SECTION 1

Dietetic practice
1.1 Professional practice

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Key points

- UK dietitians must be graduates of an approved education programme and registered with the Health and Care Professions Council.
- The British Dietetic Association is a professional association that aims to inform, protect, represent and support its members.
- Dietitians are autonomous practitioners who work within an ethical framework of conduct.
- The nutrition and dietetic process is central to dietetic practice.
- Dietetics is an evidence-based profession with research and outcome evaluation at its core.
- Dietitians engage in continuing professional development throughout their careers to ensure that their practice is robust, effective and innovative.

Dietetics is a well-respected and established profession, albeit a relatively new one. The first UK dietitian, Ruth Pybus, a nursing sister, was appointed in 1924 at the Royal Infirmary in Edinburgh. She initially sought to demonstrate that a dietetic outpatient clinic could significantly reduce the number of admissions and therefore benefit the hospital. She was successful and, after a 6-month trial, her appointment as a dietitian was confirmed. The development of other dietetic departments quickly followed, especially in London, and the first non-nursing dietitians were appointed in 1928. From these early days, dietetics has been a science-based profession and, in the 1980s, became the first of the allied health professions (AHPs) to become a graduate profession.

The British Dietetic Association (BDA) was founded in 1936 as the professional association for registered dietitians in Great Britain and Northern Ireland. The BDA promotes the vital work of its members in order to raise the profile of the profession. It represents the best interests of dietitians collectively when working with national organisations, stakeholders and key partners, and aims to influence government policy. This in turn drives demand for evidence-based nutrition and dietetics.

Dietetics is both an art and a science that requires the application of safe and evidence-based practice, reflective practice and systematic clinical reasoning. A dietitian needs to combine these skills with knowledge and experience, together with intuition, insight and understanding of the individual (or specific) circumstance, in order to maintain and improve practice. Following several public enquiries at the end of the last century, it was recognised that there needed to be greater priority given to nonclinical aspects of care, such as skills in communicating with colleagues and service users, management, development of teamwork, shared learning across professional boundaries, auditing, reflective practice and leadership. Subsequent legislative changes were implemented with the establishment of the Health and Care Professions Council (HCPC).

Dietetics as a profession

A degree of responsibility and expectation are part of being a professional. A member of any profession, including dietetics, must, within their practice, agree to be governed by a code of ethics, uphold high standards of performance and competence, behave with integrity and morality, and be selfless in the promotion of the public good (Cruess et al., 2004). Furthermore, these commitments form the basis of an understanding that results in professions, and their members, being accountable to service users and to society.

Professional regulation

To use the title of dietitian, and to practise as one, it is mandatory to have completed an approved programme of education and be registered with the HCPC. The HCPC
was set up in 2001 to protect the health and well-being of people using the services of the health professionals registered with them. It aims to:

- Maintain and publish a public register of properly qualified members of the professions.
- Approve and uphold high standards of education and training and continuing good practice.
- Investigate complaints and take appropriate action.
- Work in partnership with the public and other groups, including professional bodies.

To remain on the HCPC register, dietitians must continue to meet the standards that are set for the profession. The professional standards are:

- Good character of health professionals.
- Health.
- Proficiency (dietetics).
- Conduct performance and ethics.
- Continuing professional development (CPD).
- Education and training.

The HCPC uses these standards to determine if a registrant is fit to practise. If the HCPC finds that there are concerns about a dietitian's ability to practise safely and effectively, and therefore fitness to practise is impaired, it has the legal right to take action. This may mean that such registrants are not allowed to practise, or that they are limited in what they are allowed to do. The HCPC can legally take appropriate action to enforce this (HCPC, 2010).

**The British Dietetic Association as a professional body**

The distinction between a regulatory body (HCPC) and a professional body (BDA) is often misunderstood. It is important that dietitians be fully aware of the differences from the beginning of professional training. Much like the HCPC, the BDA is committed to protecting the public and service users. However, the two organisations achieve this in very different ways (Table 1.1.1). The HCPC has the ultimate authority to prevent dietitians from practising if, following investigation, they are deemed to be unsafe or untrustworthy. However, the BDA provides guidance, advice, learning and networking opportunities, and professional indemnity insurance cover, all with the aim of supporting the development of safe and effective practitioners. This ultimately helps protect the public and service users. The BDA also provides a trade union function and supports members throughout their working life on issues such as pay and conditions, equal opportunities, maternity rights, and health and safety.

**Autonomy**

Autonomy can be defined as the right of self-governance. As independent practitioners who practice autonomously, dietitians are accountable for their decision-making, given that they have a moral and legal obligation for the provision of safe and competent service delivery (BDA, 2017). This means they are answerable for their actions and omissions, regardless of advice or directions from another health professional. Dietitians have a duty of care for their service users and clients, who are entitled to receive safe and competent care or service. The HCPC states that, as autonomous and accountable professionals, dietitians ‘... need to make informed and reasonable decisions about their practice. This might include getting advice and support from education providers, employers, professional bodies, colleagues and other people to make sure that you protect the wellbeing of service users at all times’ (HCPC, 2016).

It is important that dietitians be aware of the boundaries of their autonomy, which will never be limitless but confined to their scope of practice. As with all health professionals, dietitians must never practise in isolation. Up-to-date knowledge skills and experience are the cornerstones of safe and effective practice, and as such dietitians should always have access to a support network of learning, development and peer review. In the National Health Service (NHS) setting, the system for learning and development is usually already established via internal processes, e.g. supervision, appraisal, local training programmes, library services and journal clubs. Outside of the NHS, these processes are not automatically in place, and it is essential that healthcare professionals actively establish a network of support and learning to match their scope of practice, e.g. freelance practice (see Chapter 4.1, Freelance dietetics).

**Scope of practice**

Identifying individual scope of practice is not easy as the boundaries will be different for each practitioner and
Extended roles and practice

The extended roles that a dietitian will undertake are those outside their core and specialist roles. They are usually (but not exclusively) roles traditionally carried out by other health professionals of at least specialist or advanced level, either as a core duty or role extension. Additional skills and knowledge are acquired through formal training. The extended role practitioner must advance dietetic practice and contribute to improving outcomes. Examples of extended roles include:

- Replacing gastrostomy tubes in the community.
- Inserting peripheral midlines for intravenous feeding.
- Supplementary prescribing of medicines.

Activities such as taking blood pressure or a finger-prick test of blood to test for blood glucose are not included in the extended roles of a dietitian. Whatever role a dietitian commits to, extended or otherwise, they must constantly be aware of their individual scope of practice, and practice within this. Extended roles and pushing the boundaries of nutrition and dietetic practice are not new. It is actively encouraged by the BDA, and is part of what continues to make dietetics the relevant, dynamic and resourceful profession it is.

**Ethics and conduct**

Conduct is the manner in which a person behaves, especially in a particular place or situation, while ethics are moral principles that govern an individual’s or a group’s behaviour. However, it is essential to put these definitions into context for them to have any meaning. In professional practice, professional ethical conduct is of paramount importance. Outside of their professional role, dietitians have the right to behave how they choose, within the limits of the law, and this will be limited only by personal ethical boundaries. In professional practice, it is the professional codes of conduct that provide the framework for how, and the benchmark by which, ethical conduct will be measured. A major function of a code of conduct is to enable professionals to make informed choices when faced with an ethical dilemma. For the dietetic workforce, the key guidance is laid out in the HCPC’s Standards of conduct, performance and ethics (2016) and Guidance on conduct and ethics for students (2009).

The BDA’s Code of Professional Conduct (2017) builds on the generic standards of the HCPC with more dietetic-specific guidance. They apply to the whole dietetic workforce from unregulated students and support workers to qualified dietitians. This code is necessarily broad and cannot provide definitive answers to every situation that members may encounter over the course of their careers. They have been written in such a way as to provide members with the freedom to advance, develop and innovate practice in their chosen area of nutrition and dietetics, centred on the needs and expectations of their service users.

**Purpose of dietetics**

The primary purpose of the practice of dietetics is to optimise the nutritional health of the service users, be they an individual, group or community, or population. By optimising the nutritional health of the service users, the dietitian expects to positively influence health outcomes. In dietetics, it is common for the dietitian to seek to influence or change other aspects of care or treatment, e.g. medication or the psychological well-being of the service user. However, the primary purpose of the dietitian is to identify and take action to improve the nutritional status of the service user and to improve those symptoms that are amenable to dietetic intervention.

Any single consultation or professional activity is incredibly complex and involves a number of different and varied strands of knowledge – from biological and social sciences to food and medicine, alongside communication and clinical decision-making skills and attributes.
such as empathy and respect. These are applied within professional and legal frameworks and boundaries and within organisational and social norms and standards. Most of this thought process is invisible to other professionals (and often to the user) as it takes place rapidly in the dietitian’s mind. The integration of all these components in a systematic way is what differentiates between dietitians and other professionals who provide some nutrition services. Service users, health professionals, healthcare organisations and governments demand high-quality healthcare. Quality in healthcare can be measured in domains such as patient experience, effectiveness and safety.

**Process for nutrition and dietetic practice**

The BDA’s Process for Nutrition and Dietetic Practice (PNDP) (the Process) (2016) demonstrates how dietitians integrate professional knowledge and skills into evidence-based decision-making, and hence the Process could be described as the cornerstone of practice. The Process describes the fundamentals of the dietetic intervention and is a tool in facilitating the profession to provide a consistent quality of care. It is applicable to all areas of practice including clinical, public health and health promotion, and whether working with individuals, groups or communities.

The Process is shown in Figure 1.1.1, and it clearly shows the central role of the service user in dietetic practice. Service users bring their culture, beliefs and attitudes to the intervention, and these values guide shared decision-making. Within statutory regulated health services, this focus on the service user is described as patient-centred care. There are many and varied definitions for patient-centred care, but that of the Institute of Medicine (2001) ‘Providing care that is respectful of, and responsive to, individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions’ encompasses all the concepts.

While providing a concept for a systemic method for practice, the Process does not undermine the professional autonomy of the dietitian, who is required to make decisions at every step. The Process clearly identifies the steps within a dietetic intervention and the skills, resources and knowledge used by the dietitian, but does not replace the dietitian’s decision-making. The BDA nutrition and dietetic process consists of five steps (Table 1.1.3):

- Assessment.
- Nutrition and dietetic diagnosis.
- Formulation and planning of the intervention.
- Implementation of the intervention.
- Monitoring and evaluation.

**Dietetic diagnosis**

As previously stated, dietitians are autonomous professionals, and therefore responsible for their actions. One of the ways in which a dietitian demonstrates this autonomy is the identification of a nutritional and dietetic diagnosis. The diagnosis step may be considered the most important step in the Process, but it is often the
1.1 Professional practice

<table>
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<tr>
<th>Step</th>
<th>Definition</th>
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<tr>
<td>Assessment</td>
<td>A systematic process of collecting and interpreting information to make decisions about the nature and cause of nutrition-related health issues in an individual, a group or a population. Its purpose is to obtain adequate and relevant information to identify nutrition-related problems and to inform the development and monitoring of the intervention. It is initiated by the identification of need, e.g. screening, referral by a health professional, self-referral, high-level public health data, epidemiological data or other similar process.</td>
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<tr>
<td>Identification of nutritional and dietetic diagnosis</td>
<td>Identification of nutritional problems that impact on the physical, mental and/or social well-being where the dietitian is responsible for action.</td>
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| Plan intervention                              | A set of activities and associated resources that are used to address the identified nutritional and dietetic diagnosis, designed with the intent of changing nutrition-related behaviours, risk factors, environmental factors or aspects of physical or psychological health or nutritional status of the individual, group or population. All interventions are planned with the communities, service users and carers who are the recipients of the intervention. This client-centred approach is a key element in developing a realistic plan that has a high probability of positively influencing the outcome. This will usually involve describing:  
  • Overall measurable and specific outcomes  
  • Intermediate goals that will achieve the outcomes, determined by the diagnosis statement and assessment information  
  • Plan designed to meet the goals and outcomes – interventions, provision of food, provision of nutritional support, education package, counselling, coordination of care, social marketing campaigns, food availability, food shopping and cooking skills  
  • Roles and responsibilities of individuals, professionals and organisations in delivering the plan. |
| Implementation                                  | The action phase of the nutrition and dietetic process. Dietitians may carry out the intervention, or delegate to or coordinate with another health or social care professional; patient, client or carer; voluntary organisation or member of the nutrition and dietetic team. |
| Monitoring                                     | The review and measurement of the client, group or population's nutritional status at planned intervals with regard to the nutritional diagnosis, intervention plan, goals and outcomes. It includes monitoring the implementation processes of the plan. |
| Evaluation                                     | The systematic comparison of current findings against previous status, intervention goals and outcomes or a reference standard, and usually takes place at the end of the process. |

Step that is missed. In making a diagnosis, the dietitian uses critical reasoning skills to evaluate the assessment information and to make judgements as to the risks to the service user(s) of taking action, or not. The dietitian will prioritise the nutritional issues identified and make a judgement as to whether taking action on these issues will make a difference to the health and outcomes for the service user (individual, group or population).

