cognitive Theory (12,15) states that the process of learning involves active participation by the patient; behavior is learned and therefore can be unlearned, and behavior is determined by multiple influences. Self-efficacy, the central concept of social cognitive theory, refers to a patient's belief in

his/her ability to change or maintain a specific behavior. The level of self-efficacy has a direct impact on a person's willingness to engage in a behavior and to persist in the face of obstacles (eg, lack of initial success, busy schedule). For example, a positive belief that one has the necessary knowledge and resources to eat a low-fat diet and is capable of doing it will lead to a greater commitment to decrease dietary fat intake and persistence in maintaining such change. Another important construct is outcome expectations, or the degree to which a patient believes that a given course of action will lead to a particular outcome (eg, how firmly an individual believes that lowering fat intake to < 30% calories from fat will reduce risk for heart disease). Outcome expectations must be favorable for behavior change to occur.

Behavioral Self-Management (16-19) emphasizes behavior modification principles, requiring increased awareness of the triggers that cue a behavior and the consequences that reinforce it. Self-monitoring strategies are useful for enhancing the patient's awareness of triggers ("high-risk" situations) and

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Eating Diary

Date/ Time	Meal/ Snack	(0-100%) Hunger Level	Location	Activity	With Whom	Mood	Self- defeating thoughts	Food Eaten/ Amount	Duration

FIG 3. Sample Self-Monitoring Form.

reinforcers (ie, short-term (taste, convenience) and long-term (disease prevention) consequences that maintain specific eating patterns. The patient can then decide whether to avoid a trigger, alter it, or substitute an incompatible behavior (that is, engage in a behavior normally incompatible with eating, such as taking a shower or going for a walk) when the trigger occurs.

THE PATIENT-CENTERED COUNSELING STEPS

The objectives of patient-centered counseling for dietary change are to: a) increase the patient's awareness of his/her diet-related risks; b) provide the patient with nutrition knowledge; c) increase the patient's confidence in his/her ability to make dietary changes; and d) enhance skills needed for long-term adherence to dietary change plans. The patient-centered counseling model helps nutritionist professionals tailor the intervention to the patient. Patient-centered counseling involves a 4-step process including: a brief, but thorough, assessment of the patient's current stage of change relative to general or specific aspects of dietary behavior; advice with respect to the need to change specific eating behaviors; assistance in changing such behaviors; and arranging follow-up to monitor how plans are proceeding. These 4 well-defined steps are discussed below.

Step 1: Assess A complete behavioral assessment is an essential component of the patient-centered counseling approach. Important information to obtain include: patient's knowledge of risks associated with current eating patterns, history of health problems associated with current eating

patterns, readiness to change (stage of change) specific eating-related behaviors (eg, dietary fat, fruits and vegetables, grains, sodium), concerns about changing dietary intake, feelings about specific changes, past experiences with change in dietary intake or other behavioral change, challenges experienced in previous attempts to change dietary intake, strategies that helped and those that did not help during previous attempts to change, reasons for wanting to make dietary changes, and reasons for wanting to maintain current eating patterns. The nutritionist can use open-ended questions to obtain relevant information that will assist him/her in tailoring the dietary intervention. Examples of open-ended assessment questions are presented in Figure 1. In addition to the use of open-ended questions, reflective statements and summary statements should be used to clarify and summarize information provided by the patient (see Figure 2).

Step 2: Advise Advice for changing eating behaviors should be personalized and refer to the patient's health concerns or clinical condition, the patient's stated reasons to change dietary intake, diet history, personal preferences, and other benefits of modifying dietary intake for the patient. Two examples of personalized advice follow:

"Mr. Jones, as your nutritionist, I am concerned about how your present diet is affecting your health. One of your major risk factors for heart disease is your high blood cholesterol level. Lifestyle changes, such as decreasing the amount of saturated fat in your diet, can reduce this

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Steps to Success

The purpose of this activity is to help you achieve and maintain healthful eating habits. The steps outlined below will guide you in 1) identifying areas for improvement, 2) setting a goal, and 3) developing a plan of action.

