Food selection is a part of a complex behavioral system that is shaped by a vast array of variables. Food is essential for life. It is a powerful symbol of cultural identity, a ritual object, and a product to be purchased. There are pleasures in eating and sometimes guilt from eating. Dietary patterns affect our health and are important factors in the risk for several major chronic diseases. Successful nutrition counseling requires understanding of why clients eat the way they do and then use of this knowledge to develop appropriate interventions.

This chapter discusses the origins of people’s food habits, often described as food behaviors. Dietetics practitioners work with people to successfully make changes in their food habits as measured by diet adherence, using strategies to motivate and improve people’s success at change. The American Dietetic Association (ADA) and its Commission on Accreditation of Dietetics Education have since the beginning of the profession in 1917 stressed communication knowledge and skills as essential for successful professional practice.

**OBJECTIVES**

- Discuss the origins of people’s food habits or behaviors.
- Identify problems of dietary adherence.
- Describe the use of the Scope of Dietetics Practice Framework and the Nutrition Care Process.
- Describe why communication is so important to the profession of dietetics.

“There is more than a verbal tie between the words common, community, and communication... Try the experiment of communicating, with fullness and accuracy, some experience to another, especially if it be somewhat complicated, and you will find your own attitude toward your experience changing.”

—JOHN DEWEY
Why do people eat the way they do? In physiological response to hunger, of course, but food choices and eating are far more complex. Cultural, social, economic, environmental, and other factors are involved in food selection in addition to individual choice, patterns, and personal taste. Understanding people’s food choices is essential before planning an appropriate nutrition intervention.

The goal of nutrition counseling and education is to help clients modify and manage food choices and eating behaviors so that individuals improve their health. However, psychologists tell us that food and language are the “cultural traits humans learn first, and the ones that they change with the greatest reluctance.” A major influence is the food eaten during childhood that forever defines what is familiar and brings comfort. Food preferences from childhood continue to be exhibited by adults, showing the profound role that early family experiences have in shaping food habits. Changing one’s dietary choices is possible but not easily accomplished, and some intervention strategies are more effective than others.

Food has been influencing cultures for centuries. Culture is the sum total of a group’s learned and shared behavior. It is acquired by people living their everyday lives and provides a sense of identity, order, and security. As a group phenomenon, culture is learned from others and transmitted formally and informally to the next generation. These learned traditions are not static; they are dynamic with some changes accepted over time. All cultural and ethnic groups sustain their identities, in part, through their food practices, values, and beliefs. Family and culture determine what foods are appropriate and inappropriate. This makes it especially important to develop good food habits in the home.

Does the person eat tortillas, croissants, cornbread, bagels or bread; hamburgers, sushi, moussaka, curry, bratwurst, pierogies, tacos, lasagna, or pizza; potato, rice, or pasta? Asian diets use rice as a staple, whereas Italians use pasta, for example. American children enjoy a peanut butter–and–jelly sandwich, whereas children from other cultures may have never heard of it. Americans, however, experiment with foods and mix the foods from a variety of cultural traditions, thus making eating practices a diverse cultural smorgasbord. Regional areas of the United States, such as Tex-Mex, New England, the Midwest, and the Southwest also may affect one’s food choices. Examples of regional

Food habits come from family habits and cultural groups.
Source: United States Department of Agriculture.
foods are New England clam chowder, Boston baked beans, Southern grits, New Orleans jambalaya, Texas chili, California sourdough bread, and a Wisconsin fish boil.

FOOD KNOWLEDGE AND BELIEFS

Social changes are determining what, where, when, and why people eat. Lifestyles are less formal. Our social occasions, parties, birthdays, holidays, and anniversaries center around food. Eating in restaurants, eating while grocery shopping, eating during weekend activities, and eating while traveling add challenges to our selection of healthful food choices. Preplanning for these circumstances helps. Food expresses friendship and hospitality, shows concern, and is a status symbol. Prestige is indicated by using expensive meats, fine wines, caviar, and exotic foods along with taking an exotic vacation, eating in a trendy restaurant, and having an expensive car.

How much do people already know about food and nutrition? How do nutrition knowledge, attitudes, and thoughts about food affect one’s food choices? What behaviors are people willing to change? What are their beliefs about the relationship of food and health? These are some of the questions that must be answered before dietetics professionals can understand individuals well enough to begin talking with them about the challenges of changing their food choices. The goal of nutrition counseling and education is to help individuals change their food and eating behaviors so that they select healthful choices. The more knowledge one has about people and their personal needs and practices, the more effective the counseling intervention will be. The goal of this book is to enhance success in communicating when counseling and educating individuals or groups.

