One of the key roles of the dietetics professional is to promote the optimal health of the public. The practitioner translates the science of nutrition into healthful food and nutrient intake for the individual or group. To achieve appropriate food intake, often behaviors and lifestyles must change. Nutrition counseling focuses on helping clients accomplish these changes. Counseling also comes into play in the managerial aspects of dietetics in the form of staff counseling for development or remediation.

The Commission on Accreditation for Dietetics Education of the American Dietetic Association requires that dietetics students have a working knowledge of counseling theories and methods and that they be able to counsel individuals on nutrition. Counseling is essential to the success of the food and nutrition professional, whether as a manager, a clinical or community care practitioner, or a counselor in private practice. As health care intensifies its emphasis on outcomes, the results of counseling will be examined more fully. If the intervention, whether assessment, education, or counseling, does not produce a change in knowledge, skills, behavior, or health outcome, the continuation of the intervention will be questioned. However, it is not always easy to measure the impact of an intervention on behavior.

Counseling may be defined as a process that assists people in learning about themselves, their environment, and the methods of handling their roles and relationships.
It involves problem solving, identifying goals, and change. Counselors assist individuals with the decision-making process, resolving interpersonal concerns, and helping them learn new ways of dealing with and adjusting to life situations. Counseling is a science with a body of literature that assesses techniques and their effectiveness. It is also an art; the skills of the counselor allow the counselor to customize the counseling to the individual client.

This chapter is an overview of the counseling process; Chapter 5 describes nutrition counseling in more detail. Counseling is a process that involves the development of a trusting, helping relationship between counselor and client, evaluation of the client issues, and various techniques of problem solving. The approaches to counseling may be classified as nondirective or directive. The nondirective or “client-centered” approach is often applied to the nutrition counseling of clients. It includes listening and helping the person determine how to proceed. Directive counseling is often applied to staff regarding job-related issues; it includes the counselor providing advice, reassurance, and clarity.

**Nondirective Counseling**

The nondirective approach to counseling is often called “client-centered” and is best represented by the writings of its originator, Carl Ransom Rogers. Dr. Rogers’ theory was first presented in his book, *Counseling and Psychotherapy* (1942) and was further refined in subsequent publications. The theory is constantly developing, changing with experience and research; however, the fundamental assumptions have not changed. The theory is one of the more detailed, integrated, and consistent theories currently existing and has led to, and is supported by, a greater amount of research than any other approach to counseling.

A basic assumption in the Rogerian client-centered point of view is that humans are basically rational, socialized, and realistic. Individuals, if their needs for positive regard from others and for positive self-regard are satisfied, possess an inherent tendency toward realizing their potential for growth and self-actualization. Counseling releases the potentials and capacities of the individual.

One of the most important characteristics of the Rogerian theory is the relationship it suggests between the counselor and the client. The underlying assumption is that the client cannot be helped simply by listening to the knowledge the counselor possesses or to the counselor’s explanation of the client’s personality or behavior. Prescribing “cures” and corrective behaviors are seen as being of little lasting value. The relationship that is most helpful to clients and that enables them to discover within themselves the capacity to use the relationship to change and grow is not a cognitive, intellectual one. “One of the phrases that Rogers used to describe his therapy is ‘supportive, not reconstructive,’ and he uses the analogy of learning to ride a bicycle to explain: When you help a child to learn to ride a bike, you can’t just tell them how. They have to try it for themselves. And you can’t hold them up the whole time either. There comes a point when you have to let them go. If they fall, they fall, but if you hang on, they never learn.” Rogers suggests that the counselor possess four specific characteristics for the therapy relationship: acceptance, congruence, understanding, and the ability to communicate these to the client.
The counselor needs to be accepting of and respect the clients as individuals as they are, with their good and bad points, their conflicts and inconsistencies. Only after clients are convinced that they are accepted unconditionally and nonjudgmentally can they begin to trust the counselor.

Exceptional counselors are characterized by congruence within the counseling relationship. They are unified, integrated, and consistent, with no contradictions between what they are and what they say. These counselors are able to express outwardly to their clients what they are feeling within themselves. Their verbal and nonverbal behaviors are consistent.

The counselor must experience an accurate, empathic understanding of the client’s world as seen from the inside, sensing the client’s world as if it were his or her own, but without losing the “as if” quality. This empathy is essential to Rogerian therapy. This understanding enables clients to explore freely and deeply and develop a better comprehension of themselves.

It is of no value for the counselor to be accepting, congruent, and understanding if the client does not perceive or experience this. The acceptance, congruence, and understanding need to be communicated to the client verbally and nonverbally. Rogers is definite in his belief that these not be “techniques,” but a genuine and spontaneous expression of the counselor’s inner attitudes, having contact with people.3

If the counselor has these characteristics and attitudes and is able to communicate them to the client, then a relationship develops that is experienced by the client as safe, secure, free from threat, and supportive. The counselor is perceived as dependable, trustworthy, and consistent. This outcome requires being a good listener, having intuition, providing feedback on both data and feelings, and providing inspiration.5 This is the type of relationship that supports behavioral change, whether you are working with clients or with staff. Central to the Rogerian approach is reflection on what the client said, the mirroring back to the client of what he or she is saying.5

The relationship is key to successful counseling.
Source: United States Department of Agriculture.