In developing the diagnosis, the dietitian identifies the relevant aspects of the assessment, and clearly states the nutritional problems that he or she and the service user have prioritised, the nutritional issues the dietitian can influence and the impact the nutritional and dietetic intervention will have on the service user’s health (physical, mental or social well-being). The benefits from making a nutritional and dietetic diagnosis include:

- Sharing with the others involved with the service user the nutritional issue(s) that the dietitian and service user have prioritised.
- Identifying the specific nutritional issue(s) that the dietitian can influence.
- Identifying the indicators in the assessment process that will form the basis of monitoring and evaluation.
- Demonstrating the thoroughness of the assessment process and clearly communicating this to other professionals.
The diagnostic statement should clearly record for all service providers the problem, its cause (aetiology) and why the dietitian considers that it is a problem (symptoms). This statement also forms the basis of the monitoring and evaluation step as dietitians will also have identified the most important indicators from their description of the symptoms.

**Recording and information management**

Another fundamental aspect of professionalism is the accurate recording of the nutrition and dietetic process. The HCPC (2013) standards of proficiency require dietitians to be able to maintain records appropriately. The information in records, including dietetic records, is used for many different purposes. Most importantly, it provides a permanent account of the dietetic process, especially the intervention, and a means of communication between all professionals and others involved, including the service user. Information contained within records is also used for several other purposes, including demonstrating the overall effectiveness of the dietetic service and, possibly, organisation, quality monitoring and service improvement, research and public health purposes. While the increasing use of electronic health records requires more systematic record keeping, there is evidence that using a systematic format in any record, paper or electronic, improves the quality of care and service user outcomes (Mann & Williams, 2003). It is therefore important that the information in professional records be recorded accurately, systematically and consistently.

**Quality improvement**

Quality (Donabedian, 1980) has many dimensions. In the health service, patients, the public and carers expect safe, effective and consistent high-quality care and treatment. For the individual dietitian, this is a requirement of registration with the HCPC. Quality improvement involves a series of activities undertaken to reduce the gap between current practice and desired practice.

As a result of the need to account for its management and clinical efficiency, effectiveness and value for money, the NHS developed the concept of clinical governance. Clinical governance is defined as ‘the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish’ (Scally & Donaldson, 1998, p. 61). The principles of clinical governance are embedded within the organisation and encompass:

- Clinical audit.
- Evidence-based practice.
- Information governance (including record keeping).
- Patient and public involvement.
- Patient safety.
- Revalidation and performance.
- Risk management and medicolegal issues.

The term clinical effectiveness was developed as a response to demands to provide evidence of effectiveness. Health professionals have developed measures to report on the quality of clinical services and assess the effectiveness of medical interventions. These include:

- Clinical or medical audit.
- Outcome measures.
- Evidence-based practice.
- Guidelines.

Clinical audit is carried out locally and nationally, and provides a method for systematically evaluating, reflecting upon and reviewing practices against evidence-based standards.

**Dietetic outcome measurement**

The provision of safe, effective and good-quality care, or intervention, is fundamental to dietetic practice and is a HCPC registration requirement. A dietitian needs to know that an intervention is evidence based and effective, i.e. that it achieves the predicted outcome and makes effective use of the available resources. To demonstrate this, dietitians need to be able to systematically and consistently identify and predict what the desired outcomes of their interventions will be, the timescale involved and to what extent this has been achieved from the viewpoint of both the dietitian and the recipient. Measuring outcomes and sharing this information demonstrate the value of a dietetic service to commissioners and to the wider health community. Systematic collection and analysis of outcome data can facilitate decision-making and enhance the quality of healthcare.

Measurement of outcomes can take place at the individual, service, multidisciplinary team, organisational or national level. Measuring healthcare outcomes is a developing field, and no single methodology is universally applicable to all situations or able to capture all dimensions of care. Outcome measurement should use SMART principles (systematic, measurable, appropriate, acceptable, realistic and timely). There are several approaches to measurement, and an increasing number of validated tools are available. Measures may be patient reported – such as patient reported outcome measures (PROMs) (see Chapter 2.2, Assessment of nutritional status) or patient reported experience measures (PREMs). Putting the patient at the centre of care is a central feature of health policy across the UK, so measuring the patient experience has to be a key component of outcome measurement. Therapy outcome measures are those where the professional measures a change in a specified domain. The use and development of validated outcome measures in dietetics is an emerging methodology, and one that is underpinned by application of the Process to enable a consistent approach to the provision of dietetic care.

**Digitalisation**

Information technologies are revolutionising healthcare delivery. Traditionally, face-to-face or telephone consultations were the mainstay of dietetic contacts but now video consultations are becoming more common, providing
Evidence-based practice

Evidence-based practice is not a single activity but must be continuous throughout a dietitian’s professional career. It is what distinguishes a dietitian from an alternative practitioner, and is an essential element in the nutrition and dietetic process. Evidence-based practice can be broken down into five key stages:

- Formulating the question.
- Finding the evidence.
- Critical appraisal.
- Using and acting on evidence.
- Evaluation and reflection.

The first three stages have been carried out in many cases by Practice-based Evidence in Nutrition (PEN) (www.pennutrition.com/bda). The PEN system aims to support dietitians to use evidence-based practice in their day-to-day roles. PEN applies the concept of knowledge translation by summarising the evidence base on a nutrition- or dietetic-related topic and providing the practical guidance for implementation into practice. Each topic in the PEN system is collated under a knowledge pathway, which is subdivided into sections such as background or practice questions. A number of training modules are available on PEN. The dietitian needs to use clinical judgement to apply the evidence to the individual situation and the clients’ needs. It is important that dietitians be research-active in order to contribute to PEN and other sources of clinical guidelines. Dietitians are in a unique position to understand the areas of their work that are lacking in terms of an evidence base and to formulate the most relevant research questions. PEN is a worldwide resource, so UK dietitians can work with their international colleagues to formulate the questions most pertinent to clinicians. PEN evidence analysts use Grading of Recommendations, Assessment, Development and Evaluations (GRADE), a systematic way of making judgements and evaluating the evidence base, developed by the GRADE working group, to evaluate the evidence.

Clinical guidelines are recommendations on the appropriate treatment and care of patients with specific diseases and conditions. Guidelines can be generated at an international level, e.g. the World Health Organization; nationally by organisations such as National Institution for Health and Clinical Excellence (NICE) or Scottish Intercollegiate Guidelines Network (SIGN) in the UK, or by other clinical specialist organisations and professional bodies, e.g. BDA, Royal College of Physicians; and associated clinical working groups, e.g. Intercollegiate Stroke Working Group. Some, such as those developed by NICE, also consider cost-effectiveness. Guideline developers are increasingly using GRADE to assist in linking their evaluation of the evidence to the clinical recommendation. GRADE provides both an assessment of the quality of the evidence – high, moderate, low and very low – and the strength of the recommendations.

Routine activities that aid practitioners include keeping a portfolio and reading and evaluating new evidence. A portfolio is vital evidence of CPD and should be used to reflect and evaluate practice and the effect of any change. Simple electronic tools are available to provide information on new evidence. These include:

- **Application software (apps)** – including EBM toolkits from publishers (e.g. BMJ), books, journals, searchable databases (e.g. PubMed) and critical appraisal tools.
- **Electronic table of contents (eTOC) from appropriate journals** – current contents pages are sent to subscribers (this is usually a free service).
Research, audit and service evaluation

The skills required to conduct research can also be applied to conduct audit and service evaluation. However, research is used to generate new evidence, while audit and service evaluation evaluate care. It is important to remember that a survey conducted in clinical care cannot be called an ‘audit’ unless the results are compared with a standard; standards are generated by research. An important distinction between research, audit and service evaluation is that research requires ethical approval from the appropriate research ethics committee (REC), while audit and service evaluation do not. Within the NHS, they all require review and approval by the appropriate department, i.e. research and development or clinical governance. Table 1.1.4 gives a brief summary of the key differences between the categories of studies. If the categorisation of the study is unclear, it is important to consult the appropriate department or committee before commencement.

Research ‘means the attempt to derive generalisable new knowledge by addressing clearly defined questions with systematic and rigorous methods’ (Health Research Authority, 2016). It underpins evidence practice and is a vital component of a dietitian’s professional role. The HCPC (2013) requires that dietitians must be able to ‘recognise the need to monitor and evaluate the quality of practice and the value of contributing to the generation of accurate data for quality assurance, governance, clinical audit, research and improvement programmes’. The essential nature of research and audit as part of professional practice is embedded within both the BDA’s Code of Professional Conduct (2017) and the Curriculum Framework for the Pre-registration Education and Training for Pre-registration Dietitians (BDA, 2013a). The BDA (2013b) defines four stages of research involvement, and details the skills required at each stage. On qualification, all dietitians should have the necessary skills to understand, interpret and apply research. If dietitians maintain and build upon these basic skills, some will eventually lead research and supervise others (Whelan, 2007).

Research governance and ethics

Research governance encompasses regulations, standards and principles of good research practice, thereby ensuring that research is conducted to high ethical and scientific standards. It applies to everyone involved in the research process, including researchers at all levels, employers and support staff. In a clinical setting, this will include care providers. In 2015, the Health Research Authority took responsibility for replacing the research governance framework with a new UK policy framework for health and social care.

Ethical approval from an appropriate committee is essential for any research involving humans, clinical data, human organs or tissues; it is a legal requirement in the NHS. Informed consent and confidentiality are central to ethical research. The review process will vary depending on the organisation. Within the NHS, the Health Research Authority offers a central and consistent service, including the integrated research application system (IRAS) (www.myresearchproject.org.uk). This is a single system of applying for permissions and approvals for health and social care and community research in the UK without unnecessary duplication. Each university will have its own system for ethical approval.

How to do research

This section gives a brief overview of research; more detailed information can be found in Ray et al. (2016). Further resources are listed at the end of the chapter.

Planning research

The first step is developing the research question, and the PICO principle can be used to generate a concise question. The aims and objectives of the research should relate directly to the research question; the methodology will be determined by the aims and objectives. When disseminating the results of the research, the discussion and conclusion of a paper or abstract should relate to the question and aims and objectives. The research question may arise from clinical practice or from the literature. A research question will lead to a hypothesis.

The research question plays a crucial role when reviewing the literature for the project. The literature review may stem from the aims and objectives, or serve to formulate the aims and objectives. The research aim is usually a broad statement outlining the goal, while objectives are more detailed statements of how the aim will be achieved. Each objective should be simple, straightforward and achievable. Well-thought-out objectives suggest a methodology and thus help determine the methodology. It is good practice to include potential participants when planning research; INVOLVE (http://www.invo.org.uk/) has more information about public involvement in health and social care research. The actual method is how the study will be carried out and includes details such as where the research will take place, who will be involved, how the participants will be recruited, the actual data collection and how the data will be analysed. It is quite acceptable to include both quantitative and qualitative methodologies in a study, but often such a study will be divided into two stages, with one stage informing the other. Table 1.1.5 gives an overview of research methodologies.