In 2007, the International Food Information Council Foundation conducted the second Food & Health Survey about Americans’ views of health, weight, and nutrition. Key findings included:

- Seventy-five percent are concerned about their weight, and 56% are trying to lose weight.
- Sixty percent of those trying to lose weight are trying to reduce calories, and 23% are increasing activity.
- Only 11% knew the recommended calories for their height and age.
- Seventy-two percent are concerned about types and amount of fat they consume, with 87% aware of trans fat.
- Seventy percent are concerned about the amount of sugar they consume.
- Food decisions are strongly based on taste and price, but “healthfulness” has increased to 65%.
- Ninety percent thought breakfast was the most important meal, but only 49% consistently had breakfast.
Snacking is an important component of the American diet, with 93% snacking at least once a day, the mean being 2.5 snacks per day, and 19% snacking more than four times per day.

Other surveys have found:

• Over 38% of our food dollar was spent out of the home in 1998, the last statistic from the Economic Research Service. 5
• The take in–take out trend is increasing, with restaurants targeting foods that can easily be brought home or back to work. 6

The interest in healthy eating is there but obesity continues to rise. 7 As dietetics professionals, our job is to capitalize on the interest in food and nutrition and provide the counseling and educational methods to promote behavior change. This huge task needs to be accomplished through professionals within and outside dietetics for the health of the public.

HEALTH BELIEFS

A person’s beliefs about health may influence his or her food choices. The Health Belief Model is a framework to predict whether a person would or would not change an activity or behavior to benefit his or her health. “Perceived susceptibility” to illness was the “strongest predictor for preventive health behaviors” and the “strongest predictor for sick-role behavior was the perceived benefits.” 8

Having positive rather than negative cognitions or thoughts helps a person to make changes. There is a big difference between “Nutrition is important and this is worth the effort for my health” and “It’s too much trouble and I feel ok anyway.” One study found that some women linked the word “diet” to losing weight, whereas men disliked the word. “Food choices” or “choose a meal” were suggested as alternatives. 9 Cognitions may be influenced by attitudes and feelings. Therefore, attitudes are thought to influence peoples’ decisions and actions. People may eat not only for physiological reasons such as hunger, but for psychological reasons, such as anxiety, depression, loneliness, stress, and boredom as well as from positive emotional states, such as happiness and celebrations. Food may assuage guilt as well as lead to guilt feelings. 10

Knowledge of what to eat is certainly a first step in influencing healthful food choices, but it is probably overrated. There are individuals who know what to eat and do not do it. When people do not eat properly, some counselors redouble their efforts in educating as if the problem is lack of knowledge. The relationship between what people know about food and nutrition and what they eat is a very weak one. Other factors may be taking precedence and need to be explored. Knowledge helps only when people are willing and motivated to change.

Thus, there are many influences on food choices, including cognitive, sociocultural, physical, and geographical factors. The nutrition counselor needs to explore all of them to understand the client, the client’s motivation for change, and the appropriate intervention to use. Figure 1-1 summarizes some of the variables motivating changes in people’s food choices and health behaviors. Discussion of variables continues in the chapters that follow.
Chapter 1  •  Challenges for Dietetics Professionals  5

**Figure 1-1** Variables Motivating Change in Food Choices and Health Behavior.

**CAUSE**
- **Level of education**

**MOTIVATIONAL FACTORS CONDUCIVE TO PROPER FOOD CHOICES**
- **Intrinsic factors**
  - Beliefs about health and nutrition
  - Cognitions (thoughts)—positive
  - Goal setting, action plans
  - Contracting
  - Self-monitoring and management
- **Extrinsic factors**
  - Praise
  - External rewards
  - Support of others
    - Family, friends, associates
    - Counselor
  - Models of proper behavior
  - Proper food available
  - Improper food unavailable
  - Physical activity

**MOTIVATIONAL FACTORS CONFLICTING WITH PROPER FOOD CHOICES**
- Personal, family, and cultural practices
- Social occasions
  - Friends
  - Movies, parties, dinners
  - Birthdays, anniversaries
- **Time**
  - Time of day, day of week
  - Lack of time
  - Holidays
- Cognitions—negative
- Job, associates
- Meals away from home
- Restaurant meals
- Entering food stores
- Travel, vacations
- Proper food unavailable
- Improper food available
- Physical environment
  - Room in house
- Characteristics of the regimen
  - Complexity, cost, etc.

**EFFECT**
- **HEALTHFUL FOOD CHOICES**

**AFFECTIVE INFLUENCES**
- Emotional states
  - Boredom
  - Fear, anxiety
  - Depression
  - Happiness
  - Stress
  - Weather
- Physical condition
  - Threat to health
  - Fatigued or rested
  - State of health
  - Severity of illness
ADHERENCE TO DIET CHANGES

Changing food choices may sound easy, but it is actually a very complex endeavor. The characteristics of the dietary regimen are the most important factors in adherence. Adherence is defined as the extent to which the individual’s food choices and behaviors coincide with dietary recommendations. Research has shown that patients with diabetes and other diseases have difficulty adapting to lifestyle changes. Poor adherence is multifaceted and is linked to both educational level and patient perception, including self-efficacy. One study showed that having greater trust in one’s physician reduced the difficulty of lifestyle change for patients. This finding is probably generalizable to dietetics professionals.