1. Identifying areas for dietary improvement. We encourage you to use information from your most recent self-monitoring and/or past experiences to identify areas for dietary improvement. List the three areas that are most important to you from a personal perspective.

- 1)
2)
3)

2. Setting a goal. Select one area for dietary modification from the list above. Your goal must be specific, measurable, and realistic. Answer all questions that apply to the area that you have selected for modification.

Area to modify:

What will you do differently so that you know (or someone else observing you knows) that you are making progress toward your goal? Be specific.

Specify a time period (eg, week, month, vacation):

Specify how often (eg, daily, one time per week):

Specify how much (eg, 1/2 cup, 1 oz):

Specify where (eg, home, work, restaurant, social gathering):

Specify with whom (eg, husband, children, grandchildren, friends):

3. Developing a plan of action. List the three challenges that you are most likely to encounter in your effort to reach your dietary goal. (Below is a list of challenges that commonly affect some women. Add your own challenges as necessary.)

Challenge #1

Challenge #2

Challenge #3

What will you do to manage your challenges in order to prevent them from affecting your ability to attain your goal?

To manage Challenge 1, I will

To manage Challenge 2, I will

To manage Challenge 3, I will

How confident are you, on a scale of 0% to 100%, that you can achieve this goal?
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

(If you are not at least 75% confident, modify your goal to increase the likelihood that you will be successful.)
I will begin working on the following goal:

on (date) I will self-monitor using an Eating Diary to evaluate my success in reaching this goal. I will bring the diary with me to my next appointment and discuss successes/challenges with my nutritionist.

Signature Date

FIG 4 Sample Personalized Goal-setting Sheet.

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risk. I would like to help you make changes in your diet so that you can decrease your risk of another heart attack."

"Mrs. Clark, as your nutritionist, I need to advise you of the importance of diet and exercise for managing your diabetes. Large increases and decreases in your blood sugar are related to your current eating patterns. I would be happy to assist you in modifying your diet to reduce the likelihood of diabetes complications, lose some weight, and feel healthier."

Step 3: Assist The type of assistance provided to patients to help them change dietary behaviors will depend on their stage of change for specific eating and related behaviors. The intervention should be appropriate to the stage of change. For all patients, but particularly for pre-contemplators and contemplators, the nutritionist should strive to provide information, correct misunderstandings, address feelings about the prescribed or recommended dietary change, provide support, and express realistic optimism regarding potential for change. This can be done through motivational statements such as the following:

Validating the patient's feelings about prescribed dietary changes

"I know it's hard to... (eg, cut down on ice cream when your roommate keeps bringing it home, adhere to your dietary goals during vacations, keep food records when you have been so busy at home and work)."

"It must be difficult to... (eg, cope with your health problem and think about changing your diet at the same time, make dietary changes when you are not in control of food shopping and food preparation at home)."

Conveying respect and support for the patient

"I'd be happy to help you when you are ready to start making changes."

"I'd like to help you with... (eg, developing a self-monitoring strategy for keeping track of what you eat, finding low-sodium recipes that appeal to both you and your husband)."

Expressing optimism about the chances for success

"I'm optimistic about your ability to... (eg, increase the amount of whole grains that you eat)."

"You appear confident in taking the necessary steps to achieve your goal of... (eg, eating fruits and vegetables for snacks, decreasing consumption of soft drinks)."

Tailoring counseling to stages of change

A patient may be at different stages of change with regard to various eating behaviors. For example, he or she may be ready (preparation or action) to reduce saturated fat intake but may not be willing to consider (pre-contemplation) increased consumption of whole grains.

Counseling a patient about eating behaviors for which he/she is in a pre-contemplation stage requires exploring with the patient his/her personal pros (benefits) and cons (disadvantages) of changing intake of specific foods. The cons of change need to be put into perspective, discussing with the patient ways to deal with them. Thus, the goal of intervening with precontemplators is not to get the patient to change immediately but simply to motivate him/her to move to contemplate the change. Open-ended hypothetical questions can be helpful in discussing pros and cons with pre-contemplators:

"What types of benefits might you expect if you were to... (eg, change your diet, decrease your salt intake)?"

