1-1-2019

Developing meaningful client-dietitian relationships in the chronic disease context: An exploration of dietitians' perspectives

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Abstract

© 2019 Dietitians Association of Australia Aim: Meaningful client-dietitian relationships are central to effective dietetic practice. The chronic disease management setting provides an opportunity to examine what is meaningful and how these relationships are constructed, because the dietitian and client generally have multiple interactions over an extended period of time. This study aimed to explore dietitians' perspectives of how they develop meaningful relationships with clients managing lifestyle-related chronic diseases. Methods: Study design and analysis were guided by Charmaz's constructivist grounded theory. Dietitians working in Australia with clients managing chronic diseases were recruited through initial, snowball and theoretical sampling. Online videoconference and telephone semi-structured interviews were conducted. Recorded interview transcripts were analysed using repeated reviews comprising initial, focused and theoretical coding and memoing. Results: Twenty-two dietitians were recruited. A conceptual model developed from the data showed the dietitian's role in developing the client-dietitian relationship is complex. Key elements were identified and described as ‘Sensing a Professional Chemistry’, and the dietitian's skills in ‘Balancing Professional and Social Relationships’ and ‘Managing Tension with Competing Influences’. Influences were categorised as relating to the client and dietitian as individuals (eg, their values), their support network and external contextual factors (eg, working with interpreters). Conclusion: Developing relationships with clients in the chronic disease context appears complex due to the dietitian's role of managing multiple interrelated elements and influential factors simultaneously. To deepen understanding, research should explore clients' perspectives of relationship development and how knowledge of practitioner-client relationships in other disciplines may be utilised to enhance dietetic service delivery.

Publication Details

Nagy, A., McMahon, A., Tapsell, L. & Deane, F. (2019). Developing meaningful client-dietitian relationships in the chronic disease context: An exploration of dietitians' perspectives. Nutrition and Dietetics,

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Methods: Study design and analysis was guided by Charmaz's constructivist grounded theory. Dietitians working in Australia with clients managing chronic diseases were recruited through initial, snowball and theoretical sampling. Online videoconference and telephone semi-structured interviews were conducted. Recorded interview transcripts were analysed using repeated reviews comprising initial, focused and theoretical coding and memoing.

Results: Twenty-two dietitians were recruited. A conceptual model developed from the data showed the dietitian's role in developing the client-dietitian relationship is complex. Key elements were identified and described as 'Sensing a Professional Chemistry', and the dietitian's skills in 'Balancing Professional and Social Relationships' and 'Managing Tension with Competing Influences'. Influences were categorised as

relating to the client and dietitian as individuals (eg. their values), their support network and external contextual factors (eg. working with interpreters).

Conclusions: Developing relationships with clients in the chronic disease context appears complex due to the dietitian's role of managing multiple interrelated elements and influential factors simultaneously. To deepen understanding, research should explore clients' perspectives of relationship development and how knowledge of practitioner-client relationships in other disciplines may be utilised to enhance dietetic service delivery.

Keywords

chronic disease management, client-dietitian relationship, patient-centred care, practitioner-patient relations, qualitative research

Introduction

Shifts in paradigms on healthcare delivery have recognised the importance of practitioner-client relationships, specifically within patient-centred and relationship-centred care paradigms.[1, 2] This has been acknowledged in dietetic practice. A recent integrative review identified a 'positive dietitian-patient relationship' as a component of patient-centred dietetic care.[3] Practitioner-client relationships appear well-researched in other disciplines, particularly within medicine and psychology.[4-6] Furthermore research shows the strength of practitioner-client relationships positively influences outcomes, including those related to clients' health.[6]

The importance of client-dietitian relationships has been reiterated throughout research to date.[3, 7] This importance is reflected in the Nutrition Care Process, a key model underpinning an approach to current dietetic practice, which articulates the relationship as the 'central component' of this approach.[8] Despite this importance, meaningful explanations of this relationship and how it is developed in dietetics are limited. Qualities of the client-dietitian relationship have been identified in qualitative and quantitative research,[9-11] however what these qualities mean in the dietetic context and how they interact with each other as a process to facilitate relationship development is not clear. Examples of qualities include the dietitian's communication skills and integrity.[9, 10] A model of how dietitians can build 'positive relationships' with clients was suggested in a recent integrative review, however this research only briefly described qualities of relationships without in-depth explanation of the interplay between them or meaningful processes underlying them.[3] As a result our understanding of how dietitians might develop relationships with clients appears superficial. The importance of this relationship drives the need to think more critically about this crucial aspect of practice to gain a deeper, more meaningful and comprehensive understanding of client-dietitian relationship development as an entire process, rather than as individual qualities. Further in-depth qualitative research is needed in order to address this.

An important setting to explore client-dietitian relationship development appears to be within lifestyle-related chronic disease management. These diseases, such as type 2 diabetes, are a global issue and dietitians play a key role in managing these diseases.[12]

Additionally, care in chronic disease settings generally occurs over an extended period of time. This sustained care and the global prevalence of chronic disease drives the imperative to further explore how dietitians deliver patient-centred care, specifically through their relationship with clients.