COUNSELING PROCESSES

Various models describe the counseling process. Many have a Rogerian foundation and incorporate the client’s readiness for change and transforming a behavior. Counseling is an individualized process that does not involve giving ready-made advice, but suggesting constructive alternatives based on what is important to and manageable for the client.6 Counseling is an interactive process that goes well beyond education of the client. Several approaches are described next, including the Transtheoretical Model, also called the Stages of Change Model, and motivational interviewing. The Transtheoretical Model
identifies stages of change that individuals pass through before actualizing a change.\textsuperscript{7} Motivational interviewing is an approach designed to “help clients build commitment and reach a decision to change.”\textsuperscript{8} Chapters 6 and 7 expand this discussion to behavioral therapy and social cognitive theory.

Assessing Stages of Change

Prochaska and colleagues have developed a Transtheoretical Model or Stages of Change Model (Figure 4-1). It is a framework for understanding clients’ readiness to change to healthier eating practices. Change is not viewed as a single event, such as “I will eat less sodium starting today.” People who need to make changes progress through six identified stages: precontemplation (no intention of changing in the next 6 months), contemplation (intending to change but not soon), preparation (intending to change in the next month), action (recent changes in food choices), maintenance (changes maintained for 6 months), and termination (changes maintained for 5 years).\textsuperscript{7}

People do not change their food choices just because we tell them to or because they know they should. The key to successful nutrition counseling and education is to assess and identify the person’s stage or readiness for change and match the intervention to it. Different counseling strategies are needed, for example, for those unaware of a problem, for those resisting efforts to change, and for those intending to change at a future time. This should increase the effectiveness of the intervention, assist the client in progressing to the next stage because of enhanced motivation and readiness, and reduce the likelihood of dropping out of treatment because the intervention was not appropriate.

Table 4-1 lists sample questions and interventions at each stage.

Precontemplation

In stage 1, precontemplation, a person is unaware or under-aware that a problem exists, denies that there is a problem or is not interested in change, and thus has no plans to change eating practices or start exercising in the near future.\textsuperscript{7,9} The person may have previously tried a change such as weight loss, and failed, and he or she may be resistant to the health professional’s efforts to suggest possible changes. Perhaps a visit to the doctor initiated a referral to see the dietitian for weight loss, even if the patient was satisfied with his or her weight. To identify this stage, you may ask: “Are you seriously intending to change (name the problem behavior) in the next 6 months?” For example, for people ignoring the relationship between a high-fat diet and coronary heart disease, you may ask: “Have you thought about eating less fat (or more fruits and vegetables) in the next 6 months?” At this stage, a person with high levels of low-density lipoprotein cholesterol may need to know the benefits of a lower blood level, for example, and the risks of not addressing the problem. An attempt to focus instead on making dietary changes may not be effective in precontemplation. Table 4-1 lists sample questions and interventions at each stage.
Figure 4-1  Clients Progress Through Stages of Change.
<table>
<thead>
<tr>
<th>Stage</th>
<th>Question for Client</th>
<th>Intervention</th>
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<tbody>
<tr>
<td>Precontemplation</td>
<td>“What can I do to help?”&lt;br&gt;“Do you ever read articles about . . . ?”&lt;br&gt;“What do you know about the relationship between . . . ?”&lt;br&gt;“Does anyone in your family have this problem?”&lt;br&gt;“Are you aware of the consequences?”&lt;br&gt;“How do you feel about making a change?”</td>
<td>Consciousness raising&lt;br&gt;Assess knowledge&lt;br&gt;Increase self-awareness, give information&lt;br&gt;Assess values, beliefs&lt;br&gt;Cognitive restructuring&lt;br&gt;Discuss risks and benefits</td>
</tr>
<tr>
<td>Contemplation</td>
<td>“What changes have you been thinking about?”&lt;br&gt;“What are the pros and cons?”&lt;br&gt;“How do you feel about it?”&lt;br&gt;“What would make it easier or harder?”&lt;br&gt;“What would be the results of the change?”&lt;br&gt;“How can I help?”</td>
<td>Assess knowledge&lt;br&gt;Assess values, beliefs&lt;br&gt;Assess thoughts, feelings&lt;br&gt;Decrease barriers&lt;br&gt;Self-evaluation&lt;br&gt;Cognitive restructuring</td>
</tr>
<tr>
<td>Preparation</td>
<td>“Are you intending to act in the next 1–6 months?”&lt;br&gt;“How will you do it?”&lt;br&gt;“What changes have you made already?”&lt;br&gt;“How will your life be improved?”</td>
<td>Self-efficacy, commitment&lt;br&gt;Decision making&lt;br&gt;Discuss beliefs about ability&lt;br&gt;Plan goals</td>
</tr>
<tr>
<td>Action</td>
<td>“What are you doing differently?”&lt;br&gt;“What problems are you having?”&lt;br&gt;“Who can help you?”&lt;br&gt;“How can I help?”&lt;br&gt;“What do you do instead of (former behavior)?”</td>
<td>Stimulus control&lt;br&gt;Self-reinforcement&lt;br&gt;Social support&lt;br&gt;Self-management&lt;br&gt;Goal setting, group sessions, self-monitoring, relapse prevention</td>
</tr>
<tr>
<td>Maintenance</td>
<td>“How do you handle times when you slip up?”&lt;br&gt;“What obstacles are you facing?”&lt;br&gt;“What are your future plans?”&lt;br&gt;“What issues have you solved?”</td>
<td>Coping responses&lt;br&gt;Relapse prevention&lt;br&gt;Self-management&lt;br&gt;Commitment, goal setting, control environment</td>
</tr>
<tr>
<td>Termination</td>
<td></td>
<td>Self-management, self-efficacy</td>
</tr>
</tbody>
</table>
Contemplation