"What problems might you experience if you decided to... (eg, cut down on fat, increase the amount of fiber you eat)?"

Previous unsuccessful attempts at dietary change should be reframed by emphasizing the positive aspects of each attempt to change. Examples of this include:

"What did you learn from your experience?"

"Most people experience ups and downs when making changes."

"It's great that you have tried to change your diet in the past. Your previous experiences will contribute to your understanding of what helps you and what doesn't."

Formal education in behavioral strategies for promoting dietary change needs to be emphasized more in dietetic training and continuing education programs

In contrast to a pre-contemplator, a contemplator needs support to attempt a dietary change and develop realistic strategies. In some patients, lack of motivation to make dietary change will be related to low self-efficacy, or limited confidence in the ability to succeed in changing dietary patterns.

With an individual preparing for action, the nutritionist should discuss dietary goals and specific steps to achieve those goals. Specific skills, such as self-monitoring, goal setting, and problem solving should be taught. Self-monitoring requires the patient to log his/her eating behavior for a determined period of time. In some cases, logging concurrent personal (ie, physiological state, thought patterns, emotional state/feelings) and environmental (ie, location, presence of others) stimuli that may trigger or reinforce specific eating patterns is helpful. See

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Figure 3 for a sample self-monitoring form. Such detailed self-monitoring reveals not only specific food intake targeted for change but also specific eating-related areas that need attention (ie, high-risk situations). It thus provides opportunities to discuss and plan strategies tailored to the patient's unique circumstances. Evaluation of the patient's self-monitoring log allows the nutritionist to discuss, in partnership with the patient, areas representing challenges, potential triggers of undesirable eating patterns, and other factors related to such patterns that should be addressed as part of the intervention.

The use of patient-centered counseling promotes interaction and collaboration between the patient and nutritionist such that the patient is actively involved in developing an appropriate care plan, including strategies for achieving dietary goals

Goal setting

Goal setting is another important aspect of patient-centered counseling. Goals are most useful when the patient sets them with the assistance of the nutritionist, after reviewing areas in need of change. An open-ended question such as "What are you ready to do now?" can encourage the patient to consider options for change. Patients should focus on only a few goals at a time (1-3, depending on the patient). Goals should be clearly defined and include specific behaviors and the specific circumstances under which these behaviors will occur (eg, when, where, how often, for how long). Goals such as "I will try to work on increasing grains" are not specific. Instead, a goal such as "I will eat a small bowl of whole-grain cereal every weekday morning before leaving for work" clearly indicates what behavior the patient will modify.

As part of goal setting, the patient's concerns and perceived or real challenges/barriers to attaining the agreed-upon goal need to be identified, and a plan for managing such barriers should be negotiated. The nutritionist's use of feedback, reflection, summary, and problem-solving strategies will encourage the patient to explore ways of coping with anticipated difficul-

ties and, thus, will enhance the patient's self-efficacy expectations. An expectation of success (high self-efficacy) is a critical factor in the degree of commitment and persistence that an individual will make in his/her efforts to make and maintain dietary changes. Open-ended questions such as the following help assess overall self-efficacy for general or specific dietary change, identify challenges with respect to stated goals, and develop problem-solving skills.

"On a scale of 0% to 100%, how confident are you that you could... (eg, decrease portion sizes of red meats containing lots of saturated fat, reduce frequency of eating high-sodium snack foods)?"

What will be the most difficult challenges for you to... (eg, attain a goal of 30% of calories from fat)?"

What steps will you take to manage ... (eg, pressure from your spouse to eat high-fat desserts, having 5 fruits and vegetables a day)?"