The aim of the research reported here was to explore dietitians' perspectives of how they develop meaningful relationships with clients in the context of lifestyle-related chronic disease management. Whilst appreciating the contribution of the client to the relationship,[13] this research focused on dietitians' perspectives exclusively. The purpose of this was to address the knowledge gap around meaningful processes of relationship development in dietetic chronic disease management from the professional perspective. The research was guided by the question 'How do dietitians perceive their process of developing meaningful relationships with clients managing lifestyle-related chronic diseases?'

Methods

This study was approved by the [blinded] Health and Medical Human Research Ethics Committee (2017/575). All participants gave informed consent prior to participating.

Qualitative research is conducted when a complex and detailed understanding is needed.[14] As this research sought to gain a deeper and more comprehensive understanding of client-dietitian relationship development than what is currently understood, a qualitative approach was utilised. Charmaz's interpretation of grounded

theory guided the study design, including sampling and data collection and analysis.[15] (Grounded theory is recognised as both a methodology and method, for the purpose of 'generating a theory for a process or an action'.[16] Charmaz assumes a constructivist view, where findings are recognised as a subjective interpretation of the researcher.[15]) This approach utilises key interrelated elements, including sampling, coding and memoing, that are conducted simultaneously to generate findings.[15] Methods were reported in accordance with the COREQ checklist for reporting qualitative research.[17]

Sampling occurred in three stages between January and July 2018. Firstly, a purposive approach was taken where initial sampling was used to identify individuals who could provide an understanding of the problem.[15, 18] This stage recruited qualified dietitians working in Australia, who were currently managing, or had recent experience managing, adult clients regarding lifestyle-related chronic diseases (overweight and obesity, type 2 diabetes, cardiovascular disease). Dietitians were required to see clients individually within the free-living environment (eg. not in hospital). Participants were recruited through approved advertisements in e-newsletters from the Dietitians Association of Australia (DAA) to its members. Expressions of interest were also collected during a workshop lead by authors at the 2018 DAA conference. Workshop attendees were informed of the study and invited to provide their contact details if interested. Dietitians known by the primary researcher [blinded] through professional networks were also contacted by email, hence a relationship with some participants existed prior to the study commencing.

The second stage used a snowball sampling technique where participants identified colleagues who might be interested in participating and these were contacted via email.[18] The third stage used theoretical sampling (as a component of grounded theory), to clarify questions generated from data in early interviews.[15] For example questions arose regarding how perspectives of relationship development may differ in dietitians practising within weight-neutral approaches,[19] so dietitians who met the original inclusion criteria and practised within these approaches were contacted. Dietitians identified by theoretical sampling were recruited through face-to-face contact during a workshop at the DAA conference. Other dietitians were identified by applying relevant search terms to the Google™ search engine, and were contacted through the email address provided. Dietitians who confirmed they met the inclusion criteria were sent an information sheet and consent form to sign and return.

Charmaz's grounded theory methodology[15] recognises the researcher as being actively involved in the research process, therefore [blinded] reflected on her biases as a novice researcher and qualified female dietitian prior to and during the study. Reflections were documented within written memos regarding emerging codes which were embedded within the analysis. This process enabled [blinded] to be aware of preconceptions held and thus facilitated a more critical approach to data analysis, where the emerging analysis was challenged in light of these reflections both throughout coding and in discussions with the research team.

A core component of grounded theory methods is simultaneous data collection and analysis and this was utilised throughout.[15] Participant demographic information was collected through an online survey.[20] Online videoconference or telephone semi-structured interviews were undertaken by [blinded] to account for distances between geographic locations. Telephone interviews were conducted as per participants' preferences, or when technical problems occurred with the videoconferencing software.[21] The interviewer undertook each interview in a private room at [blinded] with no other persons present. A semi-structured interview guide ensured key questions were addressed whilst allowing flexibility in following participants' leads. The interview guide was developed in consultation with authors and probes were identified from empirical literature.[9, 10, 22, 23] Prior to use, the interview guide was piloted with dietitians at [blinded] and recommendations were incorporated. Interview questions were open-ended and included asking participants to identify key elements of successful interactions with clients. To support the collection of rich data, participants were provided with the interview questions via email before their interview to ensure ample time to reflect on their responses.

Each participant was interviewed once, with interviews lasting between 27 and 82 minutes. To ensure thorough data collection, interviews were recorded using a digital audio recorder with consent from participants. Field notes were documented by [blinded] during and after each interview, which included details such as how the interview was conducted (including any technical problems). Recordings were transcribed verbatim by [blinded], during which participants were assigned numerical

codes and each transcript was de-identified. Transcripts were checked twice against the recording, once by [blinded] and again by a second researcher [blinded] to ensure accuracy. Participants were invited to check their transcript, however only one participant elected to do so.

Analysis was conducted manually and was derived from the data as per grounded theory methods.[15] [blinded] undertook initial coding where each line or segment of data was coded using gerunds (verbs that functions as nouns, such as 'demonstrating empathy').[15] Focused coding was then used to categorise significant and similar initial codes at a more abstract level. Finally theoretical coding was conducted where comparisons were analysed between focused codes to produce more abstract and advanced theoretical codes. Detailed memos were written throughout this process to document relationships between codes. These memos were used in conjunction with discussions with the research team to construct the final conceptual model.