It is essential to write a research protocol when planning the project and include details of the study rationale, aims and objectives, methods with specific measurable outcomes, statistical analysis, dissemination plans and timeline. The protocol can be used when...
Table 1.1.4  Differentiating clinical audit, service evaluation, research and usual practice/surveillance work [source: Health Research Authority. Reproduced with permission from the Health Research Authority, 2017 (www.hra.nhs.uk)]

<table>
<thead>
<tr>
<th>Research</th>
<th>Service evaluation*</th>
<th>Clinical audit</th>
<th>Surveillance</th>
<th>Usual practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>The attempt to derive generalisable new knowledge, including studies that aim to generate hypotheses as well as studies that aim to test them.</td>
<td>Designed and conducted solely to define or judge current care.</td>
<td>Designed and conducted to produce information to inform delivery of best care.</td>
<td>Designed to manage outbreak and help the public by identifying and understanding risks.</td>
<td>Designed to investigate outbreak or incident to help in disease control and prevention.</td>
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<td>Quantitative research – designed to test a hypothesis. Qualitative research – designed to identify/ explore themes following established methodology.</td>
<td>Designed to answer: ‘What standard does this service achieve?’</td>
<td>Designed to answer: ‘Does this service reach a predetermined standard?’</td>
<td>Designed to answer: ‘What is the cause of this outbreak?’</td>
<td>Designed to answer: 'What is the cause of this outbreak?' and treat.</td>
</tr>
<tr>
<td>Addresses clearly defined questions, aims and objectives.</td>
<td>Measures current service without reference to a standard.</td>
<td>Measures against a standard.</td>
<td>Systematic, statistical methods to allow timely public health action.</td>
<td>Systematic, statistical methods may be used.</td>
</tr>
<tr>
<td>Quantitative research – may involve evaluating or comparing interventions, particularly new ones. Qualitative research – usually involves studying how interventions and relationships are experienced.</td>
<td>Involves an intervention in use only. The choice of treatment is that of the clinician and patient according to guidance, professional standards and/or patient preference.</td>
<td>Involves an intervention in use only. The choice of treatment is that of the clinician and patient according to guidance, professional standards and/or patient preference.</td>
<td>Any choice of treatment is based on clinical best evidence or professional consensus.</td>
<td></td>
</tr>
<tr>
<td>Usually involves collecting data that are additional to those for routine care but may include data collected routinely. May involve treatments, samples or investigations additional to routine care.</td>
<td>Usually involves analysis of existing data but may include administration of interview or questionnaire.</td>
<td>Usually involves analysis of existing data but may include administration of simple interview or questionnaire.</td>
<td>May involve analysis of existing data or administration of interview or questionnaire to those exposed.</td>
<td>May involve administration of interview or questionnaire to those exposed.</td>
</tr>
<tr>
<td>Quantitative research – study design may involve allocating patients to intervention groups. Qualitative research – uses a clearly defined sampling framework underpinned by conceptual or theoretical justifications.</td>
<td>No allocation to intervention: the health professional and patient have chosen intervention before service evaluation.</td>
<td>No allocation to intervention: the health professional and patient have chosen intervention before audit.</td>
<td>Does not involve an intervention.</td>
<td>May involve allocation to control group to assess risk and identify source of incident but treatment unaffected.</td>
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*Service development and quality improvement may fall into this category.
Dissemination

It is essential that dietitians disseminate all the evidence generated, including research, audit and service evaluation. There are vehicles for every type and size of study; small and negative studies are valuable as they add to the evidence base and may inform others of potential difficulties. Dissemination can occur internally, within the department or institution, or externally, at conferences and in peer-reviewed journals. Conferences are the best way to disseminate small studies and initial findings. The most important way to disseminate work is as a manuscript published in a peer-reviewed journal. Guidance on how to write a conference abstract or a manuscript for publication can be found at www.bda.uk.com/conference/research. Publication guidelines, e.g. consolidated standards of reporting trials (CONSORT), have been produced in order to improve the quality of research reporting and are available from the Equator Network (www.equator.org.uk).

Continuing professional development

Professional practice develops over time, and individual professionals must strive, and expect, to develop and improve their practice so that services and the outcomes for their service users improve. This process is known as continuing professional development (CPD). CPD is an active process by which every day and more formal experiences are critically reflected upon to identify learning points, which are then recorded in a useful format. The BDA (2013a) defines CPD as ‘… a systematic on-going process which allows individuals to maintain, update and enhance their knowledge and expertise in order to ensure that they are able to carry out work safely and effectively’.

As defined by the HCPC (2013), CPD is how ‘… professionals maintain and develop throughout their career to ensure that they retain their capacity to practice safely, effectively and legally within their evolving scope of practice’. All healthcare professionals are expected and required to work within their scope of practice, with the understanding that this usually changes over time – from broad practice across the profession to a deeper understanding and more expert practice in a narrower, more specialist field. CPD is obviously the route to this expert standing and more expert practice in a narrower, more specialist field. CPD is obviously the route to this expertise in order to ensure that they are able to carry out work safely and effectively.

Conducting research

This stage of the research process is usually constrained by time and money. A Gantt chart detailing delivery dates and deadlines is a useful organisational tool. Difficulties in obtaining ethical approval or with recruitment of research staff and participants often delay projects, so sufficient time should be built in at the planning stage to avoid missing deadlines later. Communication is key to keeping the research process on track, e.g. if recruitment is slower than anticipated, it is helpful to let funders know before deadlines are missed; funding bodies often have a wealth of experience and can be a source of help and advice if necessary. Meticulous record-keeping will also help the research process to run smoothly. Data collection sheets that are easy to complete will be less likely to contain errors. Data collection methods should be piloted and necessary changes made. Research logs or diaries can act as a cross-check to reference dates and times during which certain activities took place. Keeping a research diary may be a requirement of an organisation.

Data analysis will probably involve transferring data into a software analysis program, and particular care should be taken at this stage to avoid introducing errors. If possible, double data entry should be used, where two people enter quantitative data on separate spreadsheets and compare them for differences. Qualitative data often need to be transcribed; this time-consuming task can be delegated to professional transcribers, although this step can be a valuable part of the process of becoming familiar with the data.

<table>
<thead>
<tr>
<th>Table 1.1.5</th>
<th>Research methodologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Descriptive</td>
<td>Cross-sectional survey</td>
</tr>
<tr>
<td>Qualitative, e.g., grounded theory, discourse analysis, ethnography, narrative research and phenomenology</td>
<td></td>
</tr>
<tr>
<td>Empirical</td>
<td>Experimental</td>
</tr>
<tr>
<td></td>
<td>Randomised parallel groups</td>
</tr>
<tr>
<td></td>
<td>Randomised crossover</td>
</tr>
<tr>
<td></td>
<td>Cohort</td>
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<tr>
<td></td>
<td>Cross-sectional</td>
</tr>
<tr>
<td></td>
<td>Case control</td>
</tr>
</tbody>
</table>

applying for governance and ethical approval, and funding and will form the basis of the eventual dissemination. When using questionnaires, or other instruments to measure variables, it is important to consider the population for which they are validated and how the results obtained from them will be analysed. If results require statistical analysis, it is sensible to consult a statistician at this stage so that any necessary modifications can be made to the planned data collection.
1.1 Professional practice

basis, selecting 2.5% of the profession for review. Those selected are required to complete the HCPC's profile-mapping CPD activity directly to the HCPC standards. Each audit covers CPD activity from the preceding 2 years. All dietitians on the HCPC register have an equal chance of selection, regardless of where they are based, within Britain or overseas, or their current work situation, e.g. part-time, full-time or on maternity leave.

Both the HCPC and the BDA identify CPD as the responsibility of the autonomous professional, i.e. the individual dietitian. Whilst many employers are supportive, it is the registered professional's personal responsibility to ensure that CPD activities and documentation are kept up to date. This may need to be met using personal time and resources. Those working outside the NHS, particular those working as freelance dietitians, will need to be proactive in sourcing opportunities for themselves. CPD helps to maintain current competence and to develop new competence, thereby ensuring that dietitians can continue to work in an evidence-based manner. If all dietitians embrace CPD, as they should, this will create departments where there is a strong learning culture with active involvement in student and staff supervision, mentoring and team and individual reflection.

Reflective practice

Reflective practice has been defined as ‘... the capacity to reflect on action so as to engage in a process of continuous learning' (Schon, 1991), and it is essential for the development of professional practice in dietetics. The purpose of reflection is to enable a practitioner to apply a systematic approach to consideration of a particular experience, thereby developing practice through analysis and consideration of points of learning for the future. Thus, dietitians use reflective practice as a method through which to make sense of their practice and development needs. Initially, the situation or experience is analysed, with consideration given to the knowledge and skills used and the individual's reaction to the experience. Subsequently, learning from experience is explored in order to facilitate professional development for future practice. During the process, further learning needs are often identified. This reflection on practice is also one method by which a professional may identify new theories of practice and so integrate the technical science basis and the practice and art of dietetics.

Reflection is a skill that requires development and practice. It requires individuals to be open to their feelings and to what they can learn from the experience.

Table 1.1.6 Examples of continuing professional development (CPD) activities

<table>
<thead>
<tr>
<th>Work-based learning</th>
<th>Professional activity</th>
<th>Formal/educational</th>
<th>Self-directed learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning by doing</td>
<td>Involvement in a professional body</td>
<td>Courses</td>
<td>Reading journals/articles</td>
</tr>
<tr>
<td>Case studies</td>
<td>Membership of a specialist interest group</td>
<td>Further education</td>
<td>Reviewing books/articles</td>
</tr>
<tr>
<td>Reflective practice</td>
<td>Lecturing or teaching</td>
<td>Research</td>
<td>Keeping a file of progress</td>
</tr>
<tr>
<td>Clinical audit</td>
<td>Mentoring</td>
<td>Attending conferences or seminars</td>
<td></td>
</tr>
<tr>
<td>Discussions with colleagues</td>
<td>Being an examiner or tutor</td>
<td>Writing articles or papers</td>
<td></td>
</tr>
<tr>
<td>Gaining and learning from experience</td>
<td>Organising journal clubs or other specialist groups</td>
<td>Distance-learning</td>
<td></td>
</tr>
<tr>
<td>Work-shadowing</td>
<td>Membership of other professional bodies or groups</td>
<td>Planning or running a course</td>
<td></td>
</tr>
<tr>
<td>Secondments</td>
<td>Presenting at conferences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Job rotation</td>
<td>Supervising research</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Journal club</td>
<td>Being promoted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-service training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervising staff or students</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Analysing significant events</td>
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<td></td>
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</tr>
<tr>
<td>Project work or project management</td>
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</tbody>
</table>
CPD, based on this particular framework that uses the following questions:

- What?
- So what?
- Now what?

This translates to a process by which an individual can identify an activity or incident (the what element), consider the impact of the activity on practice and whether, as an individual, he or she dealt with the situation appropriately (the so what element). Finally, the individual will consider the now what element, i.e. what can be learned from the incident to improve professional practice, going forward. This model enables the dietitian to describe the CPD activity, explain what is learnt and reflect on the benefits to the service user alongside the use of new skills, in addition to investigating any areas for development or improvement.

Critical analysis and evaluation refocuses the dietitian’s thinking and helps generate new knowledge and ideas. As a result, individuals may modify their actions, behaviour, treatments and learning needs. As part of their professional commitment to CPD, dietitians must make time to record their reflections, a process which often helps clarify thoughts and provides written evidence to share with others at a later date. It is important to note that reflection is undertaken from a personal perspective. This is not a team exercise but about the individual practitioner and the development of their professional knowledge, skills and competence. A professional development toolkit of support can be found in the BDA’s learning zone (www.bdacpd.co.uk).

Practice supervision

Dietitians should also seek practice supervision throughout their professional training and career. Supervision is the process of professional learning and support involving a range of activities. It enables individuals to develop knowledge and competence, assume responsibility for their own practice and enhance service user protection, quality and safety of care (BDA, 2014). The supervision process can directly influence CPD, providing a structured process of professional support that facilitates lifelong learning and personal development, and highlights training needs. Practice supervision is integral to delivering good-quality service, and should be included in working practices where work-based scenarios are explored, reflection upon practice takes place and evidence of CPD is gathered. This process of supervision will start with students in practice education and continue throughout the working life of dietitians. Examining performance, identifying strengths and weaknesses, and seeking to improve are key attributes of a professional.

Preceptorship

Ideally, professionals in the first year of practice, particularly within the NHS, should work within a structured development programme called preceptorship. The aim of preceptorship is to enhance the competence and confidence of newly registered practitioners as autonomous professionals (DH, 2010). During this time, the new practitioners, supported by preceptors, will develop their skills, behaviour and attitude to become more confident practitioners. Within the UK, access to preceptorship programmes varies at the local level. While some benefit from a structured programme incorporating a mix of theory and guided reflection, other graduates are less fortunate in their ability to access this level of support. Further guidance is available from a number of different sources, including the BDA.

Conclusion

Dietetics has a proud tradition of upholding safe, effective, evidence-based nutritional expertise, and this is fundamentally owing to the professionals who work within the discipline. The profession’s commitment to constantly be innovative, while striving for the highest standards of technical and ethical competence, have seen it evolve into the internationally respected profession it is today.

Dedication

This chapter is dedicated to the memory of Rosanna Hudson (1972–2017).

Acknowledgement

The editor acknowledges the prior contribution of Ingrid Darnley and Julie Farmer.

Further reading


Internet resources

BDA How to prepare a conference abstract for BDA events, https://www.bda.uk.com/events/research_symposium/abstract_guidance_2016
Centre for Evidence-Based Medicine, www.cebm.net/
Centre for Reviews and Dissemination (CRD), York, www.york.ac.uk/inst/crd/
Enhancing the Quality of Health Research (EQUATOR), www.equator-network.org
Health and Care Professions Council, www.hcpc-uk.org
Healthcare Quality Improvement Partnership (HQIP), www.hqip.org.uk
NHS Evidence, www.evidence.nhs.uk/
Practice-Based Evidence in Nutrition (PEN), www.pennutrition.com/bda
Scottish Intercollegiate Guidelines Network, www.sign.ac.uk
Trip Database – Clinical Search Engine, www.tripdatabase.com/
1.1 Professional practice

References

NB: BDA documents can be accessed by members via the member’s page. Non-members should contact the BDA directly.