In stage 2, contemplation, a person is aware that a problem exists and intends to do better eventually, such as eating differently or exercising more. He or she has no serious thought or commitment, however, to making a change and keeps putting it off. The person may be mentally struggling with the amount of energy, effort, and cost of overcoming a problem and may be discouraged by previous failures. You may ask:

“What have you been thinking about in terms of making a change?”
“What are the pros and cons of doing it?”
“How can you change your environment?”
“What do you think about eating less fat? What are the barriers or obstacles to doing it?”

The balance between pros and cons can result in ambivalence that keeps people at this stage for long periods of time, even months or years.

Preparation

In stage 3, preparation, a person is more determined to change and intends to take initial action soon, perhaps in about 30 days, but not today. He or she may report small changes in the problem behavior, such as reading a few food labels or buying fat-free ice cream.

Action

In stage 4, action, a person attempts to overcome the problem by actively modifying food choices, behaviors, environments, or experiences. Remember that most clients are not in the action stage when referred for counseling. Considerable commitment of time and energy is required in the action stage when people are trying to change. You may ask:

“What are you doing differently?”

Maintenance

In stage 5, maintenance, a person consolidates and stabilizes gains made over several months to maintain the new, healthier habits and works to prevent relapse. Maintaining weight loss, for example, takes continuing effort. For some people, this stage continues for months, years, or a lifetime, or until the behavior becomes a pattern and is incorporated into their lifestyle. You may ask: “How do you handle small lapses?” (Additional information on counseling about lapses and relapse is provided in Chapter 7.)

The ultimate goal is the termination stage in which changes have been maintained for 5 years. However, some types of problems, such as weight management, may require a lifetime of maintenance instead. People, for example, tend to become more sedentary and overweight as they age, thus contributing to continual problems.

Prochaska proposed that people proceed through the stages in a spiral, rather than a linear, fashion. Because lapses and relapse are common problems, recycling to an earlier stage, such as from action to preparation or from preparation to contemplation, may be expected several times as people struggle to modify or cease behaviors. People may avoid high-fat foods, for example, and then start eating them again. Lapse and relapse and the negative emotional reactions (guilt, shame, failure) that may result are discussed in more detail in Chapter 7. It is hoped that people learn from their mistakes with the help of the counselor and continue trying.
A second dimension of the model examines the processes of change or activities people use to progress through the stages of change when there are shifts in behaviors, attitudes, and intentions. The processes of change should be integrated into the stages of change so that the treatment intervention matches the client’s stage of change.

In the early stages, focusing on the benefits of making a change and how that change can improve the individual’s life or health is suggested. The goal is for the client to think about the problem. Clients may, however, doubt their ability to change and have decreased self-efficacy at this point. In precontemplation (consciousness raising), providing nutritional information (oral, written, web addresses) about the benefits of healthy choices and about the individual’s risk for chronic disease based on dietary habits with the advantages of change is suggested. Self-reevaluation of thoughts, feelings, values, problems, self, and environment is appropriate. The client needs to weigh the pros and cons of change, with the pros (“I’ll see my grandchildren grow up”) outweighing the cons (“I can’t eat whatever I want.”). Cons outweigh the pros at this stage.

Cognitive and affective self-reevaluation, in addition to raising awareness, is suggested in the contemplation stage. Self-liberation (a belief that one can change and the actual making of a commitment to it) and behavioral goals (discussed in Chapter 5) are important in the preparation stage. In the client’s assessment, the benefits or pros must outweigh the cons or costs. In the action and maintenance stages, behavioral techniques (see Chapter 6) of stimulus control, reinforcement management, self-monitoring, recipe modification, coping responses during conditions when relapse is likely, and developing a social support system of significant others are useful. Keep in mind that the client may be at an early stage for one change, such as increasing fruit and vegetable intake, while at another stage for a different behavior, such as increasing exercise or decreasing portion size.

Motivational Interviewing

Motivational interviewing was originally developed from work with “addictive behaviors,” but the intervention approach can be used in a variety of situations. It offers an approach for increasing the client’s readiness to change eating behaviors. Even if people are aware of damaging consequences of their behavior, such as overeating or nonnutritious choices, they may use “short-term gratification at the expense of long-term harm.”

This motivational approach draws on client-centered counseling; it guides rather than directs or advises the client. It can be integrated into Prochaska and colleagues’ Stages of Change Model in which people move from being unaware or unwilling to do anything about a problem, called precontemplation, to considering the possibility of change or contemplation, preparing to make a change, or determination and finally taking action. The client may be at any of several stages; thus, the initial step is to assess where the client is.