Dietary changes encompass many of the factors associated with a higher incidence of nonadherence. They include required changes in lifestyle, which tend to be restrictive, are of long duration or last a lifetime, and interfere with customary family habits and practices. If other barriers exist, such as high cost of the foods, lack of access to the proper foods, or extra effort, time, and skill required to prepare the meals, the likelihood of nonadherence increases.

To change food behaviors, the counselor and the client must have good rapport, with the counselor taking into consideration the person’s lifestyle, concerns, and expectations. Adherence may be more satisfactory if the client sees the same counselor at each visit and if clear-cut communication occurs based on what the client is willing to do. The client should set the goals for change, or select from alternatives suggested by the counselor if the client is unable to define any. A warm and caring environment and prompt scheduling of appointments put the client in a good frame of mind. Long waiting periods at an appointment do not.

In patients with diabetes mellitus, dietitians reported the following barriers to dietary adherence: lack of time, lack of health symptoms, lack of education, poor self-esteem, lack of empowerment, and misinformation from family, friends, and others with the same disease. To overcome these barriers, dietitians recommend individualizing meal plans, teaching patients to plan ahead, teaching about medical complications from lack of adherence, and setting obtainable goals.

Measures of dietary adherence are examined frequently. As clients return for follow-up appointments, discussions may focus on what worked and what went well, as well as what did not work, to define the extent to which the person’s food choices and behaviors coincide with the goals developed or the physician’s dietary prescription. This information is useful in setting additional goals for change with the client.

It is unrealistic to expect 100% adherence 24 hours a day, 7 days a week. Travel, parties, holidays, and other events may be times when people relax their diet for a limited period of time. The short-term pleasure of a piece of chocolate cake or apple pie, for example, may take precedence temporarily over the dietary regimen. In the Dietary Approaches to Stop Hypertension (DASH) trial, lack of food variety and unappetizing foods contributed to noncompliance with the DASH diet for hypertension.

How is adherence measured? Adherence to diet is often evaluated based on oral and written self-reports of foods and beverages consumed, both subjective measures. Daily self-monitoring records of food intake, interviews such as diet histories and
24-hour recalls, and the professional’s subjective judgment are used to collect data. These methods depend on the client’s honesty and accuracy in reporting.

The challenge for health professionals is to be sensitive cross-culturally in helping clients change their food choices without disturbing the sociocultural functions of food. For dietary changes to succeed, a combination of approaches—including behavioral and cognitive interventions, self-efficacy, relapse prevention, self-monitoring, stages of change, social support, and educational strategies—may be necessary to assist people to make changes in food choices. Strategies for promoting change and for working with clients to improve adherence are found throughout the book.

NUTRITION CARE PROCESS

The Nutrition Care Process (NCP) is a framework for thinking and decision making that registered dietitians use to guide professional practice in providing high-quality nutrition care. The NCP is a four-step process that includes (1) nutrition assessment, (2) nutrition diagnosis, (3) nutrition intervention, and (4) nutrition monitoring and evaluation. Nutrition education and nutrition counseling are fundamental interventions in step three of the NCP, along with coordination of nutrition care, food and/or nutrient delivery, and supplements.

After completing step one, nutrition assessment, a new component of the NCP is nutrition diagnosis. Using standardized language and terminology, a framework outlines three domains within which 62 nutrition diagnoses or problems may fall. The domains are intake (diet, nutrition support), clinical (functional, biochemical, weight), and behavioral–environmental (knowledge and beliefs, physical activity and function, food safety and access). Chapter 5 describes the nutrition care model in more detail. Communication is fundamental to each step in the process. Based on the nutrition assessment, clear documentation of the nutrition problem (diagnosis) and the treatment intervention will provide the means to document what dietetics professionals do. Some case studies in this book provide practice in following the new recommendations of using the standardized language for the NCP. As this is a relatively new development in dietetics, the language will continue to evolve.

The NCP is one part of the Scope of Dietetics Practice Framework. The three broad areas in the framework are the foundation knowledge of the profession, evaluation resources to gauge performance, and decision aids to define one’s scope of practice.
This framework provides the practitioner with the analytical tools to determine whether an activity is within the typical Registered Dietitian (RD) or Dietetic Technician Registered (DTR) skill set and how to determine whether a particular activity fits within an individual's ability to practice safely. The Scope of Dietetics Practice Framework takes into account the knowledge and skills set by the Commission on Accreditation for Dietetics Education, the Code of Ethics for the American Dietetic Association (ADA) and Commission on Dietetic Registration (CDR) members, the Standards of Practice and Standards of Professional Performance for ADA members, and numerous national and state regulations and research across the profession. As dietetics professionals refer to these materials, they guide practice, and the decision tree assists in personal assessment of competence. For example, all of the preceding references concur that dietetics practitioners educate and counsel clients. However, a personal assessment of competence could identify that the practitioner is not competent with a particular ethnic culture and should learn more before counseling individuals in that culture.