Dietary modification is a cornerstone of dietetic practice and employs a range of dietetic skills. When undertaking dietary modification, dietitians need in-depth knowledge of food composition, food availability, and factors that determine what people eat. It is well acknowledged that dietary interventions are more likely to be effective when they are based on a sound understanding of the factors influencing food choice of individuals or communities, and not on the principles of changing health behaviour alone. An integrated approach to dietary counselling that considers all the relevant factors can improve compliance, satisfaction, and clinical outcomes (Fine, 2006). The impact that these factors have on developing the most effective dietary intervention strategies will vary depending on the situation.

In the assessment step of the process for nutrition and dietetic practice, the dietitian uses skills in nutritional, dietary, and clinical assessment in order to decide the goals of dietary intervention (BDA, 2016) (see Chapter 1.1, Professional practice). Key to deciding how best to achieve these goals is an assessment of the interaction between the individual, or community, and their social situation. This assessment can also aid the identification of potential barriers that may impact the effectiveness of the intervention. Service users can and should be actively involved in their own healthcare, and the dietitian's role is to advise and help facilitate negotiated patient-centred goals. When monitoring and evaluating the effectiveness of any dietary intervention, ongoing reassessment of the factors contributing to the achievement of dietary goals will be necessary.

**Principles of dietary modification**

Dietary modification can be defined as the elimination, manipulation or introduction of dietary components to achieve dietary goals. Dietary interventions are aimed at individuals, groups, or communities and vary greatly in complexity. Modifications that are considered simple, e.g., increasing the fruit and vegetable intake of a community, may in fact be very difficult to achieve and require significant dietetic input. Similarly, those considered more complex, e.g., meeting an individual's nutritional requirements via the parenteral route, might be more straightforward to achieve.

Whether total or partial control of an individual's nutritional intake is required, challenges will almost certainly arise. A detailed knowledge of food and its composition is vital, together with an excellent understanding of the available tools and resources, to reach achievable results. Once the requirement for dietary modification is highlighted and the level of regulation has been determined, four keys factors should be considered to achieve the required result: knowledge, achievability, motivation, and communication.

**Knowledge**

In order for dietary modification to be effective, both the dietitian and service user (and any other healthcare professionals, or supporting individuals) must be knowledgeable regarding the rationale for the changes proposed. It is part of the dietitian's role to ensure that all those involved understand why change is necessary and...
how the proposed dietary modification will contribute to achieving treatment goals. From a service user's perspective, this can encourage compliance and also empower individuals to take some responsibility (NESTA & Health Foundation, 2016) for their own health and lifestyle. This process can be demonstrated through programmes such as Dose Adjustment for Normal Eating (DAFNE) and Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND), which focus primarily on the education and empowerment of the patient to allow for ongoing dietary modification that compliments individual lifestyles (see Chapter 7.12, Diabetes mellitus). Patient-centred counselling can promote collaboration between the patient and the dietitian, resulting in tailored interventions that can enhance adherence (Rosal et al., 2001).

Achievability

It is the dietitian's responsibility to ensure that the goals set for diet modification are achievable, both from the clinical and service user's perspectives. The provision of practical, tailored advice and support are useful in this process. Excellent communication and, in some cases, counselling skills are required to assess the service user's lifestyle and level of understanding, to ensure that the goals set are appropriate (see Chapter 1.3, Changing health behaviour). Within a clinical or institutional setting, dietary modification is arguably more achievable due to the more controlled environment. Meals are generally provided and nutritionally regulated, so more specific guidance is easily accessible. There may however be barriers to ensuring an individualised approach to dietary modification in an institutional setting. With regard to artificial enteral and parenteral nutrition, a prescribed regimen is normally provided and amended as required, usually resulting in greater compliance.

Working alongside service users in outpatient or community settings can pose different challenges. Dietary interventions may be targeted at individuals or groups, and, in both cases, the optimum duration and frequency of contact needed to build effective relationships will need to be considered. More frequent or longer consultations may be necessary to ensure that the dietitian can provide adequate support.

Motivation

As evident in many areas of dietetic practice, the motivation levels of both the service user and the dietitian is key to success. The Transtheoretical Model (Stages of Change Model) (Prochaska & DiClemente, 1986) demonstrates this process, highlighting those stages where successful dietary modification may be optimised. Identifying that individual service users will differ in terms of their motivation to adopt potential dietary modifications is also key, and, in all cases, targeting and tailoring of advice will probably increase effectiveness (Thomas, 1994). It may be appropriate to first make smaller dietary changes, allowing additional time and support for the adoption of more substantial dietary changes. The dietitian can use skills such as rapport building, motivational interviewing, reflective listening and problem-solving to assess and increase the motivation to change (Fine, 2006; Gable & Hermann, 2016).

Communication

Effective, clear communication underpins successful dietetic practice. The way in which dietary advice is communicated can have an important impact on its effectiveness. An individualised approach should be adopted to ensure that messages are tailored to the individual or group and that the most effective communication strategies are adopted. Recognising that dietary choices are mostly made on the basis of foods rather than nutrients and communicating actions using food terms enable the individual to take control of their dietary changes. When communicating dietary strategies to individuals, groups or communities, the dietitian may use written, verbal, audiovisual, electronic or interactive forms of communication, although a combination of these will often be used. Advances in technology have allowed for changes in how patients are supported to make dietary changes, and telehealth-delivered interventions can help improve diet quality (Kelly et al., 2016). Knowledge of tools such as dietary exchange systems and resources can also facilitate the communication of dietary modifications. Skills in changing health behaviour and effective communication are central to successful dietary modification (see Chapter 1.3, Changing health behaviour).

Types of dietary modification

Modifying dietary intake can provide a methodical and practical solution to wider health issues, and encourage an individualised and problem-solving approach. This can range from the elimination of nutrients through to the reintroduction of dietary components, and can also include the manipulation of foods (Table 1.2.1).

Manipulation of dietary components

Dietary components can be manipulated in the following ways.

Texture

The texture or consistency of the diet may be modified, e.g. in the management of swallowing disorders.

Composition

It may be necessary to alter the chemical composition of the diet in the management of conditions such as food hypersensitivity. Modification may require the use of dietary products whose macronutrient composition
has been manipulated, e.g. amino acid or medium-chain triglyceride-based formulae.

**Quantity**
When modifying the quantity of a dietary component, it is necessary to consider the frequency of consumption, portion size and any appropriate food substitutions that can be made in the diet to achieve dietary goals.

**Elimination of dietary components**
Where possible, dietary interventions should always take a total diet approach and focus on the overall pattern of foods eaten rather than on specific foods or nutrients (Freeland-Graves & Nitzke, 2013). In the majority of cases, the elimination of individual foods will not be necessary; instead, modifying the quantity of the food consumed alongside the frequency of consumption will be sufficient to achieve dietary goals. The elimination of dietary components will be necessary in some conditions, e.g. inborn errors of metabolism. Where dietary components are excluded, it is important to assess the role they play in the individual's diet and what substitute foods need to be recommended to ensure that nutritional requirements are met.

**Introduction and reintroduction of dietary components**
A starting point for dietary modification is often to base recommendations on an individual's current dietary intake, although achieving dietary goals will involve the introduction of new foods. The introduction of dietary components will range from simple to complex recommendations, all of which should meet individual requirements. Where foods have been eliminated from the diet, it will be necessary to plan their reintroduction, e.g. a food challenge with an identified allergen in the management of food hypersensitivity (see Chapter 7.11.2, Food hypersensitivity).

### Table 1.2.1 Approaches to dietary intervention

<table>
<thead>
<tr>
<th>Dietary intervention</th>
<th>Example of dietary modification to achieve dietary goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elimination</td>
<td>Weight management</td>
</tr>
<tr>
<td></td>
<td>Food hypersensitivity</td>
</tr>
<tr>
<td></td>
<td>Eliminate energy-dense foods</td>
</tr>
<tr>
<td></td>
<td>Eliminate foods containing allergens</td>
</tr>
<tr>
<td>Manipulation</td>
<td>Weight management</td>
</tr>
<tr>
<td></td>
<td>Oral nutritional support</td>
</tr>
<tr>
<td></td>
<td>Substitute foods to increase energy density</td>
</tr>
<tr>
<td></td>
<td>Texture modification</td>
</tr>
<tr>
<td></td>
<td>As per the <em>The Nutrition and Hydration Digest: Improving Outcomes through Food and Beverage Services</em> (BDA, 2017)</td>
</tr>
<tr>
<td></td>
<td>Artificial nutritional support</td>
</tr>
<tr>
<td></td>
<td>Manipulation of chemical composition of dietary components, e.g. elemental feed</td>
</tr>
<tr>
<td>Introduction or reintroduction</td>
<td>Restrict nutrients</td>
</tr>
<tr>
<td></td>
<td>Healthy, balanced diet</td>
</tr>
<tr>
<td></td>
<td>Elimination diet</td>
</tr>
<tr>
<td></td>
<td>Foods are eliminated and reintroduced slowly, assessing symptoms (e.g. FODMAP diet, suspected allergies)</td>
</tr>
<tr>
<td></td>
<td>Weight management</td>
</tr>
<tr>
<td></td>
<td>Oral nutritional support</td>
</tr>
<tr>
<td></td>
<td>Introduce substitutions for high-energy-density foods</td>
</tr>
<tr>
<td></td>
<td>Introduce substitutions for low-energy-density foods</td>
</tr>
</tbody>
</table>

**Process of dietary modification**

**Rationale**
The first step in dietary modification is to ascertain the purpose of the modification based on a comprehensive assessment and the identification of the nutritional problem. The aim of dietary modification may be to:

- Achieve a nutrient profile that offers greater health benefits.
- Meet dietary needs in a safer way.
- Correct a dietary deficiency or surplus.
- Avoid the consumption of a particular dietary component.
- Achieve symptom relief.
- Achieve specific metabolic or clinical effects.

Key dietetic skills of clinical reasoning and evidence-based practice are employed to develop a dietary intervention plan. Dietary modification should provide benefit to the individual or group, but it should be noted that the interactions between foods and nutrients are complex, and altering one dietary component may affect another, e.g. increasing the energy density of a diet in oral nutritional support may increase the intake of saturated fat with the associated cardiovascular consequences. A total diet approach allows for an overall view of the likely consequences.

**Factors that influence food choice**
In deciding the most effective dietary intervention, any factors that will potentially influence adherence to the proposed modification should be identified.

**Access to food**
This will include factors such as purchasing patterns, budgetary constraints and cooking skills. To achieve dietary
1.2 Dietary modification

change, it will be necessary to identify whether the foods that have been recommended are available where the individual shops, if support is needed with shopping or if the individual has the required skills to prepare the foods in the modified diet, e.g. for a texture-modified diet, it is important to assess if the necessary equipment is available to modify foods to the correct consistency. At a community level, shopping and leisure facilities available in the local area may influence the effectiveness of interventions.

Taste and food preferences

Individual food preferences and the role food plays in an individual’s life need to be considered when making dietary modifications.

Lifestyle influences

The lack of time and the burden of juggling work and home commitments can be significant constraints in adopting healthy eating practices or dietary advice. It is important that the burden of the proposed dietary modification in terms of time and effort be considered.

Cultural background

Developing effective dietary intervention strategies for individuals and groups from minority ethnic backgrounds requires an understanding of their relevant health behaviours (Thomas, 2002). The factors affecting food choice and health are complex, and dietitians should ensure their cultural competence. When developing dietary interventions for minority ethnic groups, it is necessary to take account of dietary patterns and acknowledge the variations in health beliefs, attitudes and practices within each cultural group (Bronner, 1994; Satia-Abouta et al., 2002) (see Chapter 3.5, Working with minority ethnic groups).

Religious or ethical beliefs

In order to ensure that dietary modifications are compatible with an individual’s or group’s beliefs, it is necessary to establish them and the extent to which they are followed. There can be a wide variation in the interpretation of and adherence to the dietary restrictions associated with a particular faith.

Media

The media plays an important role in influencing food choice and shaping beliefs about nutrition and the role of the dietitian. It is important that dietitians keep abreast of media reporting on nutrition and diet in order to ensure that dietary education is effective and targeted, and that incorrect dietary beliefs are addressed.

**Practical aspects of dietary modification**

All dietary modifications should be individualised and based on a detailed assessment. Box 1.2.1 presents information on how dietary modification can be approached in order to achieve a range of dietary goals. In addition, a range of other modifications may be used in order to achieve dietary goals, including:

- **Meal patterns** – the timing or frequency of meals may be adjusted, e.g. the provision of small, frequent meals may promote dietary intake. It may also be necessary to also consider whether or not foods or fluids should be consumed together.