Low self-efficacy may be due to either perceived or actual deficits in personal knowledge, skills, resources, or environmental supports. For patients with low self-efficacy for a specific diet change (ie, <80% on a 0%-100% scale), the intervention should begin by working on the areas where deficits have been identified. For patients who identify limited knowledge as their main obstacle to change, additional information or additional means of providing dietary information (eg, pamphlets, videos, internet) should be considered, depending on the patient and the available resources. When deficits in one or more skills are identified, priority should be placed on addressing them. These deficits can include, but are not restricted to, limited cooking experience, poor assertiveness skills (eg, to communicate dietary needs to others, to refuse unhealthy food offers), difficulties in soliciting social support from others (eg, spouse, children, close friends), or perhaps lack of information about where to buy specific foods. In managing high-risk situations, strategies may include: avoiding the situation; engaging in behaviors incompatible with eating (such as going for a walk); having substitutes available to deal with the high-risk situation (eg, having fruits available for dessert); and developing alternative coping skills to use in high-risk situations, such as learning to feel comfortable when refusing food offers that are inconsistent with specified dietary goals. Referral to appropriate professionals should be made if the identified obstacle is beyond the nutritionist's level of competence (eg, referral to a psychologist for patients with an eating disorder or with deficits in the skills needed to make desired dietary changes).

Re-assessing self-efficacy

The nutrition profession should assess the patient's self-efficacy expectations with regard to each negotiated goal to ensure that the patient's beliefs about his or her ability to achieve the goal are favorable to facilitate behavior change. Self-efficacy expectations should be reassessed and, if necessary, enhanced at every intervention step to increase the likelihood that the plans for change negotiated with the patient will be successful.

Behavioral contracts

Behavioral contracts signed by the patient can help clarify individual goals and strategies and reinforce commitment to make the negotiated changes, thereby enhancing the likelihood of goal attainment. See Figure 4 for a sample of a personalized goal-setting sheet.

CONTINUING PROFESSIONAL EDUCATION QUESTIONNAIRE

Continuing professional education questionnaire

After reading the continuing professional education article, "Facilitating dietary change: the patient-centered counseling model," please answer the following questions by indicating your responses on the self-assessment questionnaire form located on the next page.

This activity has been approved for 1 hour of continuing professional education credit for registered dietitians and dietetic technicians, registered, by the Commission on Dietetic Registration. Answers to the continuing professional education questionnaire can be found on page 383.

ADA members should cut out the completed form and return it, with a check for \$18 each (nonmembers \$25) to cover processing, to: American Dietetic Association, PO Box 97215, Chicago, IL 60678-7215.

Questionnaires must be returned within 1 year of their appearance in the *Journal* in order to be eligible for credit. Notification will not be sent if the hour is approved.

1. All but which of the following is an objective of patient centered counseling:

- A. increase awareness of diet related risks
- B. provide nutrition knowledge
- C. emphasize short term adherence to dietary changes
- D. increase confidence in the ability to make dietary changes

2. Avoidance of the abstinence violation is part of which of the following strategies:

- A. validating patients feelings
- B. conveying respect for patient
- C. preventing relapse
- D. goal setting

Questions 3-6 match the theory or model described in each statement:

3. Behavior is learned and can therefore be unlearned:

- A. Health Belief Model
- B. Stage of Change Model
- C. Social Cognitive Theory
- D. Behavioral Self-Management

4. Individual change behavior by moving through a series of stages:

- A. Health Belief Model
- B. Stage of Change Model
- C. Social Cognitive Theory
- D. Behavioral Self-Management

5. The individual must be aware of the cues that trigger a behavior:

- A. Health Belief Model
- B. Stage of Change Model
- C. Social Cognitive Theory
- D. Behavioral Self-Management

6. An individual will change a behavior if he believes there are serious consequences if the behavior is not modified:

- A. Health Belief Model
- B. Stage of Change Model
- C. Social Cognitive Theory
- D. Behavioral Self-Management

Questions 7-12 match the patient-centered counseling step described in each statement