The Scope of Dietetics Practice Framework is particularly helpful as practitioners diversify their practice into newer career options. Several of the developing careers are health coaching, supermarket tour guides, and virtual (online) diet counseling. Basically health coaching is providing information to help clients lead healthy lifestyles. Dietetics professionals have the skills to provide this information. Generally the coach determines gaps in knowledge or skills and advises clients on how to fill them. Health coaching is not medical nutrition therapy. Medical nutrition therapy provides a systematic assessment, diagnosis, treatment, and intervention as described in the NCP, whereas health coaches provide advice. Health coaches may work independently or with the physician to improve disease management. Skills coaches include questioning, listening, and visioning.

Other dietetics business ventures are built on counseling and education skills. Supermarket tours require that dietetics practitioners know the science of food and nutrition and translate it into terms, graphs, and languages that the consumer can understand and use.

Of course, our traditional roles also rely on communication. Translating the science of nutrition into practical food preparation, and food and meal intake and patterns, is fundamental to dietetics whether this is applied to a community, group, family, or individual. The art of communication also is essential in the manager's role played by many dietetics professionals. All professionals need the ability to communicate and work effectively with their employees, with others on their same level, with superiors who are in authority, and with customers and clients. Dietetics professionals communicate to both individuals and to groups in meetings and classes. The basic principles of communication in the following chapters apply in all practice settings, although the details of application may differ.
Varying roles, varying settings, and the terminology of the moment all contribute to different names for practitioners and the individuals with whom they interact. For the purposes of this book, practitioners may be referred to as dietetics practitioners or professionals, food and nutrition practitioners or professionals, counselors, teachers, dietitians, or technicians. The receiver of the information may be the client, individual consumer, patient, or group. The authors intermixed these terms throughout the text based on what seemed to fit best. There is no correct terminology.

Knowledge of food, food habits, the cultural influences of food, and the factors influencing lifestyle behaviors are fundamental for dietetics professionals. The ability to communicate with others is essential to all dietetics practitioners independent of their type of position or practice setting. The use of the new standardized language and terminology for the profession of dietetics improves our communication in providing effective, quality nutrition care. The use of the Scope of Dietetics Practice Framework assists us in considering boundaries of practice and providing quality, safe care to those we serve.

CASE STUDY 1

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

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

1. What lifestyle factors may help or hinder Karen in adhering to different food choices so that she can lose weight?
2. What suggestions or alternatives can you give Karen to overcome any problems identified in question one?

REVIEW AND DISCUSSION QUESTIONS

1. How do dietetics professionals use communication skills?
2. List five influences on people’s food habits or behaviors.
3. What factors influence dietary adherence?
4. What strategies can be used to help people make dietary changes and promote better dietary adherence?
5. What are the major three components of the Standards of Dietetics Practice Framework?
6. Where in the Nutrition Care Process is education and communication incorporated?

**SUGGESTED ACTIVITIES**

1. With someone trying to make changes in food choices, discuss the changes and the factors influencing the changes, including any opportunities, challenges, or barriers. What are the factors influencing the person’s adherence?
2. Select a dietary regimen, such as increased fiber, restricted sodium, reduced calorie, or reduced fat and cholesterol, and follow it yourself for 7 days. Keep a daily record of all foods eaten. How easy or difficult was it to comply with the dietary change for a week? What factors helped or hindered your adherence?
3. Write down what you would eat in these situations if you were following the same dietary regimen: birthday, wedding, holidays such as Christmas or Passover. How are decisions made regarding food choices for these events?
4. Think about your own food practices. What influences them? To what extent are social and cultural factors involved?
5. Discuss with peers the family and cultural origins of your food habits.
6. Watch three hours of television or examine three current magazines. What food products are advertised? What are the messages? How do these ads influence food choices? Compare with peers.
7. In your culture, what foods are served on special occasions, such as weddings and holidays. Compare with peers.
8. Interview a person from a different cultural or ethnic group to determine what is eaten on a daily basis and on holidays.
9. Visit the American Dietetic Association (ADA) web site at www.eatright.org and look at the standardized language textbook and the Dietetics Scope of Practice Framework. Discuss how they will be relevant to your professional education.

**WEB SITES**

http://culturedmed.sunyit.edu/bib/food/index.html Bibliography on cultural issue and food
http://www.nal.usda.gov/fnic/pubs/bibs/gen/ethnic.html Resource on food and culture

**REFERENCES**