<table>
<thead>
<tr>
<th>Box 1.2.1</th>
<th>Practical examples of dietary modification strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Macronutrient modification</strong></td>
<td>• Aim of dietary modification is to decrease the percentage energy contribution of dietary fat:  ◦ Identify foods contributing to dietary fat intake  ◦ Limit frequency of consumption of high-fat foods  ◦ Limit portion size of high-fat foods  ◦ Recommend lower-fat alternative foods  ◦ Recommend lower-fat cooking methods</td>
</tr>
<tr>
<td></td>
<td>• Aim of dietary modification is to increase dietary intake of protein:  ◦ Increase frequency of consumption of high-protein foods, including between-meal snacks  ◦ Increase portion size of high-protein foods  ◦ Fortify commonly consumed foods with additional protein  ◦ Consider need for supplements to achieve dietary aim</td>
</tr>
<tr>
<td><strong>Micronutrient modification</strong></td>
<td>• Aim of dietary modification is to increase dietary intake of iron:  ◦ Increase frequency of consumption of high-iron foods  ◦ Increase portion size of high-iron foods  ◦ Consider foods that increase or decrease the bioavailability of dietary iron  ◦ Consider need for supplements to achieve dietary aim</td>
</tr>
<tr>
<td></td>
<td>• Aim of dietary modification is to decrease dietary intake of potassium:  ◦ Eliminate or limit frequency of consumption of high-potassium foods  ◦ Recommend cooking methods to reduce potassium content of foods</td>
</tr>
<tr>
<td><strong>Single/multiple food exclusion</strong></td>
<td>• Aim of dietary modification is to exclude cow’s milk protein and egg:  ◦ Eliminate all food sources of cow’s milk protein and egg, including where these are present as ingredients  ◦ Advise alternatives to foods eliminated in order to ensure nutritional adequacy  ◦ Consider need for supplements to ensure nutritional adequacy of diet</td>
</tr>
</tbody>
</table>
• **Meal environment and eating behaviour** – altering the environment in which food is consumed may be an effective modification strategy. Changing feeding behaviour may be an important part of achieving dietary targets, and may involve other healthcare professionals.

Dietary modification underpins many aspects of dietetic practice, and it is vital that dietitians understand the principles detailed in this chapter, so that they can then be applied in practice.

**Acknowledgement**

The book editor acknowledges the prior contribution of Katherine Law.

**References**


‘I do not understand my own actions. For I do not do what I want, but I do the very thing I hate’
(Romans 7:15 Revised Standard Version).

Dietetics was originally based on the traditional medical model of expert-led advice-giving with the expectation that, once people are told what to do, they will follow this advice. However, it is well established that advice alone does not automatically change behaviour (e.g. Contento et al., 1995). The challenge for dietitians is to develop an understanding of what influences health behaviour and acquire the necessary skills to facilitate change. Traditional medical care has moved towards a patient-centred model, which takes into account the psychosocial aspects of care, as well as the clinical picture (Stewart, 1995). The National Institute for Health and Care Excellence (NICE) recommends such an approach (NICE, 2014). Although not universal, patients attending dietetic consultations tend to prefer this approach (Hancox et al., 2012).

However, changing behaviour is inherently difficult; behaviours are complex and result from the interplay of habit, unconscious responses to the environment, and conscious choices, influenced by complex social environments and cultures (Kelly & Barker, 2016). It is therefore important to consider the broader context; the environment in which people live has a major influence on their health. This chapter focuses on achieving change in individuals and maximising interventions by enhancing traditional practice to form an integrated approach.

**Key points**

- The art of dietetic practice is to integrate the science of food and medicine with psychosocial aspects of people's lives in the context of changing health-related behaviours.
- An integrated approach embraces the underlying theory, principles, skills and processes necessary to initiate and maintain change.
- A behavioural approach is directive and client-centred. Consultations are structured and focused, with both practitioners' and patients' agendas taken into consideration through collaborative working.
- Increasing self-awareness is important for becoming an effective change agent.

**An integrated approach to changing health behaviour**

There is a range of approaches for facilitating change. Different approaches may work for different people at different times. An integrated approach:

- Aims to enable patients to take the next concrete, practical step to change eating or other lifestyle behaviours.
- Combines a directive and nondirective patient-centred approach by using a ‘guiding’ style (Rollnick et al., 2010).
- Should be evidence-based (drawn from relevant theories of behaviour change or clinical approaches, using appropriate behaviour change techniques).
- Includes a range of tools and approaches adapted from the world of psychology to provide information, strengthen motivation and facilitate change.
- Integrates the most relevant approach for that individual at a given time, e.g. exploring motivational difficulties or working on modifying behaviour.
- Treats the whole person, taking into account the environment in which the individual lives, what matters to the individual and the factors likely to influence the individual's health behaviour.
- Recognises that the skills and mindset of practitioners will influence how effective they are as behaviour change agents; practitioners should engage in ongoing self-development and self-awareness as part of continuing professional development (CPD).
Differences between traditional advice giving and an integrated approach

Traditional medical approaches often consist of advice giving and guiding patients towards a preferred course of action. Advice giving has a role, but advise must be delivered in the context of a helping relationship with a solid foundation of engagement. Authoritarian advice is unlikely to be well received and may induce defensiveness (Miller & Rollnick, 2013). Practitioners need to be mindful of the patient’s personal circumstances and viewpoint rather than just following the clinical agenda. If the patient has not asked for advice, ask permission before doing so, e.g. ‘Would you like me to suggest some options … ?’. A consultation based on an integrated approach has the following characteristics:

• The patient and practitioner are working together equally.
• The patient is treated with courtesy and respect.
• There is a sharing of information and ideas.
• The language and approach is collaborative.
• The patient is actively involved – there is a two-way conversation.
• The practitioner is actively listening and interpreting what the patient says, checking for understanding.
• There is common agreement and a clear plan about the way forward.

Foundations underpinning behaviour change approaches

The foundations of an integrated approach to changing health-related behaviours are its theoretical underpinning, guiding principles, interpersonal skills and ongoing practitioner development. An overview of each is provided in the following text.

Theoretical underpinning

What is theory, and why use it?

Interventions are more likely to be effective if based on good understanding of the behaviour in question and the conditions in which it takes place. Health behaviours are particularly complex as they are usually several (e.g. achieving good diabetes control comprises numerous dietary, activity and monitoring behaviours) with differing social contexts. Interventions are correspondingly complex, which can be challenging. Theories of behaviour change seek to ‘explain why, when and how a behaviour does or does not occur, and the important sources of influence to be targeted in order to alter the behaviour’ (Michie et al., 2014b). These are conceptualised as health behaviour models. The actual strategies used are called behaviour change techniques, and these are informed by the theory underpinning the dietetic interaction. Many of these techniques cut across different approaches, e.g. behavioural goal setting. In addition to making change more likely, good use of theory to inform practice means that interventions have the potential to be described accurately and replicated. NICE guidelines specifically recommend that interventions be evidence-based and use proven behaviour change techniques (NICE, 2014). Interventions should ideally be developed in a structured way using theory; theory can also be used less formally to inform clinical practice.

Models

There are a number of health behaviour models that contribute to the understanding of human behaviour in relation to health. A model attempts to understand and describe factors affecting a behaviour, and, from this, specific approaches can be developed to influence it. The model that has probably had the most influence on dietetic practice is the Transtheoretical Model of Change (Prochaska & DiClemente, 1986). While somewhat out of favour now, as it was difficult to apply to complex behaviours (being originally designed for addictions), the spirit of the approach is still useful (i.e. that change is complex, comprises different stages each requiring differing approaches, usually involves relapse and is influenced by self-efficacy). A newer model, the COM-B model, conceptualises behaviour as part of an interacting system involving capability (C), opportunity (O) and motivation (M) (Michie et al., 2011; Michie et al., 2014a). In this model, one or more must be changed for behaviour (B) change to occur. It is useful as it is an overarching framework that is compatible with other models and approaches. Also, it is mentioned in the NICE (2014) review, and hence may increase in prominence over the coming years. For a comprehensive overview of behaviour change theories, see Michie et al. (2014b).

Although not a theoretical behaviour change model, Egan’s three-stage helping model is a problem management framework that has had considerable impact on dietetic practice (Egan, 2013). It helps to form a structure for the dietetic consultation:

• Stage 1: Current scenario (described as the ‘assessment’ in clinical practice).
• Stage 2: Preferred scenario (exploring options and goal setting).
• Stage 3: The action stage (involves the patient implementing a plan of action).

Counselling and psychological approaches

A counselling approach uses active listening skills to work in a patient-centred way. Approaches from the world of motivational interviewing, behavioural therapy and cognitive behavioural therapy are the most commonly used psychological approaches in dietetic practice. Rather than being theories per se, these clinical approaches draw upon several behaviour change theories.

Motivational Interviewing (MI)

Motivational difficulties are often the greatest challenge for people struggling with change. The task of the healthcare professional (HCP) is to tap into the intrinsic motivation that exists within each individual and help build and strengthen that motivation to facilitate change. Patients often express a desire to change but get stuck
in ‘I want to, but I can’t …’. MI aims to help individuals explore and resolve the discrepancy between where they are and where they want to be in relation to their health behaviours, through the use of a collaborative conversation style of consulting for strengthening a person’s own motivation and commitment to change (Miller & Rollnick, 2013). It is part of an integrated approach, rather than a standalone therapy, and consists of a range of therapeutic strategies underpinned by a person-centred approach. The use of high-level interpersonal skills in this context enables the client to build commitment and reach a decision to change if appropriate (Miller & Rollnick, 2013; Rollnick et al., 1992).

**Behavioural Therapy (BT)**

BT helps patients identify unhelpful behavioural patterns and develop ways of modifying them. It is largely drawn from behavioural learning theories (see Michie et al., 2014b). These relate to identifying and modifying the triggers and responses to a behaviour. This can be conceptualised as an A–B–C model; behaviours (B) have antecedents (A) and consequences (C), and changes to one or both of these can bring about change in behaviour. These behaviours may be eating or activity related and could be targeted for increase (e.g. vegetable eating, walking) or decrease (e.g. sugary drinks, sedentary time). The behaviour change techniques most commonly used by dietitians with these theories are self-monitoring (to identify triggers), stimulus control (to modify or avoid triggers), response substitution (to learn to respond differently to triggers), reinforcement (use of rewards) and goal setting (particularly the gradual shaping of behaviours). NICE (2014) recommends that such techniques be used to support change. There is a wide range of practical techniques commonly used in dietetic practice that help patients manage eating and activity behaviours (Pearson & Grace, 2012). The techniques used will depend on what is appropriate for the person and condition at that time. Some examples are listed in Box 1.3.1, and other techniques are described later in this chapter.

**Cognitive Behavioural Therapy (CBT)**

This includes behaviour modification techniques as well as cognitive restructuring, which aims to help patients identify and then change unhelpful thoughts, ideas and beliefs that might maintain unhelpful, undesirable behaviours. Rapoport (1998) has described the application of these approaches to dietetic practice. Gable and Herrmann (2016) describe specific situations when CBT approaches may be useful, e.g. when the patient uses all or nothing language (‘I can’t’, ‘it always goes wrong’, ‘I never…’). In these situations, it can be helpful to work with the patient to distinguish thoughts from feelings (as feelings cannot be challenged but thoughts have the potential to be challenged) and then generate new, more helpful ways of thinking. It is essential that appropriate clinical supervision be in place for practitioners using this approach.

**Guiding principles**

Health professionals ideally base their practice on underlying principles, ethics and beliefs. Good communication skills play a major role in the outcome of a consultation, and underlying these skills are principles that guide the practitioner and influence how they apply any skills they have acquired. These principles provide a foundation for any model, theory or skills, and include the following:

**A person-centred approach**

A person-centred approach forms the basis of the helping relationship. Carl Rogers (1951) described the core conditions that must be present to work in a person-centred way:

- **Empathy** involves caring in a truly genuine and accepting way and developing a sensitive and accurate understanding of how patients perceive their experience. It means sharing another person's experience as if it were our own, while being aware throughout that it is not. From the patients' perspective, they feel heard and understood.
- **Genuineness** (congruence) is important for forming a helping relationship built on trust. It means being who we truly are, being honest and matching what we say with how we say it, both verbally and nonverbally.
- **Acceptance** (unconditional positive regard) means having respect for others as human beings, regardless of who they are or what they have done. This means accepting the patient unconditionally and being nonjudgmental. We find it relatively easy to accept someone we like or who does what we want. It is more difficult to accept someone we dislike or who does not act as we would wish. Health professionals need to guard against forming judgments about patients who do not adhere to recommended treatments and should seek to understand their perspective, rather than labeling them as noncompliant.