Motivational interviewing strategies draw on principles of social, cognitive, and motivational psychology; on ambivalence, or the conflict between restraint and indulgence, which can be immobilizing; and on the theory of self-regulation. The approach works well with people who are reluctant to change. These people are the “precontemplators” and “contemplators.” The concept of the “importance” of the change to the person and the “confidence” in the ability to make the change are importance to the determination of readiness to change. Rollnick suggests that you can assess readiness for change by asking two questions: How important is the change to you? How successful do you think you will
Box 4-1

Assessing Importance and Confidence of the Patient

Useful Questions to Explore Importance
- What would have to happen for it to become more important for you to change?
- What would have to happen before you seriously considered changing?
- How important is this change on a scale of 1 to 10?
- What would need to happen for your importance score to move up from . . . to . . .?
- What stops you moving up from . . . to . . .?
- What are the motivators to retain your [current behavior]?
- What are some of the concerns you have (or things you dislike) about . . . [current behavior]?
- What concerns do you have about . . . [current behavior]?
- If you were to change, what would it be like?
- Where does this leave you now? (When you want to ask about change in a neutral way).

Useful Questions to Build Confidence
- What would make you more confident about making these changes?
- How confident are you about accomplishing this change?
- How could you move up higher, so that your score goes from . . . to . . .?
- How can I help you succeed?
- What have you found helpful in any previous attempts to change?
- What have you learned from the last time you tried this type of change?
- If you were to decide to change, what might your options be? Are there any ways you know about that have worked for other people?
- What are some of the practical issues you would need to address in order to achieve this goal? Do any of them sound achievable?
- Is there anything you can think of that would help you feel more confident?


Box 4-1 gives you a series of questions to use in assessing these two areas with clients. These questions assist in determining the stage of change.

What is motivational interviewing? It is “a particular way to help people recognize and do something about their present or potential problem.” It is especially useful with clients who are ambivalent about or reluctant to change. It helps to resolve the ambivalence and move them toward change. Once people become unstuck from the conflicting motivations of whether or not to change that immobilize them, they can move toward a decision and a commitment to take action.

What is the role of the counselor? An authoritarian role that sends the message “I’m an expert and will tell you what to do” is counterproductive. The responsibility for change lies with the client: “It’s up to you to decide what to do. It’s your choice.” The goal is to “increase the client’s motivation, so that change arises from within rather than imposed
from without." The client, not the counselor, needs to develop and speak aloud the arguments for change. One image of the counselor is that of a helper accompanying a person on a journey. The guide "needs the qualities of a companion and the skills of someone who knows the route," but acknowledges the client’s personal responsibility for change and freedom of choice. Individuals who successfully conduct motivational interviewing focus on reflection, including reinforcing positive statements about change, rather than responding with questions and advice.

Motivational interviewing is described as having an "‘elicit–provide–elicit’ framework." The counselor elicits what the person understands or needs about the situation, provides information in a neutral manner, and then elicits what the client thinks about the provided information. In this way, the counselor directs the client toward motivation to change. Once the client is motivated to change, behavioral motivation or cognitive counseling strategies are often started.

Principles of Motivational Interviewing

Five general principles underlie this approach:

1. Express empathy.
2. Develop discrepancy.
3. Avoid arguments.
4. Roll with resistance.
5. Support self-efficacy.

Express empathy

Empathy suggests acceptance. The counselor seeks to understand the client’s feelings and beliefs in a noncritical, nonjudgmental manner. The counselor listens carefully and respectfully. Empathy involves the counselor verbally reflecting what the client says to clarify and amplify the client’s experience, feelings, and meanings, even if the counselor has not had a similar experience. Sharp attention to each client statement allows the counselor to hypothesize as to the meaning. The best guess as to the meaning is then reflected back to the client for verification. Ambivalence is considered normal. The client often considers continuing the current behavior desirable. The reasons must be explored, so attempts can be made to decrease or counterbalance them.

Develop discrepancy

The counselor seeks to develop discrepancy between present behavior and a new behavior, that is, where the person is and where he or she wants to be. One approach is to examine the implications and benefits of the current course of behavior as well as the benefits and implications of change, determining the relative importance of each (see Table 4-2). If the person has a conflict with an important goal, such as better health, self-image, or happiness, change is more likely. An individual’s motivation to change increases when people see a discrepancy between present behavior and goals that are important to him or her.

People who come for counseling on their own, as opposed to those referred by a health care provider, can be expected to perceive some discrepancy already. But they may be ambivalent, stuck between the conflict of whether or not to change. Then it is necessary to clarify the client’s important goals and explore how present behavior conflicts...
with them. The goal is to increase the discrepancy until it overrides the attachment to the current behavior. Eventually, clients may see and articulate the arguments for change as their own. The client has more commitment to change when he or she makes the decision, thus increasing motivation.

Avoid arguments

A third principle is that the counselor avoids arguments and confrontation. When a counselor argues that the client needs to change, the client defends the opposite view and resists change. People assert their ability to do as they please and make their own decisions. Although the purpose of motivational interviewing is to increase awareness of a problem and the need to change, the counselor does not want to confront and thus increase resistance to change.

Roll with resistance

If the client is resistant, the counselor can acknowledge that reluctance to change and ambivalence are natural and understandable. The client may be offered new information or alternatives to consider. Or, rather than generating solutions, the counselor can ask the client for solutions to his or her problems. This involves the client in problem solving.