The constant comparison technique was applied to the interviews as a whole to distinguish similarities and differences between codes, for example how self-disclosure is used, and memos regarding this were documented. This technique was also used once the conceptual model was finalised to ensure the analysis reflected transcripts and memos, and to enhance study rigour.[15] Other memos were kept to document code definitions, possible analytical avenues and further questions of the data. Findings were presented during regular meetings with authors where raw data was discussed, the emerging analysis was critiqued and potential analytical avenues raised.

Data collection and analysis ceased when data saturation was reached, that is when no new codes emerged as per grounded theory methods.[15, 16] The use of cross comparison techniques, recording detailed analytical memos and discussing the analysis with the research team throughout the study allowed for continuous interrogation of the data and recognition of data saturation.

Results

Interviews were conducted with 22 dietitians (online n=14; telephone n=8). A total of 47 dietitians were contacted or expressed interest in participating. Dietitians declined participation due to time constraints (n=4), health reasons (n=1), or because they did not meet the inclusion criteria (n=2). Some dietitians did not respond to email communication (n=18). The majority of participants identified themselves as female (n=19, 86%), aged between 20 and 39 years (n=16, 72%) and working in New South Wales or Queensland (n=14, 64%) (Table 1).

A conceptual model of relationship development was developed from the data, consisting of three main categories (Figure 1). Two categories related to the direct interaction between a client and dietitian: 'Sensing a Professional Chemistry' and 'Balancing Professional and Social Relationships'. These categories are shown in blue at the centre of the model, representing this direct interaction. A third category 'Managing Tension with Competing Influences' emerged relating to influences on the direct interaction. This category is shown in orange, with inward-facing arrows representing this influence. The model shows that from the dietitian's perspective,

developing relationships with clients managing lifestyle-related chronic diseases appears complex. This complexity relates to the dietitian's role in managing both the direct interaction and influences on it simultaneously.

The first category 'Sensing a Professional Chemistry' reflected an undefinable quality of relationships apparent in dietitians' responses that was suggestive of a connection between people. Having this sense of a professional chemistry seemed to be important in whether dietitians were able to develop a functional relationship with their client in the context of undertaking their professional activities. The importance of this sense of chemistry to the potential for a functional relationship is represented visually in Figure 1, where 'Sensing a Professional Chemistry' is embedded within 'Balancing Professional and Social Relationships' (where 'Balancing Professional and Social Relationships' reflects the functional relationship).

The category 'Sensing a Professional Chemistry' arose from dietitians' descriptions of good relationships, where 'gelling', 'clicking', 'connection', 'subconscious aspect' and 'vibe' were used. Dietitians further explained these terms to some extent, describing them as finding a commonality, openness, trust and rapport. Dietitians also noted this chemistry may reflect their personalities and the client's motivation. It also appeared that dietitians had some difficulty articulating these terms:

"*it's one of those things (gelling) that I don't know that I could put words to*" (P20)

"it's hard to explain, cause you feel it... you get this feeling they're being open towards you, and that you can be open towards them... and you have that trust" (P15)

Dietitians' responses also reflected that this sense of chemistry was unmodifiable, that is dietitians expressed they would not be able to 'gel' with a client in the future if they were not able to initially. This quality further contributed to the sense of a professional chemistry in that dietitians perceived it as natural and unable to be forced:

"there's some element of subconscious aspect with that... there's lots of people no matter what I do we still just don't connect" (P3)

"there's gonna be people that you just don't gel with, and you're never gonna gel with" (P20)

The second category 'Balancing Professional and Social Relationships' described the dietitian's skill in balancing two functional relationships within the client-dietitian relationship. 'Professional relationship' referred to a relationship where roles as either professional or client are fulfilled and focused on skills needed in upholding the professional nature of the interaction. 'Social relationship' differed in that it referred to humans interacting without labels of 'dietitian' or 'client', and reflected the importance of ensuring humanity exists within the client-dietitian relationship. Table 2 and Figure 2 provide further explanation of subcategories within this category.

The perceived need to maintain an appropriate balance of professional and social relationships was evident. However dietitians recognised the difficulty of achieving this in practice, and suggested the appropriate balance depended on each client and dietitian. The need for established indicators and strategies to ensure dietitians address their professional obligations was recognised. Indicators of balance appeared education-based, such as providing new individualised education, or outcome-based, such as tracking clients' progress. The importance of utilising clinical expertise was also a concern:

"*I don't think there's much point being all 'nicey nicey'... saying 'don't worry you can eat whatever', but also being able to (answer) should I eat butter or margarine, being able to give them a decent answer*" (P6)

An example of a strategy to ensure professional obligations were addressed was to focus on developing the social relationship in the initial stages of engaging with a client. Establishing a social relationship first appeared to ensure the professional relationship had more value and meaning for the client. This appeared particularly important for 'resistive' clients.