These core conditions are not always easy to adhere to, and their importance highlights the need for continual reflection on practice. When consultations do not

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**Box 1.3.1 Examples of behavioural strategies used in dietetic practice**

- Do nothing else while eating; sit down at a table
- Do not eat when watching TV or reading
- Chew each mouthful thoroughly
- Put down the knife and fork between mouthfuls
- Use a smaller plate or bowl
- Put food away – out of sight
- Plan menus for the week ahead
- Always shop from a list
- Never shop on an empty stomach
- Do not sit for longer than half an hour
- Plan activity for the week ahead
- Eat little and often
- Do not overfill the plate
go well, a natural response is to blame the patient as being difficult. It may be more productive to first look to oneself and consider if any of the core conditions were absent.

In an effort to address the limitations of the biomedical model, Stewart et al. (2014) combined it with a patient-centred approach to create a patient-centred clinical method. This went beyond the conventional biomedical approach to include consideration of the patient as a person. The method comprises four interactive components:

1. Exploring health, disease and the illness experience.
2. Understanding the whole person.
3. Finding common ground.
4. Enhancing the patient–clinician relationship.

A patient-centred approach has been associated with improved health status, increased efficacy of care and reduced costs (Stewart et al., 2000, 2011). It contains many of the elements outlined in the following text.

Respecting patient autonomy
This is key for facilitating change; it is an acceptance of the right of individuals to make choices about their own actions. Practitioners need to resist the urge to ‘fix it’ or to tell people what to do, in the belief that they know what is best. Experience and expertise need to be shared in a collaborative way in order to achieve the best outcomes for each individual. Patients need to be fully involved in any decisions about their own future.

Client responsibility
This principle acknowledges that people are responsible for their own actions. However, practitioners need to try to understand the difficulties that people experience with change while respecting patient autonomy.

Social influence
HCPs have a remit to influence health behaviour. This influence can be very powerful, even when time is limited. Practitioners may feel that a situation is hopeless when the patient has multiple problems, e.g. poor relationships, low income and poor health. Although everybody has the ability to change, this does not necessarily mean that everyone will, but they may be able to take some steps towards improving their health.

Collaboration
The principle of collaboration helps to accommodate both the patient’s and the practitioner’s agenda. It recognises that two people with expertise have met; one with expertise about themselves (the client) and one with expertise in the topic area, along with specific helping skills (the practitioner). A collaborative helping relationship is built on trust and mutual respect; both parties are equals in exploring the possibilities for change (Pearson, 2010).

Self-efficacy
In order to change, people need to believe that change is possible. The practitioner’s task is to help people develop self-belief in their ability to make changes. This can be achieved by helping to build the patient’s confidence and competence (Bandura, 1977).

Empowerment
Empowerment is a process through which people gain greater control over decisions and actions affecting their health. This principle has especially influenced the development of care offered in diabetes management (Funnell & Anderson, 2003). It recognises that patients are in control of and responsible for the daily self-management of diabetes, and that, to succeed, a self-management plan must fit patients’ goals, priorities and lifestyle, as well as their diabetes.

Interpersonal skills
Effective patient care relies heavily on good communication skills which can be applied in any setting, e.g. during consultations and while discussing patient care with medical staff, relatives, administrators, etc. These skills are variably described as counselling, consultation, interviewing, active listening, reflective listening and communication or inter-personal skills. Many practitioners are naturally good listeners; others develop their listening skills through years of practice. These skills should be continually developed and refined. Using these skills throughout the consultation can facilitate health behaviour change. There is good evidence to support the use of communication skills in healthcare generally (e.g. Najaits & Weiss, 1994; Stewart, 1995), but less so in dietetics. Surveys of UK dietitians show that a majority view communication skills as very important, and, encouragingly, the proportion receiving training appears to have increased over time (Whitehead et al., 2009; Rapoport & Nicholson Perry, 2000).

Attending behaviour
This conveys acceptance by actively listening, both verbally and nonverbally. Attending also involves being aware of our own verbal and nonverbal behaviour, which reflects our thoughts, feelings and attitudes.

Nonverbal communication
In addition to the words we speak, we give powerful messages through nonverbal communication. This has been shown to be extremely important and may account for as much as 85% of communication (Ivey et al., 1997). The practitioner can learn a lot by taking note of patients’ nonverbal cues.

Important aspects of nonverbal communication include:

- Body language needs to be appropriate for the context of the conversation. An open, relaxed posture, leaning slightly forward, is generally recommended, rather than an unnatural or stiff posture. It is also important to avoid distracting behaviours such as constant nodding, fiddling with pens, swinging feet or looking at a watch. Hand movements are a normal
part of nonverbal communication, but they should not be invasive. Sit at an appropriate distance so as not to invade the other person’s space, but not being too far away.

- Eye contact that is varied and without staring.
- Facial expressions that convey empathy and provide encouragement, e.g. an encouraging smile or nod. Facial expressions should match the mood of the conversation, e.g. not smiling when the person is describing something sad.
- The pace of an interview is important. Rushed consultations can leave the patient feeling confused or unsure about what has been discussed. It is important to allow time for patients (and practitioners) to think clearly and express their thoughts. The use of a brief silence or a pause can help achieve this.
- Tone of voice and general demeanour also influence the meaning of what is said. It is important for practitioners to take note of these factors as patients may be communicating something different from the actual words said. Practitioners need to be aware that their own tone of voice and body language can convey meaning in either a more or less helpful way (e.g. it can communicate disapproval or encouragement).

Practitioners need to be familiar with and take into account cultural differences, along with the age and gender of the person they are working with. Disabilities such as hearing, sight or cognitive impairment also impact on communication.

Minimal encouragers

These indicate to patients that they are being actively listened to and encourage them to talk. This includes nonverbal language such as nodding, an encouraging smile or minimal utterances, e.g. ‘mm, mm’, ‘ab-bab’, ‘and’, ‘so…’, etc. Finding the right balance of how and when to use (and not to overuse) minimal encouragers is a skill requiring practice. Some words used in everyday conversations such as ‘right’ and ‘ok’ can convey the wrong meaning or become irritating if constantly repeated.

Verbal following

This consists of a word, a phrase or a sentence (sometimes phrased as a question) that repeats what the patient has just said (although not in a parrot-like fashion). For example:

Patient: ‘I’m really struggling to fit this diet in with the rest of the family.’
Dietitian: ‘Family?’ or ‘You are struggling to fit the diet in with the family.’
Patient: ‘Yes, they all like…’

It encourages the person to expand on what they have said, and needs to be used skilfully and not overused, but combined with other skills to convey accurate empathy.

Paraphrasing

Paraphrasing means rephrasing the factual content of what has been said, and is used to reflect back the essence of the conversation in pieces, e.g.:

Patient: ‘This diet is just too hard to follow when I’m eating out.’
Dietitian: ‘You are struggling to manage with eating when you are not at home…’

To be effective, it requires a level of accuracy, which helps provide clarity for both the patient and practitioner. A paraphrase should be used tentatively, so that the client can agree or correct any inaccuracies. A succinct, accurate paraphrase is very powerful in helping clients feel understood.

Reflecting feelings

A reflection of feeling conveys to patients that the practitioner is trying to understand what they are experiencing emotionally. People can show their feelings in different ways: verbally, nonverbally or a combination of these. Asking people how they feel is not always helpful as people can struggle to express their emotions, so avoid questions such as ‘How do you feel?’ It is more useful to reflect tentatively, and at the right intensity, what the person appears to be experiencing, e.g.:

Patient: ‘And then he told me that I have got diabetes!’
Dietitian: ‘It sounds as if the news was upsetting for you…’

Many dietitians are wary of addressing feelings (for fear of ‘opening a can of worms’), but to neglect how people are feeling in relation to their health is to miss a vital element of what is likely to influence their behaviour. However, dietitians need to recognise their limitations in this area and know when and how to refer on.

Questions

Questions are useful for eliciting important information. Closed questions are efficient for gathering specific information, e.g. ‘Do you take milk in your tea?’, whereas open questions encourage patients to explain things from their perspective, e.g. ‘Can you fill me in on what led up to your doctor suggesting you come to see me?’ Most consultations require a combination of open and closed questions. However, questions need to be used selectively to avoid what can feel like an interrogation. In general, try to ask open questions (unless specific information is required), avoid asking two questions in a row and, for every question, offer at least two responses (Miller & Rollnick, 2013).

Summarising

Summarising helps to pull things together at different points in the consultation, and is especially useful at the
beginning and end of the session. Short summaries help to clarify the situation as the consultation proceeds, e.g.:

Dietitian: ‘Can I check what we have covered so far? You went to see the doctor because you were feeling unwell, and the result of all the tests was that he told you that you have diabetes, which was unexpected, and the news has left you feeling upset and worried. Is that right? (Pause) Is there anything else?’

Longer summaries may be needed to clarify long and complicated stories. They provide a pause, time to think and help give direction on what to focus on next. Summaries are also useful to help dietitians remember what needs to be recorded in notes.

Potential pitfalls for practitioners

Dietitians and health professionals often feel an obligation to make patients change, but we cannot make people change. Despite the best of intentions, this can get in the way of facilitating change. In an integrated approach, the dietitian aims to enable the patient to choose and implement changes to their health-related behaviour. Anything which leaves the patient feeling disempowered or criticised may inhibit this. Examples of common pitfalls are:

• Trying to persuade or force patients to change, e.g. ‘Your blood pressure is raised; you really must make some changes...’. Using pressure to try and convince someone to change assumes that the practitioner knows best. If a person feels under pressure, they are less likely to make a free choice.

• Trying to solve the problem, e.g. ‘I think you need to cut out chocolate and go walking instead’. This is often portrayed as well-meaning advice or a solution offered from the practitioner’s point of view. In practice, however, patients are their own experts and are best at finding a solution that will work for them. They may need some guidance, but the practitioner should facilitate rather than dictate.

• Underplaying the real health risks, e.g. ‘The situation could be worse...’. This may take the form of trying to appease patients. It arises from a desire to protect patients and is often due to fear of upsetting them or a fear of not knowing how to cope with a patient’s distress if they become upset. How information about health risks is presented is of vital importance.

• Presenting information in a threatening manner, e.g. ‘If you don’t lower your cholesterol, you risk getting...’. Fear can motivate some people, but others may become defensive.

• Hiding behind or dictating policy, e.g. ‘If you don’t lose more than a couple of pounds by your next appointment, you will be discharged’. This strategy may be an attempt to control caseload by discharging anyone who is not succeeding, but in practice is likely to reinforce a person’s sense of failure and may put him or her under unrealistic pressure. Policies need to incorporate negotiation and flexibility.

• Interrogating, e.g. ‘Why didn’t you follow your eating plan?’ The why question is difficult to answer and may induce defensiveness. Asking lots of questions, often in a desire to get to the heart of the problem so that it can be solved, or to try to get the patient to be truthful, is counterproductive. It does not encourage patients to talk openly as the agenda is practitioner-led and can close down the conversation.

• Blaming and/or judging, e.g. ‘You must be eating more than you have said or you would have lost weight’. This assumes that the patient is lying and that the practitioner knows better than the patient.

Ongoing practitioner development

In psychology and counselling, practitioners routinely receive supervision on developing their own responses and understanding as well as improving how they work with their patients. This is not generally the case with other health professionals. It is unrealistic to expect anyone to be totally empathic, unconditionally accepting and genuinely collaborative, while also being free from judgement, blame and criticism, and having the desire to want to rescue, protect or fix it for their patients. Although dietitians can aspire to these qualities, they are not necessarily given. Some elements can be acquired through skills training and can be further enhanced through self-development (Gable & Herrmann, 2016). Ongoing self-evaluation, developing self-awareness and life management skills can help this process. A tool to assess communication skills in dietitians has recently been developed and validated, which could facilitate CPD (Whitehead et al., 2014). Regular supervision is essential, and all health professionals should ideally be involved in ongoing self-development work as an essential foundation to their practice and as part of CPD.

The dietetic consultation in practice

The setting

A dietetic consultation has the explicit intention of discussing the person’s diet in relation to the individual’s health. It is clearly very different from an informal meeting, and therefore needs to operate within certain boundaries, but should not be so formal that it feels uncomfortable. The environment or setting in which people are seen clearly needs careful consideration. Is the waiting room arranged in a way that is welcoming, with suitable seating and reading material? Is the consultation room arranged in the best way? Has clutter been removed, and telephones or other interruptions diverted? The dietitian (as the patient’s advocate) has a professional responsibility to seek optimal consultation settings.