Support self-efficacy

Self-efficacy refers to a person’s belief in his or her ability to succeed with a specific task. It is a key to motivation for change. If a person does not believe he or she can change, little or no effort will be made. A client may be encouraged by the counselor’s offer of help or by seeing the success of others in the same or similar situations (role models). The counselor needs to reinforce the client’s hope, optimism, and self-efficacy.

Reflective Listening

How the counselor responds to what the client says is an important element of reflective listening. Reflective listening may be one of several types. The counselor may repeat part of what the person said or may rephrase slightly using different words. Paraphrasing is a more major restatement in which the counselor tries to determine the meaning in the statement and reflects back in new words adding to or extending the meaning. Finally, the deepest form of reflection is to reflect feelings in a paraphrase that searches for the client’s emotions behind the statement. Thinking up a response to what the client is saying and

<table>
<thead>
<tr>
<th>Table 4-2</th>
<th>Cost–Benefit Analysis for Change</th>
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<tr>
<td><strong>Continue to Eat as Before</strong></td>
<td><strong>Change Eating Behavior</strong></td>
</tr>
<tr>
<td><strong>Pros</strong></td>
<td><strong>Cons</strong></td>
</tr>
<tr>
<td>Pleasurable</td>
<td>Damages health</td>
</tr>
<tr>
<td>Comfortable</td>
<td>Bad example for family</td>
</tr>
<tr>
<td>Easy</td>
<td></td>
</tr>
<tr>
<td>Decreases loneliness</td>
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*Table 4-2: Cost–Benefit Analysis for Change*
offering it is not reflective listening. Nor is giving advice, making suggestions, criticizing, consoling, reassuring, sympathizing, probing, or telling clients what they “should” do.

**Example:**
Client: “I just don’t know if I can lose weight, but I need to.” (ambivalence)
Counselor: “Of course you can.” (reassuring)
Client: “But it is so difficult.”
Counselor: “Yes, it is.” (sympathizing)
Client: “I never have eaten breakfast, because I don’t have time.”
Counselor: “Just have some cereal and milk.” (giving advice)

In the above example, the counselor is not really listening or giving the client a chance to explore the problem. Instead, the reflective listener hears and decodes the message, makes a reasonable guess as to the meaning, and puts the guess into a responding statement. The statement is a declarative one and not phrased as a question, as follows:

**Example:**
Client: “I just don’t know if I can lose weight, but I need to.” (ambivalence)
Counselor: “It sounds as if you are pulled in two ways. You want to lose weight. At the same time, you wonder if you can do it successfully.”[Avoid: “You are concerned about losing weight?” as a question.]
Client: “But it is so difficult.”
Counselor: “You found that your past efforts to change what you eat and lose weight were difficult. I think it’s great that you want to try again.”
Client: “I never have eaten breakfast, because I don’t have time.”
Counselor: “Your morning schedule must be a busy one.”

Reflective listening and responding is a way of checking the meaning rather than assuming that you know exactly what is meant. It is a guess or hypothesis. This allows the client to keep moving in thought. Not every comment is reflected, however. The counselor decides what to emphasize and what to ignore.

In the early stage of the interview, open-ended questions allow individuals to explore the problems and help establish an atmosphere of trust and acceptance. The counselor may say: “In the time we have together, I want to get an understanding of any issues you have with your choices of foods. I’ll be listening so I can understand your concerns. I’ll also need to get some specific information from you. What do you see as the issues? What would you like to discuss first? What concerns you about your food intake?”

The client does most of the talking. The counselor may ask what problems concern the person or do the benefit analysis for change. Follow up with the reflective listening. Periodic summaries move the interview along. You may summarize the client’s statements about the problem, the client’s ambivalence, self-motivational statements made by the client, and your assessment of the situation. Draw together the reasons for change. This helps clients make up their minds. It reinforces what they may already know to be true, but may be avoiding. Reflection is especially important after answers to open-ended questions and after self-motivational statements.

Motivation may be defined as “the probability that a person will enter into, continue, and adhere to a specific change strategy.” The counselor needs to increase the likelihood that the person will move toward change. The counselor wants to note and facilitate any self-motivational statements on the part of the client. There are several possible examples. First, the client recognizes that a problem exists. (“I guess my weight is a problem
affecting my blood pressure.”) Second, the client may express concern about the problem nonverbally, for example, by facial expression, sighing, tone of voice, or verbally (“I’ve got to make changes now and eat better for the sake of my health.”) Finally, the client may feel positive about the change, thus reflecting self-efficacy. (“I’m sure I can start exercising this week.”) Reflecting back these types of statements allows the client to hear the message for the second time and enhances self-motivation. The counselor can reinforce nonverbally, such as by nodding the head.

The counselor may question the client to evoke self-motivational statements.

**EXAMPLE:**

For problem recognition: “What difficulties have you had in relation to your choices of foods?”

For concern: “In what ways does choosing different foods or eating differently concern you?”

For intention to change: “What are the reasons you see for making a change?”

For optimism: “What encourages you to think that you can make this change?”

When clients reach the action stage of change, their questions can still be met with reflections. Here are possible questions to ask:

“What is the next step?”

“What do you plan to do?”

“Where do we go from here?”

“What good results will occur from this change?”