7. Information depends on the stage of change:

- A. assess
- B. advise
- C. assist
- D. follow-up

CONTINUING PROFESSIONAL EDUCATION QUESTIONNAIRE

8. History of health problems:

- A. assess
- B. advise
- C. assist
- D. follow-up

9. Evaluate and monitor progress:

- A. assess
- B. advise
- C. assist
- D. follow-up

10. Should be personalized and refer to health concerns of the patient:

- A. assess
- B. advise
- C. assist
- D. follow-up

11. Address benefits of modifying dietary intake for the patient:

- A. assess
- B. advise
- C. assist
- D. follow-up

12. Discuss pros and cons of dietary change:

- A. assess
- B. advise
- C. assist
- D. follow-up

For items 13 to 17, decide if the statements are true or false

13. A patient may be at different stages of change regarding various eating behaviors

- A. True
- B. False

14. Reflective statements should not be used during the assessment step

- A. True
- B. False

15. The goal of intervention regarding a pre-contemplator is immediate change

- A. True
- B. False

16. A contemplator needs support to attempt change

- A. True
- B. False

17. Goals and steps to achieve these goals should be discussed with patient preparing for action

- A. True
- B. False

CONTINUING PROFESSIONAL EDUCATION REPORTING FORM

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2. Did this article impact your practice? Yes, How so? _____

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After reading each statement, please select the best answer(s) or completion(s):

- | | | | | |
|-----|---|---|---|---|
| 1. | A | B | C | D |
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| 6. | A | B | C | D |
| 7. | A | B | C | D |
| 8. | A | B | C | D |
| 9. | A | B | C | D |
| 10. | A | B | C | D |
| 11. | A | B | | |
| 12. | A | B | | |
| 13. | A | B | | |
| 14. | A | B | | |
| 15. | A | B | C | D |
| 16. | A | B | C | D |
| 17. | A | B | C | D |

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PERSPECTIVES IN PRACTICE

Step 4: Arrange for follow-up Maintenance of dietary changes is often difficult. Follow-up is an important component of any behavioral intervention because it allows the nutritionist and the patient to evaluate and monitor progress and to determine whether the plan is appropriate. Questions such as "What part of the plan was most helpful?" and "What part of the plan did not work?" can help the nutritionist and the patient revise the plan and future goals. Arranging for a time when progress and attainment of goals will be evaluated communicates to the patient that the dietary change is important, the nutritionist is willing to spend time to help the patient monitor the change, and that difficulties encountered will be examined and strategies to overcome them will be discussed. Examples of open-ended follow-up questions are provided in Figure 1.

Preventing relapse

As part of follow-up contacts, relapse prevention strategies initially introduced by Marlatt and colleagues (20, 21) should be taught. These strategies include: a) continued identification and awareness of high-risk situations; b) additional problem-solving strategies to manage such situations; c) identification of thoughts that undermine dietary goals (eg, "I deserve to eat this bag of chips, I've been good with my diet for a week.") and combating them; and d) avoidance of the abstinence violation effect (eg, attributing lapses to internal weakness and personal failure, such as lack of will power, with a resulting decrease in motivation to maintain dietary changes—"I can't change."). Nutritionists can help patients avoid this by making them aware that this reaction is common, clarifying the difference between a lapse (slip) and relapse (return to an old behavior), emphasizing the importance of taking a lapse as a quick cue to do something so that it does not turn into a relapse, and combating irrational interpretations of a lapse (eg, "I can't change."). It is useful to emphasize that one mistake does not make a person unable to change, unless the person uses it as an excuse to not continue pursuing his/her goals.

conjunction with feedback from a behaviorist, and application in clinical and community settings. The use of patient-centered counseling promotes interaction and collaboration between the patient and nutritionist such that the patient is actively involved in developing an appropriate care plan, including strategies for achieving dietary goals. Nutritionists should master counseling skills to assist their patients in acquiring knowledge, attitudes, and skills needed to move through the process of change and, ultimately, adopt diets consistent with favorable health outcomes.

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APPLICATIONS

Patient-centered counseling has widespread application for nutritionists in a variety of clinical, community and public health specialties. Previous research using the counseling techniques described herein provides empirical evidence demonstrating the effectiveness of this approach (8,9). Formal education in behavioral strategies for promoting dietary change needs to be emphasized more in dietetic training and continuing education programs. Training should include the theoretical basis for counseling, observation of professionals with expertise in behavioral medicine, extensive role playing in