"*it is a priority... I think you have to get that before talking nutrition, cause if (you) go straight into the nutrition and say someone comes to see you... and it's automatically into 'this is how much you need of carbs, fat, protein', there's not gonna be a connection and they're gonna say 'well who are you to say that*?'" (P15)

Although the need to balance professional and social relationships was recognised, the professional relationship appeared to be the foundation of the client-dietitian relationship as the dietetic consultation is a professional service. This is exemplified in a statement by a dietitian who noted that the relationship weakened if the professional attributes of the interaction, such as goal setting, were missing:

"It weakened at the end, because we were done with what we set out to do and they were... smashing their goals so to speak" (P10)

The third category 'Managing Tension with Competing Influences' reflected dietitians' perspectives that developing both professional and social relationships with clients, and achieving an optimal balance between them, can be influenced by factors unrelated to their direct interaction. Dietitians' responses suggested that tension exists between the need to develop and achieve optimal balance between professional and social relationships, and influential factors of that interaction (Figure 1). This category suggests a need for dietitians to be skilled in managing this tension in order to maintain an optimal balance of professional and social relationships with their client and thus uphold an interaction that supports overall relationship development.

Influences were further categorised as being related to clients and dietitians as individuals, their support network and external contextual factors. Factors related to the dietitian and client as individuals were their values, beliefs and opinions, and their health. Dietitians' responses suggested that the client's opinion of the dietitian's

297 expertise, the client's value of the dietetic input generally and the client's motivation
298 and belief in their ability to change were influential. The dietitian's value of
299 relationships, their negative opinions of clients and their belief in their professional
300 ability appeared influential. For example, responses suggested that when dietitians
301 have negative opinions of clients, they perceive practising in a way that facilitates
302 relationship development to be more difficult:
303
304 "*I find it really hard to not have my back up with those people cause they've been quite*
305 *demanding*" (P9)
306
307 Another dietitian recognised qualities of clients that could bring on negative thoughts,
308 such as when the client makes sexist statements. Hence it appears that dietitians may
309 develop negative opinions towards clients when there is conflict between how the
310 client behaves and the dietitian's values.
311
312 Tension between clients' and dietitians' physical and mental health and their ability to
313 form relationships was identified, where poorer health appeared to make relationship
314 development more difficult. It was suggested that for clients, this may be due to
315 having lower motivation and attending fewer consultations. Dietitians described
316 'running with their own agenda' when they felt stressed, tired or sick. The negative
317 impact poor health had on the dietitian's ability to be empathetic, patient and
318 motivating was also identified:
319

"*if you're feeling sick or tired... you're like I don't even want to do this job, I hate this job, it's gonna be so hard to overcome that and put a smile on and be really perky and... get people motivated*" (P25)

The need for clients to have a supportive network, including their broader socioeconomic context and their home environment was expressed. Clients of lower socioeconomic status were described as being likely to attend consultations less frequently, impacting contact time and therefore relationship development. Dietitians described situations where the client's support network caused tension between their relationship. For example, the impact of the involvement of a client's family was described:

"*the conflict between this young man and his family became so significant because he felt they were over-involved in his care... he slipped away in the end*" (P13)

Dietitians' responses also reflected a need to form a relationship with the client's support network, such as their family or friends:

"no one is a silo, everyone is part of a network, unless you can engage effectively with the entire network you will never be an effective clinician" (P14)

Additionally, dietitians recognised the influence of their own support network, including working within a supportive multidisciplinary team and having a network to

engage in reflective practice with. Dietitians described reflecting formally through regular clinical supervision, whilst others described reflecting informally with fellow colleagues.

"that... formal supervision process, particularly for a private practice practitioner, who's isolated is absolutely essential for me, and has made such a difference to my mental health, and my capacity to work more meaningfully with my clients" (P13)

External contextual influences were unrelated to the client and dietitian, but seemingly needed managing by dietitians to ensure meaningful relationships with clients. These included influences on their contact time, such as their workplace, the physical environment of the consultation, having an interpreter present, the need to complete documentation and sources of conflicting information. For example, dietitians perceived having insufficient time with clients as negatively impacting their relationship, which exposed the issue of who determines how much time dietitians spend with clients. Some dietitians described their time with clients being governed by workplace constraints enforced by the Medicare Chronic Disease Management Plan and expressed their frustration at this. For example, one dietitian questioned their ability to develop a relationship under the time constraints of Medicare-funded consults:

"you're so time limited that I mean what chances (are) there of developing trust and rapport?" (P9)

Hence consultation time appeared to influence how dietitians address key elements of both professional (trust) and social relationships (rapport) (Figure 2).

Discussion

This study has produced a novel model of relationship development in chronic disease management from the dietitian's perspective, that offers a more in-depth and comprehensive representation than what is currently understood in dietetics. It has done this by building on the knowledge of individual qualities important for client-dietitian relationships within literature,[3, 9-11] and by identifying meaningful processes underlying those qualities and how they might interact with each other. Furthermore this model offers a more comprehensive picture of relationship development by recognising not only the direct interaction between clients and dietitians as important, but also influences on this interaction. As a result, this model demands an additional skillset of dietitians in being able to manage the tension between this direct interaction and factors that may influence it. Thus this study offers a unique insight into the complexity of our role as dietitians in establishing meaningful relationships with clients in a chronic disease context. By exposing this, our findings have also contributed to the evidence describing how dietitians can be patient-centred in their practice and key tenets to be addressed. The need for more in-depth understanding of relationship development in dietetics, and for further professional support in this crucial aspect of practice has been identified.