If the client asks the counselor for advice or information, one approach is to offer several alternatives rather than only one. For example: “I can give you several alternatives. Then you can tell me what you think will work for you.” When the client selects an alternative, he or she is more likely to try it and adhere to it than if the counselor provides only one option. The client takes responsibility for a personal choice. In the case of only one alternative, the client may say: “That sounds good, but it won’t work for me,” thus rejecting the solution.

**Goal Setting**

Reaching a final plan requires setting clear goals. Having goals can facilitate change. Goals have been found to motivate because they set a standard against which the client can compare a current with a new behavior. They should be clearly stated, reasonable, and attainable. Selecting goals enhances personal choice and control, making it more likely that the person will succeed. Goals motivate change.

Effective counseling helps clients to identify and overcome any barriers to change and acknowledges that lapses and
relapses are a normal part of the change process. These may include, for example, lack of time, cost, family environment, lack of social support, nonsupportive friends, fear of adverse psychological or physiological consequences, and so forth.

Clients need feedback about the change to enhance motivation. It can be provided in many ways. Examples are self-monitoring records; results of improved medical laboratory tests; positive comments from friends, family, and the counselor; and the client’s own positive self-talk (“I’m doing better”).

**FRAMES**

When time is limited, brief interventions have been found to be effective. They commonly include six elements, summarized by the acronym FRAMES.

- **Feedback**
- **Responsibility**
- **Advice**
- **Menu**
- **Empathy**
- **Self-efficacy**

After the counselor’s initial assessment, feedback about relevant health information is given by the counselor. Personal responsibility for change is emphasized. “It’s up to you to decide. You’re the one who has to make changes in your food choices.” Choices must be made freely and decisions to change are made only by the client. The client decides what, if anything to do with the feedback. Clear advice to change or make changes may be given as a menu of the variety of alternative ways that changes could be accomplished. Motivation can be enhanced when a person freely makes a decision and feels responsibility for the change. Empathy for the client is emphasized and expressed. Finally, attempts are included to strengthen the person’s self-efficacy for change, to reinforce positive thoughts, and to reinforce the ability to succeed.

Motivational interviewing can overcome ambivalence and move the client from pre-contemplation to contemplation. It promotes the client’s readiness to change and to try various courses of action. The client elaborates and the counselor reflects back again. Rollnick and colleagues consider motivational interviewing a form of guiding rather than directive of giving advice. Rollnick is suggesting that all consultations be based on a guiding style even if full motivational interviewing is not done.

What variables promote or cause behavioral change is subject to much discussion and much-needed research. Resnicow and Vaughan are proposing that we need to look at health behavior change as a complex system, and borrowing from Chaos Theory the concept of fractal patterns. In this view, there are common patterns of behavioral change but “infinite combinations of knowledge, attitude, efficacy, and intention.” They suggest that the goal of education or counseling is to create “motivational storms.” Their example is that changes in knowledge, attitude, efficacy, and intention are like “the spinning ping pong balls (the interventions) in a lottery machine.” The more the balls spin the greater the potential adherence to the receptor of change; periodic interventions keep the balls spinning, and tailored interventions increase the possibility of a motivational change. The beauty of this theory is that it is nonlinear and may expand our understanding of why and when interventions work.
The remainder of this chapter focuses on the general applications of directive counseling strategies as they might be used in nutrition counseling and in employee counseling. The discussion of nutrition counseling in Chapter 5 focuses on the application of nondirective counseling. Directive counseling tends to be most appropriate when the counselor is aware of the problem or is concerned about the behavior of the client, or both, but the client is unaware of the problem or is avoiding acknowledging it. Nondirective counseling tends to be most appropriate when the client has insight and calls on the counselor to assist in the problem solving. In practice, many counseling sessions use a composite of the two approaches such as in motivational interviewing.

In directive counseling, the counselor initiates discussion or approaches the client or staff member based on a direct referral from another practitioner or an employee situation. In nondirective counseling, the client or staff member is aware of the problem and seeks help from the counselor. Clients or staff tend to be far more likely to become defensive and resist problem solving under the conditions of directive counseling. For this reason, counselors using this method need to be especially sensitive to all verbal and nonverbal behaviors and to be supportive while attempting to explore the issue at hand.

Directive counseling is most common in the manager–employee relationship rather than in the dietetics practitioner–client relationship. Directive counseling techniques are used for remedial counseling sessions to address poor employee performance when employees are unaware or unwilling to address it themselves. Nondirective counseling is ordinarily the preferred counseling method when dealing with clients who need to plan and set wellness goals or with employees who have sought out the help of their manager or supervisor.  

Applications of Directive Counseling

Managers have a skill set that is different from a clinician’s skill set. Often, individuals who are extraordinary in their professional expertise or ability to perform a professional task are selected to manage others. Promoting technical professionals into management without first providing them with adequate training for the job is like sending individuals to bat with two strikes against them. Although all dietetics practitioners have a strong foundation regarding the competencies for being a supervisor or manager, additional continuing professional education in directive counseling or conflict resolution is often desirable.

The use of directive counseling is for discussing unsatisfactory job performance. Counseling occurs after the manager has assessed that the employee knows his or her job description, has been trained for the position, and knows the performance expectation. Directive counseling of employees is a form of discipline, and those administering it need to understand the concept. The root of the word “discipline” comes from Latin and means “to train” or “to mold.” The attitude of the counselor needs to be that of a caring teacher who wishes to assist the other in improving. The objective of employee counseling is to change behaviors and develop productive members of the organization. After a manager has assembled and reviewed the facts surrounding a problem with sufficient detail, these must be shared and discussed with the employee. Next, the employee
should be given options on how to correct the behavior and the consequences of failing to improve the behavior.

