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Building bridges in dietary counselling: an exploratory study examining the usefulness of wellness and wellbeing concepts

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Publication Details

McMahon, A. -T., Tay, P. C., Tapsell, L. & Williams, P. (2016). Building bridges in dietary counselling: an exploratory study examining the usefulness of wellness and wellbeing concepts. *Journal of Human Nutrition and Dietetics*, 29 (1), 75-85.

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Building bridges in dietary counselling: an exploratory study examining the usefulness of wellness and wellbeing concepts

Abstract

Background Over the last decade, professional discourse around health ownership has been evolving to recognise an individually-driven wellness/wellbeing approach. Concurrently, dietetic competencies have changed to include client-centred counselling incorporating individual client's perspectives within dietary prescriptions. The present exploratory research aimed to explore how client-centred counselling practice was being represented in the dietetic literature and to examine dietitians' perspectives about working with clients in the current environment. **Methods** To explore the professional position, a literature search was conducted using keywords encompassing client-centred care and competency within professional dietetic journals (2001-2010). To develop a contextual case study, 10 in-depth interviews with dietitians delivering weight-loss prescriptions within a clinical trial were conducted. Recordings of their perspectives on roles, opportunities/barriers and counselling strategies were transcribed verbatim and examined using inductive thematic and content analysis. **Results** Eleven articles were incorporated into a narrative review describing practice issues related to traditional forms of consultation and the effectiveness of client-centred approaches. The over-riding theme from the interviews (Professional Identity Dilemma) highlighted tension felt by dietitians in their dual role as nutrition expert and counsellor, trained to deliver biomedical imperatives (clinical targets), and their challenge to accept client-defined health perspectives. Supporting themes (Adherence factors and Constructs of health) exposed details on barriers to dietary change and the impact of contextual factors on this change that were linked to wellness and wellbeing concepts. **Conclusions** Appreciating wellness and wellbeing concepts may add a useful adjunct to client-centred approaches to dietary counselling through building bridges between clinical targets and client health perspectives.

Disciplines

Medicine and Health Sciences | Social and Behavioral Sciences

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Building bridges in dietary counselling: an exploratory study examining the usefulness of wellness and wellbeing concepts

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Abstract

Background: Over the last decade professional discourse around health ownership has been evolving to recognise an individually-driven wellness/wellbeing approach. Concurrently dietetic competencies have changed to include client-centred counselling incorporating individual client's perspectives within dietary prescriptions. The aims of this research were to explore how client-centred counselling practice was being represented in dietetic literature and examine dietitians' perspectives about working with clients in the current environment.

Methods: To explore the professional position, a literature search was conducted using keywords encompassing client-centred care and competency within professional dietetic journals (2001-2010). To develop a contextual case study, 10 in-depth interviews with dietitians delivering weight-loss prescriptions within a clinical trial were conducted. Recordings of their perspectives on roles, opportunities/barriers, and counselling strategies were transcribed verbatim and examined using inductive thematic and content analysis.

Results: Eleven articles were incorporated into a narrative review describing practice issues related to traditional forms of consultation, and effectiveness of client-centred approaches.

The over-riding theme from the interviews (*Professional Identity Dilemma*), highlighted tension felt by dietitians in their dual role as nutrition expert and counsellor, trained to deliver biomedical imperatives (clinical targets) and their challenge to accept client-defined health perspectives. Supporting themes (*Adherence factors* and *Constructs of health*) exposed details on barriers to dietary change and impact of contextual factors on this change which were linked to wellness and wellbeing concepts.

Conclusion: Appreciating wellness and wellbeing concepts may add a useful adjunct to client- centred approaches to dietary counselling through building bridges between clinical targets and client health perspectives.

Key words: dietary advice, qualitative, professional practice, wellness, wellbeing, dietetic education

Introduction

Working with individuals to change their food behaviour is complex as it encompasses knowledge pertaining to physiological, psychological and social imperatives as well as a level of practitioner competency to identify the needs of the individual and work co-operatively with them (Rosal et al., 2001). The patient or client-centred approach is generally accepted as helpful in managing this complexity in dietetic counselling practice (Maclellan and Berenbaum 2007; The British Dietetic Association 2008; Dietitians Association of Australia 2009). Client centred practice has been developed over time with reference to theoretical positions, including Carl Rogers perspectives on counselling (Rogers 1951). A key objective is to allow the individual patient to identify their specific diet-related issues and possible solutions within an empathetic counselling environment (Holli et al., 2009). The

dietitian supports this process by providing, interpreting and translating the most current scientific understanding on food and health that fits with the individuals' lives and biomedical requirements (Holli et al., 2009). The dietitian's responsibility is to ensure the individual understands relevant information and has sufficient skills to articulate and commit to strategies that address related health challenges and personal goals (Rosal et al., 2001; Holli et al., 2009). For successful management of chronic lifestyle disorders the dietitian needs to consider multiple factors, including not only the individual's food choice behaviours but also their access to appropriate health, environmental and social support systems (World Health Organization and Food and Agriculture Organization 2003). Hence the depth and breadth of information to be considered in the dietitian-client interaction is considerable. For example, working with obese individuals requires not only substantial food knowledge but also a sympathetic understanding of how this condition affects the individual's quality of life, encompassing psychological and social aspects of health (Testa and Simonson 1996; Kolotkin et al., 2001; Hassan et al., 2003). The challenge lies in achieving essential and meaningful clinical outcomes while encouraging a positive attitude toward behaviour change.