Research in psychology and medical disciplines has established therapeutic relationships as multidimensional.[5, 13] An example from psychology-based research describes therapeutic relationships consisting of personal role investment, interactive coordination, expressive attunement, affective attitude and experiential congruence. These dimensions are each articulated in detail, for example 'expressive attunement' is described as the quality of communication consisting of expressiveness, empathic understanding and communicative rapport.[13] This example highlights the degree to which therapeutic relationships are understood in this field. The difficulty dietitians had in explaining ambiguous terms they had used, such as 'gelling', were represented within the category 'Sensing a Professional Chemistry'. This may suggest a limited understanding of, or limited language to describe aspects of therapeutic relationships within dietetics in comparison to other disciplines. For example, what does it mean to 'gel' with a client? Thus, it appears there is a need to further explore what this sense of 'professional chemistry' is in dietetics, and how it might compare to dimensions of therapeutic relationships explicitly identified in other disciplines. Interdisciplinary collaboration between dietetics and psychology, for example through education and training, and overt recognition of the psychology existing in this aspect of dietetic practice may benefit dietitians in better understanding therapeutic relationships.

Psychology-based literature also recognises that different types of relationships exist within the therapist-client relationship: the working alliance, transference and countertransference, and the real relationship.[24] This supports our finding that the client-dietitian relationship consists of both professional and social relationships, as

411 the working alliance is based on therapeutic 'work' (professional relationship),
412 whereas the real relationship is recognised as the 'person-to-person, non-work
413 connection' (social relationship).[24] Thus the support of this finding within established
414 psychology-based literature highlights the need to explore if, and how, dietitians are
415 aware of these dimensions of relationships and to further understand how they might
416 co-exist in client-dietitian interactions, particularly in the chronic disease context. A
417 deeper understanding of how to appropriately balance professional and social
418 relationships when interacting with clients may further support dietitians to deliver
419 optimal dietetic care.
420
421 The need to balance professional and social relationships within the client-dietitian
422 relationship exposes a potential grey area in the blurring of professional conduct.
423 Dietitians receive payment from clients and hence there is an obligation to deliver a
424 professional service. Therefore ethical questions can be raised about the responsibility
425 of the dietitian in fulfilling the professional relationship. Key dietetic bodies recognise
426 the ethical obligation of dietitians to deliver a professional service and this was
427 reflected in dietitians' responses where the importance of the professional
428 relationship was expressed.[25, 26] This is further supported and discussed in other
429 healthcare disciplines, where for example Zur[27] identified a direct impact of
430 maintaining therapeutic boundaries on the effectiveness of psychotherapy. Therefore
431 further research is needed in understanding how this is expressed and managed in
432 dietetic practice, particularly within education and training, and how it can be
433 integrated into meaningful relationship development.

The finding that dietitians' values, beliefs and opinions, and their health, can influence relationship development reflects the need to consider our own lens as dietitians: who we are, what we bring to the relationship and what impact it may have. Research suggests dietitians can show weight stigma towards clients,[28, 29] whilst a cross-sectional study[30] surveyed dietitians about their management of obesity and found they experienced frustrations with clients' lack of motivation, commitment and compliance. Furthermore, Diversi et al[28] acknowledge the negative impact these emotions may have on client-dietitian relationships. Quantitative research in psychotherapy suggests that therapists are less able to develop strong relationships with clients when they feel burdened in their personal lives.[31] In addition, Vandenberghe and Martins de Silveria[32] describe a type of psychotherapy where therapists engage in mindfulness exercises in preparation for interacting with clients by reflecting on themselves and their past experiences. This literature supports our findings and suggests a need for dietitians to reflect on who they are as a person and how this may impact relationship development, particularly how this might contribute to their sense of a 'professional chemistry' with their client. Thus the need for dietitians to be self-aware and be able to self-manage this for optimal relationship development with clients managing chronic diseases seems important, and further accentuates the importance of dietitians engaging in regular and critical reflective practice. It seems that further emphasis on dietitians' self-awareness and self-management skills is needed within professional development opportunities, and increased professional support in this area of service delivery, to continue advancing dietitians' relationship development skills.

There are strengths and limitations of this study. From the limited data available the sample appears to reflect the mostly female-dominated dietetic profession in Australia that primarily works in New South Wales, Queensland or Victoria.[33, 34] Also it is likely that dietitians who participated were motivated to share their perspectives due to their own interest in the topic. Hence this research may offer a 'one-sided' perspective from dietitians who sought to express their views, and that perspectives of dietitians not interviewed may have differed. The reflexive processes employed by the first author meant that their preconceptions of relationship development seen through a dietetic lens, could be challenged by psychology-based perspectives offered by the interdisciplinary research team. Finally, the constructivist approach to this research acknowledges findings as embedded within a specific context, where the researcher's involvement is recognised as part of this context.[15]

In conclusion, developing meaningful client-dietitian relationships in the chronic disease context appears complex for dietitians due to needing to manage multiple interrelated elements and influential factors simultaneously. The appropriate management depends on the dietitian as both a person and professional, and the individual client. Further research is needed to advance the profession's understanding of meaningful relationships, particularly from the client's perspective, and how knowledge of practitioner-client relationships in other health disciplines may be utilised to enhance dietetic service delivery.