As pointed out earlier, clients or staff are far more likely to become hostile and defensive in directive counseling than in nondirective counseling, because they are “called in” rather than doing the “calling,” and they may be more concerned with exonerating themselves of blame than with collaborating to solve the problem.

**Employee Counseling**

Employee counseling includes the discussion of a work-related problem. Unless dietetics practitioners have advanced degrees with appropriate clinical counseling experience, counseling staff should be limited to the job-related concerns and should not include probing into personal problems such as depression, drug abuse, alcoholism, and mid-life crisis. For such personal problems, the dietetics practitioner should provide referrals to professional therapists or employee assistance programs. When employee counseling loses its problem-performance orientation, it runs the risk of being interpreted as meddling or an invasion of privacy.

Managers have an obligation to conduct work-related counseling sessions with employees. These should be held as often as necessary, assisting the staff in their professional development as well as dealing with career problems as they occur. The manager should not postpone employee counseling until the annual or semi-annual performance appraisal interviews. Allowing problems to accumulate and handling them all at one time is generally ineffective. Employee counseling should occur as close to the incident as possible.

**Guidelines for Directive Counseling**

There are several stages in the counseling interview. They include involving, exploring, resolving, and concluding stages.

**Involving Stage**

In opening the discussion with the staff member, the counselor must be explicit in the desire to solve a problem rather than to punish. The aim is to improve the staff member’s performance. One way of keeping the conversation from becoming threatening is to keep remarks performance-centered rather than to make judgments about the staff member. It is more supportive and factual to say, “You have been late six times in the past 2 weeks,” than to say, for example, “Lately you don’t seem to care about your job; your attitude is poor.” Inferences are not facts. The manager could not possibly know the quality of the
employee’s “caring” for his job or the condition of his “attitude,” but she does know the objective facts—that the employee has been late six times in 2 weeks.

Exploring Stage
Throughout the interview, the counselor focuses on objective facts, being specific about what has been seen, about what behaviors need to be improved, and about the consequences of not changing the behavior. If the complaint is from others, and the supervisor or manager is unable to document the examples from personal observation, discuss the situation with the individual with an emphasis on clarifying the issues and hearing the staff member’s vantage point.

Resolving Stage
As in nondirective counseling, the counselor should provide adequate opportunity for employees to tell their side of the story, and their remarks should be paraphrased as well. Not only do people not know what they do not know, but they easily fall into traps of seeing, hearing, and selectively perceiving what they expect to see and hear. Giving employees an opportunity to tell their side of the story and then paraphrasing it and empathizing with what the employee is feeling usually leads to collaboration in the conflict-resolution process. There may be extenuating circumstances that no one on the staff is aware of, which account for the dysfunctional behavior of the employee. Having employees explain the problem from their own perspective may add significant insight and understanding.

Concluding Stage
After an agreement on a solution has been reached, the counselor should describe as specifically as possible what the consequences will be if the agreed-upon changes in the employee’s behavior are not actualized. You might say, for example, “If you are absent without notice again, I am going to file a warning notice with human resources.” The manager needs to remember at this point not to exaggerate the consequences or to mention consequences that will not be carried out. If the employee does continue the problematic behavior, the manager must go to the next level of the disciplinary process.

Although verifying understanding is important in nondirective counseling, it is even more important in directive counseling. The tendency for employees to experience physiological stress symptoms from the threat of being called in by the manager heightens the possibility of their misunderstanding some of the communication. Both the manager and the staff member need to paraphrase one another to verify that each has understood the other and that they agree on the final solution. An expression of confidence and support by the manager can help ensure successful implementation of an action plan that both parties have agreed on. Rather than saying, “Well, let’s see what will happen,” the manager provides more motivation by saying, “I think these are the kinds of ideas that can make a difference.” Employees should be reminded that they are an important part of the team, that the manager does indeed care for them personally, and that their contributions to the staff are valued. If the action plan includes a multistep process for improvement, it would be wise to set follow-up meeting dates. Doing so not only confirms commitment, but adds incentive to begin the performance changes.

As in nondirective counseling, managers must attend to the supporting nonverbal behavior throughout the directive counseling interview. They should select a private
place free of interruptions. The spatial dynamics of the location should allow the two people to feel close and intimate, since feelings are being shared and help is being given to solve the problem. The manager needs to act, talk, look, and gesture in a manner that allows the subordinate to infer that the purpose of the counseling session is to change dysfunctional behavior, not to reject or punish. Finally, the manager has to remember to allow adequate time for full expression of thoughts and schedule multiple sessions when appropriate.

**Measuring the Outcomes of Counseling**

The outcome of successful counseling is attaining the desired goals. These goals may be those of the employer, primary care provider, counselor and, most important, the clients or employees. The measurement may be short-term or long-term. Chapter 5 identifies many nutrition outcomes that can be measured. Beyond individual client or staff outcomes, dietetics practitioners need systematically to assess the results of their counseling to determine effectiveness. Questions such as the number of counseling sessions generally needed to create client change are essential to determine recommendations for care and reimbursement norms. Self- and periodic client evaluation of your counseling skills will assist in your professional counseling skill development.