The proposed framework for the consultation

The dietetic consultation comprises a series of elements. Suggested frameworks for initial and follow-up consultations are shown in Figures 1.3.1 and 1.3.2, but
## 1.3 Changing health behaviour

### Figure 1.3.1 A suggested framework for an initial dietetic consultation

- **Meeting and greeting**
- **Capturing the overall picture (Assessment)**
  - (Clinical picture and medical history, anthropometrics, psychosocial history, expectations, current lifestyle, difficulties/barriers, exploring motivation)
- **Exploring options for change**
- **Negotiating and agreeing on goals (Change plan)**
- **Ending the interview**
- **Between visits: Implementation and monitoring progress**

### Figure 1.3.2 A suggested framework for a follow-up dietetic consultation

- **Meeting and greeting**
- **Review progress**
- **Problem solving**
- **Exploring further options for change**
- **Develop a plan**
- **Ending the interview**

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should be used flexibly, with different elements applied interchangeably within each interview, depending on the patient's needs. Not all elements are necessarily included in all interviews. For example, if someone is very ambivalent about making changes, the whole of the first session may involve exploring this. The following text explores how interpersonal skills link to the elements involved in the consultation, and how to manage difficulties. It is important to be aware of one's limitations and to refer on appropriately. Difficulties generally outside a dietitian’s expertise include psychiatric or psychological problems, relationship problems, bereavement, stress, social and
economic problems, and problems which are more properly the remit of other health professionals such as physiotherapists or speech and language therapists.

Elements of the consultation

The following elements within the dietetic consultation form a highly specific focus within an integrated approach to changing health-related behaviours. These relate to rapport building, assessment and ending the interview as well as specific behaviour change techniques. NICE (2014) specifically identifies the following behaviour change techniques as being effective: goals and planning (agree behavioural and outcome goals, develop action plans and prioritise actions, develop plans for dealing with relapses and consider future goals and plans), feedback and monitoring, and providing input regarding social support. In all cases, the art of practice is to skilfully interweave interpersonal skills with specific elements, but not all of these elements will necessarily be used in each consultation. The skilled practitioner learns to work flexibly.

Meeting and greeting the patient

This is easy to rush in busy clinics, but it is worth taking time to greet patients in a warm and friendly manner. Introductions are important, including checking how the patient wishes to be addressed and stating the amount of time available. It is important to involve patients’ relatives in the conversation, if it is their wish, and treat them in the same respectful manner. The consultation itself should start with an open invitation to talk, allowing patients to state what is on their mind, as well as giving an indication of their understanding for the referral. For example:

‘Your doctor has written and asked me to see you. Would you like to fill me in on what has been happening from your point of view that led up to this?’

Or, for a review appointment:

‘How have things been going since we last met?’

Assessing the overall picture

Assessment is standard practice and is likely to take up most of the first consultation, but it also needs to continue throughout further consultations as changes take place. It needs to be undertaken collaboratively, so that a true picture of the person’s situation emerges, and subsequent treatment goals can be tailored. The initial assessment should include the overall clinical and medical picture as well as the patient’s experiences and circumstances. For example:

Dietitian: ‘Can you tell me a bit about your current situation – family, job, that kind of thing – so that we can see how any dietary or lifestyle changes may fit in…?’

Patient: ‘Well, I work part-time…’

Dietitian: (paraphrase/reflect this information)

Try to avoid asking several questions in a row without reflecting back responses. If a series of closed questions needs to be asked, it is less intrusive if permission is asked first, e.g.:

Dietitian: (assessing calcium intake): ‘Would it be alright with you if we go through a number of questions, so that we both get a clear picture and don’t miss anything important?’

Patient: ‘That’s fine’.

Dietitian: ‘Can you tell me how much milk you take? … do you eat cheese? … how often? … how much? … what about yogurt?’

Providing information

Pitfalls in a dietetic consultation include:

- Making assumptions about the patient’s current levels of knowledge or understanding.
- Interrogating them.
- Imposing information that they do not want or are unable to assimilate at that time. This may increase resistance to change.

Exchange of information needs to be interwoven through every aspect of the consultation. It can either focus on providing information to patients or gathering information about their overall situation. The aim is to assess what patients know about their own condition – biochemistry results, approaches to treatment, etc. – and to offer information based on this to help them in their decision-making regarding making changes or managing their condition better. Exchanging information needs to be patient-centred, so that the person feels free to disclose relevant information. For example:

- Find out what they know (e.g. about their diabetes)
  Dietitian: ‘Has your doctor/nurse explained what diabetes is?’
  Patient: ‘Yes…’ (Sounding unsure).

- Ask permission to give them further information
  Dietitian: ‘Would it be helpful if we talked a bit more about that now?’ or ‘Would you like me to go over any of it again?’

Some people do not want or need information, either because they already know the facts or because the timing is not right. If someone is genuinely not interested or ready to know more, asking permission alerts the dietitian to this and enables the consultation to progress at the patient’s pace. Information given when someone is not ready for it can seem like undue pressure and may even stop people from engaging or from returning. When patients agree to receive information, they listen more carefully.

- Provide the information in an objective, neutral manner. Information should relate to current scientific understanding and be given simply and objectively, e.g.:

  ‘There is good evidence that losing weight can help lower blood pressure’.
• Try to avoid long, complicated explanations and the use of jargon or technical language. Find out what their interpretation is of the information you give them.
‘What do you think about that?’ or ‘Does that make sense?’

**Motivation**

Motivation is affected by many factors and can fluctuate. The amount of importance people attribute to a change, in terms of their overall life, will affect the likelihood of them implementing it, and this should be explored, e.g.: 

*Dietitian:* ‘Would you say that making changes to your diet in order to lose weight is a priority for you at the moment?’

*Patient:* ‘Oh, yes, I mean if it will help with my blood pressure…’ or ‘I’m not sure it will make any difference…’.

*Dietitian:* (Reflecting the response and continuing to explore) ‘You are keen to get your blood pressure down’ or ‘You can’t see much point in making any changes to your diet…’

This is part of establishing a common agenda. It is the responsibility of practitioners to ensure that patients are offered accurate information. This helps to raise awareness in a nonthreatening manner about unhelpful behaviours and their implications. Increasing concern about a behaviour may increase its importance, making change more likely. This can be done by providing information in a helpful way (see the preceding text).

If the change is important for the individuals, the next step is to explore whether they feel confident in their ability to change and to offer support, e.g.: 

*Dietitian:* ‘Do you feel able to make some change to your eating at the moment?’

*Patient:* ‘I know I should if it will help with my blood pressure…’ or ‘I have tried lots of times…’

*Dietitian:* (Reflecting the response and continuing to explore) ‘You have tried lots of times, and are feeling a bit disheartened by that experience?’

*Patient:* ‘Yes’

*Dietitian:* ‘Is there anything that we could do together that would help?’

It is possible to use scaling questions to explore motivation (e.g.: ‘On a scale of 0–10, where 0 is not important/not confident at all and 10 is extremely important/confident, where would you place yourself?’) (Mason & Butler, 2010). This approach needs to be used with a high level of good interpersonal skills, and applied sensitively; it should not be used simply as a tick box approach. It can be a helpful way to broadly establish where change sits on the patient’s agenda but should not be a rigid assessment tool. Responses should be met with reflective statements rather than judgments.

**Eliciting information on current health-related behaviours**

A picture of current eating and activity levels can be gained by asking the patient to describe a typical day, e.g.: 

*Dietitian:* ‘Can I ask you to describe a fairly typical day, in terms of how food (or activity) fits into that day, starting from when you get up in the morning to the last thing at night?’

*Patient:* ‘Well, the mornings are always a rush…’

*Dietitian:* (Follow the person’s description with reflective responses and summarise to capture what has been said).

Taking a diet history is another way of gathering detailed information about current diet. It is traditionally the mainstay of dietetic practice, but has pitfalls:

• It involves lots of questions, so can feel interrogative and risks damaging the helping relationship. People who eat for emotional reasons are less likely to disclose this with intensive questioning. They may feel vulnerable, and being under the spotlight can expose this and increase defensiveness.

• All methods of assessing dietary intake, and especially dietary recall, have inaccuracies (see Chapter 2.3, Dietary assessment). People are likely to report what they think the professional wants to hear rather than what they actually do.

Initially, general information about how diet fits in with their overall life (typical day) can be gathered, and further necessary information can be uncovered when options for change are discussed. Self-monitoring (see the following text) is another tool that can be used to gather information about diet; this can be informative and illuminating. Once a supportive alliance is formed, patients are more likely to offer accurate information. By threading the process of exchanging information about dietary intake and activity into different aspects of the interview, patients are less likely to feel they are being judged.

**Exploring options for change and help with decision-making**

Once someone decides to make changes, it is helpful to explore the possible options. It is initially helpful to identify the change most favoured by the patient, and then assess how realistic this is for them. Focusing on this makes it more likely that the change will be implemented and maintained. However, it may be necessary to concentrate on the option that will have most impact on the immediate health concern (e.g. reducing saturated fat intake when cholesterol level is raised). Generally, the following approach can be helpful:

*Dietitian:* ‘There are a range of possibilities which would help your overall health – changing the types of fat you eat, eating more fruit and vegetables, eating less sugar, etc. – where do you think you would like to start?’
Visual aids are useful, e.g. the Eatwell Guide (see Chapter 2.1, Dietary reference values and food-based dietary guidelines). The recommendations for each food group can be discussed and further information about a person’s diet gathered at the same time, e.g.:

Dietitian: ‘The recommendations are to eat five portions of fruit and vegetables per day. How does that compare with what you are doing at the moment?’

Negotiating goals and developing a change plan
Setting appropriate behavioural goals is the basis to achieving a successful outcome. These should be negotiated with patients so that they are actively involved in deciding what is realistic. Goals set by practitioners may not take account of other factors in people’s lives. Unrealistic goals can set patients up for failure and undermine the confidence of both the patient and the practitioner. Patients should be encouraged to use a stepwise approach to achieve a particular goal.

Goals should ideally fulfil SMART criteria (i.e. be specific, measurable, achievable, relevant and time specific). For example:

- **Specific** – eating less fat might be achieved by spreading fat more thinly on bread.
- **Measurable** – eating five portions of fruit and vegetables each day.
- **Achievable and realistic** – reducing chocolate intake by only consuming one bar each day instead of two.
- **Relevant to the goal of treatment** – if the aim of treatment is to decrease fat intake, patients need to concentrate on eating foods that are low in fat.
- **Time specific** – setting a goal to be achieved within an agreed time frame.

For a goal to make a difference in the time set to achieve it, it needs to be as far reaching as possible. For example, if the main goal is to reduce fat intake, the main dietary source of fat intake needs to be identified and reduced to a level that will make a difference. If fried foods are eaten daily, an appropriate weekly goal may be to use fat-free methods of cooking. This would have a bigger effect than a goal of, say, not eating doughnuts if doughnuts are only consumed once a fortnight. Only two or three specific, realistic and achievable changes should be chosen. Successful negotiation of each of the smaller steps gives people a sense of achievement and helps maintain motivation.

Once a specific goal has been agreed on and the ways of implementing it explored, it is helpful to summarise this in a change plan (an example is shown in Figure 1.3.3). Any change plan should be a starting point which is regularly reviewed and updated in light of what works in practice. Once goals have been established and a change plan agreed on, other strategies can be implemented to support behaviour change, e.g. rewards and support.

Identifying and implementing rewards
Rewarding behaviour change is a way of reinforcing new behaviours and is commonly used in BT. It is important that rewards be contingent on carrying out specific behaviours (as set out in SMART goal setting) rather than abstract outcomes such as weight loss or eating more healthily. Such discussions must be carefully negotiated as patients may find it difficult to identify appropriate rewards or indeed consider that they are worthy of receiving them (often encountered in weight management). Suitable rewards include doing enjoyable leisure time activities and hobbies, being with favourite people, buying small things they want or doing whatever they find relaxing or fun (Holli & Calabrese, 1998). Rewards need to be truly pleasurable (and non-food based). Practitioners should avoid suggesting rewards that would appeal to them personally. People should also be encouraged to mentally congratulate themselves

<table>
<thead>
<tr>
<th>Name: __________________________</th>
<th>Date: ______________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do I want to achieve overall?</td>
<td></td>
</tr>
<tr>
<td>Why is it important to me?</td>
<td></td>
</tr>
<tr>
<td>Specific goal (What exactly am I going to do?)</td>
<td></td>
</tr>
<tr>
<td>Steps to achieve this (How am I going to do it?)</td>
<td></td>
</tr>
<tr>
<td>What needs to be in place?</td>
<td></td>
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<tr>
<td>What might get in the way?</td>
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<tr>
<td>I will ask for support to help me work towards my goal from:</td>
<td></td>
</tr>
<tr>
<td>What will help to reinforce new habit (reward or encouragement)?</td>
<td></td>
</tr>
<tr>
<td>How will I keep a record of progress?</td>
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<tr>
<td>When will I review progress?</td>
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<tr>
<td>When will I start?</td>
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</tbody>
</table>

**Figure 1.3.3** Step-by-step guide to making changes
on every effort and achievement, however small, to help build feelings of self-esteem and self-efficacy. Other methods of reinforcing new habits may not necessarily be pleasurable, e.g. asking the family to remind you to go for a walk each evening, but can still be effective.