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Tables

Table 1. Participant demographic characteristics (n=22)

	n (%)
Gender	
Female	19 (86)
Male	3 (14)
Age	
20-29	8 (36)
30-39	8 (36)
40-49	2 (9)
50-59	4 (19)
State or Territory	
New South Wales	7 (32)
Queensland	7 (32)
Victoria	3 (14)
Australian Capital Territory	2 (9)
South Australia	2 (9)
Western Australia	1 (4)
Geographic Area	
Metropolitan	13 (59)
Regional	5 (23)
Rural or Remote	4 (18)
APD[(a)] Status	
Provisional APD	5 (23)
APD	17 (77)
Years of Experience	
Private Practice	
0-2	7 (32)
3-5	5 (23)
6-10	4 (18)
11-20	4 (18)
Not applicable	2 (9)
Other Areas	
0-2	10 (46)
3-5	2 (9)
6-10	3 (14)
11-20	2 (9)
20 or more	3 (14)

Not applicable	1 (4)
Unanswered	1 (4)

[(a)]Accredited Practising Dietitian

592 **Table 2.** Description and illustrative quotes of subcategories relating to either professional or social relationships, as part of main
593 category 'Balancing Professional and Social Relationships'

Professional Relationship		
Subcategory	**Description**	**Quotes**
Managing differences	Refers to dietitians managing points of difference between clients and themselves as points of difference were recognised as potential barriers to relationship development. Differences were categorised as misaligned preconceptions and expectations, values and opinions, and gender and cultural differences.	*"it was difficult for me to help her achieve her own goals when I disagreed with them"* (P15) *"and his idea of... I wasn't a good dietitian because I hadn't helped him lose as many kilos as this other dietitian... it was quite a like, not a fraught relationship but we were both coming from very different angles, he was so, so, so weight focused and I was very slowly trying to guide him away from it"* (P16) *"I try to take the gender aspect out of it I guess and just talk about that I've got the knowledge regarding what you're here for and it doesn't matter that I'm a male telling you this.. a female (dietitian) would be telling you the same sort of information"* (P22)
Grounding practice in client	Refers to dietitians modifying their practice to ensure that every aspect of their practice is driven by the client's needs, which includes: • Respecting the client's expertise in their own lives (asking the client for their perspective; giving the client time to express themselves; ensuring the client's perspective is addressed) • Reading the client and recalibrating practice according to the client's needs (acknowledging and responding appropriately to client's emotion; recognising and responding to client's need to have interest shown in them; recognising where continuing to focus on data collection would be detrimental) • Being attune to and interpreting verbal and non-verbal cues from clients • Applying motivational interviewing techniques	*"I sort of start the interview... so my standard is 'now I've received this lovely referral from your doctor and I'm very interested to see what your doctor has to say, but tell me how can I help you today?'... so it's this idea that you acknowledge the human being in front of you, that the doctor's sent something and that's important but what are you hoping to get out of it?"* (P13) *"I guess I showed interest in him you know he has tattoos everywhere so I was like oh wow what's that tattoo on his leg, that I probably did do different behaviour on that front, to build that relationship"* (P9) *"ah body language, you know if they're crossed up or hunched up and hiding behind their hand bag or not making eye contact then there's that barrier that they're not feeling open, so you can pick up on those signals"* (P15)

Establishing reciprocal honesty and openness	Refers to needing honesty and openness within the relationship, and that one person's honesty and openness seems to enable the other to feel they can also be open and honest within the context of the dietetic consult.	*"you just get this feeling like they're being open towards you, and that you can also be open towards them a little bit more as well"* (P15) *"they can tell us what they're eating but if they're not telling us the truth it's really hard for us to help where we can"* (P19) *"if I'm not comfortable with the content, being able to tell the person that I'm not comfortable with the content like, when I try and fluff my way through it, people can generally tell"* (P3)
Communicating with transparency and clarity	Refers to the dietitian being clear in their communication with the client to minimise the potential for misunderstandings that may impede relationship development. This primarily involved providing explanations to clients about the dietitian's role and scope of practice, what they can expect from the consult and the consult process, the dietitian's approach to practice, the rationale for the client receiving dietetic input and stopping consultations once therapeutic benefits cease.	*"if people don't understand why I'm asking questions that are involving them talking more than I need to talk, I explain to them that I really need to know what's happening for you otherwise you're just going to walk out with a plan that could be given to anyone, and that won't be the best thing for you. And they really come around to that"* (P17) *"So in the initial (consultation)... we talk about before we go into anything deeper, we talk about how I work and that it's not the only way to work, this is one of the options that they have and the reasons why I work from that (Health at Every Size approach)"* (P18)
Establishing two-way communication	Refers to establishing communication pathways where dietitians and clients are able to communicate with each other equally and feel comfortable in doing so. Importance was placed on enabling clients to feel comfortable instigating communication with the dietitian, as it allows the client to perceive their dietitian as approachable and supportive. The medium of communication (eg. email, telephone, face-to-face) and how dietitians manage that medium also appeared important.	*"I always end my consult with giving my business card and saying if you've got any questions my email's there, send me an email or admin are always happy to take calls and get them to give them a call back so that approachability really comes through"* (P22) *"Yeah that was definitely the issue, it was the promising something I couldn't deliver and then avoiding the communication of that.. because of this desire to be able to do it for them, but not prioritising or having the time to be able to do it so yeah definitely communication was an issue there"* (P24)
Using comfort carefully to enable progression	Refers to the dietitian's skill in utilising comfort appropriately within the consultation to ensure it facilitates relationship development, rather than impedes relationship development. The need for dietitians to create a calm, relaxing and comfortable interaction for both themselves and clients was evident. Managing this balance of comfort was suggested as a skill for dietitians in ensuring clients feel comfortable but also recognising when the	*"I think that that's one of the thing(s) that they feel quite comfortable, I mean that's possibly not a great thing, because I think sometimes it's a way to just listen to all their stuff that's going on... they can manipulate, maybe so we don't give it to them for instance?"* (P7)