Communication effectiveness is enhanced when the food and nutrition professional uses appropriate theories and strategies that promote behavioral change. This chapter examined several theories and models used in counseling. These include directive and nondirective counseling, the Transtheoretical Model (Stages of Change), and motivational interviewing.

**CASE STUDY 1**

The dietetics counselor is employed at a WIC (women, infants, and children) clinic. Her client is a 16-year-old who has just learned she is 4 months pregnant with her first child. Her older sister, 18, is accompanying her. Her diet history reveals the following:

- **Breakfast:** None or soda and potato chips
- **Lunch:** French fries, soda, and cookies
- **Dinner:** Meat such as ham, potatoes, bread and butter, and soda
- **Snacks:** Soda, snack foods, crackers, and cookies

Using the motivational interviewing process, respond to the following client’s statements reflectively.

1. “My sister says I need to eat differently now that I am pregnant, but I like the foods I eat now.”
2. “I’m not hungry in the morning. I have to leave for school at 7:15.”
3. “I spend a lot of time with my friends. They can eat whatever they want.”
REVIEW AND DISCUSSION QUESTIONS

1. Why is counseling important to most dietetics practitioners?
2. What are potential key outcomes from a counseling session, or a series of sessions?
3. Identify three differences between nondirective and directive counseling.
4. Describe the four characteristics of a quality counselor–client relationship and why they are important.
5. How is motivational interviewing different from the Transtheoretical Model of counseling?
6. List and explain the stages and processes of change.
7. Why is it important to know the person’s stage of change when counseling a client?
8. What are the five principles underlying motivational interviewing?
9. Define and give two examples of reflective listening.
10. Why is it better to give the client more than one suggestion when he or she asks for suggestions?
11. Explain the four-stage process of counseling used in the directive counseling section.
   Provide an example of how this would work with an employee absenteeism issue.

SUGGESTED ACTIVITIES

1. To practice reflective listening statements, form groups of two, one playing the role of a client and one a counselor. Each client should think of two or three things about himself or herself that he or she would like to change (e.g., get more sleep, eat better, lose weight, get more organized and use time better, overcome procrastination, be happier, watch less television, make more friends). This can be stated as: “One thing I would like to change about myself is...” The counselor develops one or two hypotheses of what the person means and puts one of them into a reflective statement rather than a
question. A reflection may be started with the following: “You are feeling . . .” “It sounds like you. . . .” “You are saying that. . . .” “So you think. . . .”

2. During the next week, practice paraphrasing what others say. What reactions do you get? Does your paraphrasing tend to cause the other to go on talking?

3. Write both a paraphrase and an emphatic comment to the following comments made by a counselee:
   A. “I feel awkward discussing my eating habits. I feel embarrassed about my diet.”
   B. “With working all day and a hungry family when I get home, I don’t have time to cook.”
   C. “I am at a point now where I don’t believe I will ever lose the weight.”

4. Form triads consisting of a counselor, counselee, and observer. Each individual should take a turn in each of the roles for 5 to 7 minutes. Try three approaches to counseling, the motivational interview, the Rollnick approach, and the four-stage approach. The counselee should play the role of a client interested in healthy eating. After each round, the observer should share reactions to the counselor’s approach and encourage feedback from the counselee to the counselor. From the counselee’s perspective, what did the counselor do that helped their interaction; what did the counselor do that hindered it? At the end, discuss how each approach helped you.

5. Repeat the activity in number 4. The counselee is a staff member who is not completing his work in a timely manner. Which approach was most helpful here and why?

6. During the next week, make arrangements to view a dietitian’s counseling session, noting particularly what occurs during each stage of the process. What behavior on the part of the dietitian facilitates the building of rapport and trust? What techniques did you see that were reflected in the chapter? Discuss which characteristics of a successful counselor were expressed.

7. After each of the statements below, use the FRAME acronym approach to consider the comment.
   A. “My work situation is impossible. It seems that I’m the scapegoat for everybody. I’m beginning to wonder if I should consider looking for another job.”
   B. “It doesn’t seem fair to me that I should have to work weekends when the staff members who have been here only 2 years longer don’t have to.”
   C. “It seems easy every morning to promise myself that today I will stick to the program we designed. By noon, however, I begin thinking that I’ll never be able to comply with the dietary changes for the rest of my life, so why bother?”

8. To practice developing understanding and using reflective listening, divide into pairs. Ask each person to prepare to discuss a personal experience that would be difficult for someone else to understand. The counselor can use open-ended questions but primarily reflections. The task is to use verbal and nonverbal skills to seek to understand the experience being described by the other. After 10 to 15 minutes, the pair may switch roles. At the conclusion, the instructor may wish to answer questions and ask for reactions to the activity.

9. Count the F’s in the following statement:

   FASCINATING FAIRYTALES ARE THE RESULT OF YEARS OF SCIENTIFIC STUDY COMBINED WITH THE EXPERIENCE OF CREATIVE MINDS.

   Compare answers with several people. Why did you get different answers. How does this relate to issues as a counselor?
WEB SITES

http://www.motivationalinterview.org/  Information about motivational interviewing
http://www.oprf.com/Rogers/  Information about Carl Rogers

REFERENCES