Building support
The importance of social support from a range of sources cannot be underestimated. In addition to dietitians and other health professionals, support from family members, friends and colleagues can be key. Responsibility for enlisting support from elsewhere lies with the patient, but they may need guidance. Relatives can be included in consultations, and leaflets produced for family members outlining how they can support the patient. The patient may need to clarify the type of support that would be most helpful, e.g.:

'I really appreciate your support. It would help me even more if you don’t nag me but offer practical support and encourage me – such as helping me with the planning and preparation of meals'.

Other sources of support include self-help groups, books, telephone help lines, websites and social networking platforms. Dietitians can link patients up with these as appropriate.

Self-monitoring/Developing self-awareness
Self-monitoring or diary keeping supports behaviour change. The prime purposes are to increase self-awareness of current behaviours, highlight problem areas and reinforce successes. A willingness to observe behaviour often indicates a willingness to come to terms with it and change it if appropriate.

Self-monitoring can be used in many ways, e.g. to identify:

- Time and place of eating.
- What a person was doing prior to eating.
- With whom eating occurred.
- How the person felt and what they were thinking.
- Symptoms.
- The behavioural outcome.

However, it would not be realistic or appropriate to ask patients to record all these, all the time. Diary keeping should focus on the behaviour currently being targeted, e.g. timing of meals, nutritional content of the diet or portion sizes. It is a difficult skill that needs practice. To be effective, the individuals should know what is expected of them and the purpose of monitoring; they need to agree to do it and be able to use their preferred method, i.e. pre-printed sheets or their own notebook. It should not be used to check up on patients. In order to reinforce that self-monitoring is for the patient’s benefit, it is helpful to ask what they have learnt from it. Diaries should be used collaboratively and not simply sent to patients without prior discussion and agreement. Any monitoring needs to be regularly reviewed by the patient, so that they can use it to adapt and update their change plan. Difficulties with self-monitoring may indicate that unresolved motivational issues exist which need to be addressed (see the section ‘Managing common difficulties’ in the following text).

Ending the interview
This is just as important as a good beginning. Sufficient time is needed to ensure that the main points of the consultation are summarised and that agreements are clear about goals set, monitoring, review and follow-up. The patient should be given the opportunity to ask questions to clarify anything unclear.

Managing common difficulties
Clients who want advice
Patients usually come to see a dietitian recognising that they have expertise in an area. They will often ask, ‘what do you think I should do?’ It is important to give information when patients are seeking it (can be an indication of readiness to change), but at the same time drawing on the expertise that patients have about themselves. For example:

Dietitian: ‘You would like me to tell you exactly what to eat in order to …?’
Patient: ‘Yes, what I need is a diet sheet; that is what I have come for’.
Dietitian: ‘It sounds like an eating plan would really help, as well as being clear which foods are best to avoid and which ones to include. I can certainly give you that information, and we can work out what would be the best eating plan for you, together. That way, we can make sure that we include some of the foods you really like and make sure that the plan fits in around your life. How does that sound?’

Referred patients who do not want advice
Sometimes patients feel that they have been sent to the dietitian, rather than choosing to come. Engaging in such a consultation is likely to be met with resistance. It can help to explore their understanding of what led to the referral. It is more helpful to ask ‘Can you tell me what led up to your doctor suggesting that you come to see me’ than ‘Do you know why this appointment was made?’ It is useful to find out what their thoughts are about the referral – ‘I wonder what your thoughts were when the doctor suggested coming to see me?’ – rather than ‘How do you feel about coming here?’ Clarify that your role is to explore the situation with them and to consider possible options, but not to tell them what to do. Ask permission to progress on that basis and explain what service you can offer.

Clients who cannot come up with their own solutions
Patients should be given the opportunity to make their own suggestions but not all patients can come up with ideas. It is tempting to jump in with suggestions, but
the dietitian's ideas might be inappropriate, and patients may feel under pressure to agree without thinking it through, later finding that they cannot do it in practice. In this situation, it can help to present possible solutions in the context of what has worked for others; options which may or may not work for them. This still leaves a space for them to either take up a particular option or decline it. Always ask permission before making suggestions, e.g. ‘Would you like me to tell you about some of the things that have worked for other people?’

Ambivalence about change and motivational difficulties

Ambivalence about change is normal – patients often feel torn between wanting better health and not wanting to change established habits. Sometimes people get stuck thinking, ‘I want to, but I can’t’. The task of the practitioner is to listen out for and reflect back any talk about change, e.g. ‘I want to …, I could …, I should …, I need to …’. This is described as ‘change talk’ in motivational interviewing, which signals movement towards a commitment to change (Miller & Rollnick, 2013).

A decision not to make a change at the present time is a viable option, as it may be better not to start making changes before the patients are ready. If they have already tried and failed many times, a further half-hearted attempt and failure might reinforce their already low levels of self-esteem. Providing unwanted advice in this situation may be met with resistance. It is important to respect patient autonomy regardless of the decisions made.

Motivation for change can be triggered by helping a person become more aware of the discrepancy between where they are and where they would like to be. But this needs to happen in their own mind (facilitated by a skilled practitioner who highlights the discrepancy between their intentions and their actual behaviours), rather than having it exposed as a product of their inadequacy. For example, instead of ‘You need to keep away from the biscuits, you know the effect it has – you need to work on your willpower’, a reflective response can be more helpful ‘So although you want to lose weight, you are finding it hard to keep away from the biscuits’.

Importance and confidence

Importance and confidence are key constructs of motivation. Exploring the importance of change can help build motivation by encouraging patients to talk about their reasons for wanting to change. How confident people are about their capacity to make and sustain a change is also key (Miller & Rollnick, 2013). The dietitian can assist by:

- Exploring what worked in the past.
- Encouraging patients to talk about their past and present successes.
- Drawing attention to success in other areas of life.
- Helping to devise a change plan with small, achievable steps.

- Looking for opportunities to support patients’ confidence in their ability to change.
- Conveying optimism, e.g. ‘It sounds like that would work for you’.
- Using affirmations, e.g. ‘You have made good progress; you must be pleased’.

Internal and external triggers that get in the way of planned change

A number of feelings, thoughts, beliefs, events and situations can influence the likeliness of behaviours happening (or not happening). As discussed in the preceding text, techniques from BT can help to change the environment to make it more conducive to desired behaviours and less conducive to undesired ones. Such techniques can be implemented at the planning stage (i.e. people may be able to anticipate problems likely to arise) or when particular problems arise. Planning ahead can help draw attention to problems that could be addressed in advance, and also makes revising the plan easier, as they know clearly what they are expecting of themselves. Any changes need to be worked out collaboratively with the patient, rather than presented as solutions from the practitioner’s viewpoint, e.g. ‘Why don’t you…’, ‘Do you think you could…’, ‘How about…’.

The following are examples of strategies for modifying external triggers (also called stimulus control techniques) to eating for weight management, but they can be adapted for other conditions:

- Planning meals and shopping in advance so that appropriate foods are available to eat regularly.
- Planning daily eating times in advance.
- Carrying suitable snacks.
- Asking a friend, partner or colleague to change at the same time, or to be encouraging.
- Avoiding tasting when cooking, as this may result in overeating.
- Limiting the opportunities for seeing tempting foods other than at mealtimes, e.g. put things away in cupboards; do not shop when hungry.
- Taking a route home which does not involve passing a tempting food shop/bakery.
- Always making sure there are suitable foods (e.g. fruit and vegetables) available at home to avoid being tempted to eat less suitable foods if hungry.
- Not buying, or only occasionally buying, tempting/calorie-dense foods such as chocolates, cakes and crisps.

Strategies for modifying internal triggers include:

- Asking in response to an urge to eat, ‘Am I really hungry?’ Urges to eat (sometimes called cravings) need to be distinguished from hunger. The former are psychological triggers to eating and distinct from physical hunger. Real hunger needs to be responded to but a number of strategies can be learned to help overcome psychological urges. Some people find it helpful to use a hunger score (How hungry am I on a scale of 0–10 where 0 is not at all hungry and 10 is...
extremely hungry) to check if they are truly hungry. Cravings are sometimes described as waves; they build until they are at their peak, but then break on the shore and fade away within 15–30 minutes (Brownell, 2004). A craving can be withstood by doing something incompatible with eating until it has faded away.

- Making a list of activities that are incompatible with eating (called response substitution, e.g. walking, reading, phoning a friend, cleaning the car, planning a holiday, running, having a relaxing massage or bath, painting or practicing a relaxation exercise). When faced with an urge, patients can choose something from this list.
- Modifying unhelpful thoughts. The way people think can have a huge impact on their subsequent actions. People can be helped to identify unhelpful thoughts and to replace these with more helpful, coping thoughts. As this process can be complex, further training, accompanied by appropriate supervision, is recommended. Referral to specialist practitioners may be necessary.

Steps involved in modifying unhelpful thoughts include:

1. Identifying unhelpful thoughts through diary keeping, e.g. 'What were you thinking at that time?'
2. Generating alternative ways of thinking, and testing out if these alternatives are more helpful in everyday life.

Sometimes mood changes can be due to other worries, e.g. relationship problems, being depressed about one’s job or long-term effects of an illness. These may need to be addressed, and it may be necessary to refer the patient for more in-depth counselling/therapy.

Problem solving

Problems can arise at all stages of making change, and need to be addressed. It is important to address any difficulties related to change and to encourage patients to generate solutions to the perceived difficulties themselves. This helps to increase their sense of confidence and competence. There is no one right option; it is a question of experimenting to find what works best for each person. The following steps are key elements of problem solving and can be used at any stage in the intervention:

1. Identify and clearly define the problem.
2. Explore all possible options and weigh up the pros and cons of each.
3. Choose the preferred option/s.
4. Develop a plan.
5. Implement and monitor the plan.
6. Review the plan.

Setbacks

Lapsing from a planned change or a change one has made is normal, but patients frequently see it as a failure (Marlatt & Gordon, 1985). Prevention and management of lapses need to be anticipated and worked with throughout the whole consultation process. Many of the strategies already outlined can help. Lapses often lead to feelings of guilt, which increases susceptibility to other slips and the possibility of complete abandonment of changes and a return to previous patterns.

How a person thinks about a lapse is likely to determine the outcome. It can be helpful to explain the following:

- Lapses are a natural and accepted part of change. Eating an unplanned food is a slip and not a personal failure.
- High-risk situations (ones which present an increased and significant risk of returning to old behaviours) are either triggered by internal states (e.g. anxiety, boredom, anger, loneliness) or external events (e.g. social situations, passing a bakery, smell of food) – or a combination of both. Individuals can learn to cope by identifying their particular high-risk situations and learning how best to manage these.
- Change is an ongoing evolving process, a goal in itself. The process should be the focus rather than perceived failure or success at any given step. Every small change in behaviour along the way in the desired direction is a step forward and a sign of important progress.
- Lapses can be a learning experience.
- Even if patients abandon their change plan for now, all is not lost.

Dietitians can help people to identify what leads to lapses, so that plans can be made in advance to prevent them, rather than just relying on will power. A list of coping strategies can be established which could be accessed when necessary, akin to a first aid plan. The way a person copes after a setback can affect the likelihood of further lapses. The following six steps can be offered to help the person cope during a lapse:

- **Stop**: Go away from the situation to a safe place to think about what has happened.
- **Say**: It is not a catastrophe. One error does not mean the end of the world.
- **Learn**: What was happening before the lapse? Analyse the situation to see why it happened.
- **Plan**: What can be done in the same situation to avert another lapse? Use the preceding information to plan in advance to reduce the risk of it happening again. Decide what can be done immediately to stop the slip spiralling out of control. Put these strategies into practice at once.
- **Be positive**: Has anything really changed? Review personal goals and motivation for change.
- **Ask**: Is there anything that can be done to balance up the slip? For example, do some extra exercise. (It is not recommended that patients skip a subsequent meal as this can trigger overeating.)

Implications for practice

Integrating a behavioural approach to changing health-related behaviours involves using a wide range of skills. Behaviour change interventions have been described as combining art and science (Hunt & Pearson, 2001).
In other words, not only the message but also the way in which it is delivered is important. Dietitians need to ensure that they equip themselves with the necessary skills to integrate a behavioural approach into practice. This includes having appropriate training and clinical supervision and ensuring that this way of working becomes an integral part of CPD. This also has implications for future preregistration training and research.

References