	client's comfort may be detrimental to their progress. Comfort and discomfort appeared to be drivers of relationship development when utilised appropriately by the dietitian.	*"people do need to feel like they don't need to change everything and that there are things that they're actually doing quite well, so being comfortable and remembering to give that positive feedback to people I think is quite important"* (P17) *"embracing discomfort is something that we can all do better because by doing so we really can connect with that human in front of us, and it's both embracing our own discomfort as well as the client's discomfort"* (P13)
Building sense of trust	Refers to dietitians building clients' trust in their role delivering a professional service. Building a sense of trust appeared to be determined by multiple factors, such as the ability of the dietitian to fulfill promises made to the client, and as needing to be developed over time.	*"trust is probably 99% of what we do because if they don't trust you... they're not gonna tell you the truth, they'll tell you what they think you want to hear"* (P4) *"because if people don't trust you they won't listen to you and they won't open up to you, so you'll never know, you'll never be able to address the right barriers with them and help them find solutions to those barriers"* (P17) *"I've got a good location, but I guess it (trust) just takes time doesn't it? To build trust, and I don't rush people in their appointments so they're half an hour or an hour so they have time for questions if they've got any"* (P7)
Demonstrating empathy and acknowledgement through listening and understanding	Refers to a process of interaction between the client and dietitian which includes: • Listening to the client using interpreting, clarifying and probing skills, being present and focused and giving the client uninterrupted time to talk • Developing a holistic understanding of the client and their story, perspectives, culture and experiences • Acknowledging client's progress, feelings and experiences throughout the consult • Demonstrating empathy (creating a comfortable and supportive environment; being non-judgemental; conveying a sense of working together, showing understanding of the client's history and integrating understanding verbally throughout consult; using body language)	*"the empathy is a big part to be able to have that relationship because if you just disregard everything then there's that lack of respect isn't there?"* (P10) "*anyone with a chronic disease has been in the health system for a long time and often they've dealt with a lot of challenging situations and without identifying that and acknowledging it, you'll get nowhere"* (P14) *"just asking them you know how does it feel to be in that situation, and just trying to tease out their story more, and also recognising that story throughout the consultation, so even when setting the goals... reiterating look I know that you're going to find this part challenging because in the past this has happened to you here"* (P10) *"I will actually paraphrase back to them emotions and feelings... so that they know I've heard what they've said, in you know I'm busy I don't have time to cook dinner, but then I'll also say something like gosh that sounds really challenging... we're all expected to be on 24/7... we're only human, that sort of thing so that then they feel like I'm hearing them but I'm also actually understanding where they're coming from, from an emotional point of view"* (P20)

Managing goal-setting process	Refers to the dietitian's skills in managing the goal-setting process to facilitate relationship development, particularly regarding how it impacts the client's perception of the dietitian's value of their opinion. This skill overlaps with the need to respect the client's expertise in their own lives (as part of the skill 'grounding practice in client'). Dietitians appeared to involve clients in the goal-setting process to varying degrees, ranging from dietitian-lead approaches to client-lead approaches. Goals were identified as needing to be specific, long-term and understood by the client.	*"I think it has a big impact (setting goals with clients) because it actually shows that you're listening to them, and you're valuing their opinion and what they think that they can actually achieve"* (P10) *"I always try to encourage them to have participation in setting their goals so that it's something they they're interested in"* (P19) *"Sometimes it's as simple as getting through their diet history and then just saying what do you think about your diet? What do you think you do well? What do you think you'd like to change and what do you think you can change?"(P14)*
Removing judgement and blame	Refers to dietitians removing any judgement or blame they may contribute to the consult. Dietitians perceived clients to appreciate a non-judgemental approach, and that it enabled clients to be more comfortable within the consultation and open to change. Verbal and non-verbal techniques were identified.	*"I guess the way I respond to, you know if we're going through a food diary, how much soft drink do you drink or something and they go oh two litres, I wouldn't respond in a way that's ah, wow that's a lot but sort of pointing out that, that is something that we need to change, so not being judgemental in a way I respond I guess to some element of the food diet history that is out of the ordinary or needs to be changed"* (P22) *"Once a client realises that they're not being judged and their situation's unique... you can take the pressure off that it's not their fault, then they're more open to change"* (P23)
Facilitating focus on positivity	Refers to dietitians facilitating positivity within the consultation to promote relationship development. Strategies included focusing on food in a positive light, such as focusing on foods that the client can eat.	*"Well you want it to be positive for everybody I mean, who wants to sit there and just hand out meal plans and tell people what not to eat all day, like that's pretty awful"* (P6) *"I think what made it successful is that I tend to work more from a, working with where they're at, making it positive about foods that they can have, and why certain foods are better choices, or why certain foods aren't great say in terms of cholesterol, and then turning that into well here's a meal you could make or here's something you could take for lunch that would be a better option, and might help your cholesterol"* (P6) *"so what I'm trying to do especially for the overweight or obese patients... I won't restrict their diet but instead I will encourage them to make some healthy changes for example maybe just to get them to eat more vegetables and drink more water to keep them full, so they don't have to starve themselves and they can build a happy and positive relationship with food"* (P21)

Social Relationship		
Subcategory	**Description**	**Quotes**
Being warm and personable	Refers to dietitians being warm and personable when interacting with clients managing chronic diseases due to clients likely experiencing feelings of confusion and anxiety. Dietitians reflected a need to behave in a way that was more 'human' than 'clinical' and included: • Engaging in casual and non-dietetic related conversation • Remembering and following up on personal details of client's life • Being reassuring • Providing positive feedback • Responding with emotion, such as smiling and laughing when appropriate • Displaying a genuine interest in the client	*"the second time they come in you know really trying to remember small things about what they said first consult, so they might have been a bit (stand-offish) because they were having (a) bad day, the car broke down... and if you sort of make little notes about that next time you come in you ask them so how did it go with the car, like little personal details, I think they appreciate that a bit more then they start to open up a little bit to you, so that persistence as well, will help, just that personal touch I think makes a bit of a difference"* (P12) *"I think in terms of warmth it's showing that you're genuinely interested in the person, explaining to them what you know changing could mean for them so really linking it, not just to like biochemical parameters but really like explaining to them what it could mean for their life and their lifestyle and their future"* (P17)
Duality of developing rapport	Refers to dietitians developing rapport with clients, and that rapport development appears to have a sense of duality. This refers to dietitians' perspectives of rapport development suggesting contrasting qualities, in that it appeared to be both a natural and unnatural skill for dietitians, both easy and difficult with particular clients, and that it should be a focus both during initial stages of interacting and throughout all interactions. This apparent duality suggests that rapport development may depend on the individuals within the interaction.	*"there are people who have a natural tendency towards looking for that rapport building and I know for myself that is very much what I do with every body, in every social interaction"* (P3) *"Building rapport is also really important and I spend any opportunity I can in the consult to have those human interactions and emotional connections"* (P24) *"with those one(s) I find the thing that really helps with the interaction... is needing to establish rapport early on"* (P12) *"I think rapport building is something that you do every single session even though after a few months you know there's that strong relationship you still want to make sure that you're welcoming her in and really listening to what they want"* (P18)

Connecting through seeing each other as relatable humans	Refers to clients and dietitians seeing each other as relatable humans through identifying similarities in each other. Generally dietitians recognised the importance of relating to each other however some questioned its importance. How dietitians develop a sense of relatability appeared multifactorial and dependent on each client. Factors include: • Seeing each other as human • Showing understanding and acknowledgement • Establishing a shared experience • Ensuring clients feel normal • Using self-disclosure • Verbal and non-verbal language	*"I find especially you know budget related to food, if you can relate to them that 'oh yeah I know, you gotta buy sausages, isn't steak expensive', it is where I mention I do things myself you know 'oh yeah for my family too I'm buying up on mince'"* (P9) *"I'm hoping that I've tried to actually have an angle of what I would call common humanity, where people say things like 'oh you know and then I did this and then I ate another chocolate'... and I'd say 'well yes because that's what human beings do, that makes you a normal human'"* (P20) *"I think being authentic is really important, and say knowing that you're not perfect either and you don't have to resemble the Australian Dietary Guideline(s) every single day is really important"* (P18) *"So if I was seeing a young woman who was dealing with similar issues, cause that's one of the things that I think actually does help me, cause I'm dealing with my own chronic disease, and so I think I can relate a lot to that myself, but if someone was very different and was sort of, again like the classic example, a middle aged white man, I wouldn't be as nearly as open with them as I would be if I had somebody who was really struggling with a lot of issues who was a lot more similar to me"* (P20)

Figure Legends

Figure 1. Client-Dietitian Relationship Development in Lifestyle-Related Chronic Disease Management from the Dietitian's Perspective: A Conceptual Model

Figure 2. Subcategories of main category 'Balancing Professional and Social Relationships'