Patients or clients (the terms may be interchangeable) are also members of the community at large. At the community level, messages actively encouraging appropriate food and lifestyle behaviours to improve health outcomes and overall wellbeing have long been promoted by health authorities and non-government organisations (Smith et al., 1998; Diabetes Prevention Program Research Group 2002; National Health and Medical Research Council 2003; National Health and Medical Research Council 2004; National Heart Foundation of Australia 2004; O'Brien and Webbie 2004; Cancer Council Australia 2009). Despite these efforts there appears to be limited adoption of recommendations on food choice and physical activity (Bessesen 2001; Australian Bureau of Statistics 2006; Department of Health and Ageing, Australian Food and Grocery Council 2008). Perhaps part of the issue lies in what people

consider important as endpoints for living well. Whilst health outcomes have objective measurements in terms of biochemical or physiological responses, the broader concepts of achieving wellbeing or wellness have not yet been well defined and may well be useful in practice.

The lack of definition for wellness and wellbeing is not uniquely problematic as the definition of health is also ambiguous. Larson (1999) suggests there are four major models to define the meaning of health. These include: the 'Medical model' defining health as the absence of disease/disability; the 'World Health Organization model' defining health as incorporating physical, mental, and social well-being; the 'Wellness model' defining health in health promotion terms integrating mind, body, and spiritual functioning; and the 'Environmental model' defining health as an adaptation to physical and social surroundings free from excessive pain, or disability. Other authors (Saylor 2004; Cronin de Chavez et al., 2005; Bourne 2010) suggest that concepts embodied in the terms wellness and wellbeing incorporate several interrelated dimensions affecting a person's life: physical, psychological, social, economic, environmental, spiritual, occupational and intellectual. Whatever the exact definition might be, wellness and wellbeing terms can be found in connection with health and food choice in public health discourses over the last decade (Noakes and Clifton 2005; Carlisle and Hanlon 2007; McMahon et al., 2010). The use of these terms over this timeframe is concordant with changes in social paradigms around health, where holistic outcomes beyond biomedical defined endpoints are recognised as being important in the broader community (Ickovics and Park 1998). These changes around the perspectives on desirable outcomes may have specific implications for dietetic practice in that concepts embodied in the terms wellness and wellbeing may provide useful adjuncts for the client-centred approach by building bridges between biomedical imperatives and individual perspectives on health. The aims of this exploratory research were to investigate how client or patient-centred

counselling practice was being represented within dietetic literature, as well as examine dietitians' perspectives about working with clients in the current environment.

Methods

Two methodological approaches were used for this exploratory research. First, to examine if client centred practice is relevant to dietetic practice, a literature search was conducted using keywords encompassing patient-centred care and competency within professional journals (2001 – 2010). Second, an ethnographic case study of a specific practice context was utilised to examine challenges being felt by dietitians engaged in delivering dietary prescriptions.

Literature review

A computerized search of Canadian, British, American and Australian dietetic journals was conducted using Scopus, Sciencedirect, Proquest, and Medline databases. Inclusion criteria were English language full text papers published from 2001-2010 using the following truncated terms within the title, abstract or keywords: patient-centred, client-centred, dietetics, counselling and competency. A narrative review was formed from an analysis of the way in which patient-centred practice was described and the key practice issues raised for professional dietetic practice.

Ethnographic context

The case study context was delineated by a set of interviews conducted by an experienced dietitian research-practitioner with early career dietitian practitioners who were providing counselling in a 24 month dietary intervention trial for weight loss (NHMRC project grant #514631. *The SMART diet: investigating the role of foods in weight-loss* - see Appendix D). The early career practitioners were required to assess dietary intake and deliver individualised dietary advice within a strict protocol as well as encourage appropriate behaviour change

with free-living clients. Clients were recruited from the community and those meeting the inclusion criteria participated in a twelve month dietary trial. Each client was assigned to one of three treatment groups which all incorporated a 2 Megajoule deficit low fat dietary plan for weight loss. Treatment arms included: general advice with placebo supplement (Treatment Group 1); and specific dietary advice on foods incorporating omega 3 fat acid intakes with either omega 3 or placebo supplement (Treatment Groups 2 and 3). The client enrolment and participation was staggered over a two year period. Whilst dietary targets for reduction in kilojoule content with or without omega 3 foods focus were set as part of the weight loss dietary trial protocol, the dietitians were able to negotiate the delivery of these targets with the participants at their regular consult times scheduled at the 0,1,3,6 and 9 month time points. However the constraints to keep participants to the dietary targets would likely over-emphasize the tensions between clinical imperatives and more general perspectives of wellbeing and thus expose the challenges being felt. The experienced dietitian research-practitioner was not involved with the provision of dietary counselling in the trial, but brought to the case study research knowledge of client-centred practice and more holistic views of health. The study received ethics approval from the University of Wollongong Human Research Ethics Committee (HE08/037).

In-depth interviews

The interviews were digitally recorded and transcribed verbatim. All dietitians (n=7), referred to as Dietitian 1 (D1) to Dietitian 7 (D7), involved in the trial were invited. All agreed to participate in the study and provided their basic demographic details (age, gender, length and main areas of practice) (see Table 1).

Table.1 Summary of Demographic Details of Participating Dietitians

| Demographics | Number (n=7) |
|---|-----------------|
| Sex | |
| Female | 6 |
| Male | 1 |
| Age | |
| 20-29 | 6 |
| 50-59 | 1 |
| Length of employment after graduation | |
| 1-3 years | 7 |
| Area of practice | |
| Research/education > 30 hours per week | 7 |
| Private practice/consultancy 8 hours per week | 1* |
| Level of education | |
| Bachelor | 4 |
| Masters | 2 |
| Doctorate | 1 |

* One dietitian also had a private practice

Interview data was collected in the first three months (denoted as D1-D7 no.1) and on completion of their involvement with the trial. Exit interviews were only conducted with the dietitians who were involved in the whole trial (D2-D4 no 2 respectively). The exit interviews were used to gather details on changes in perceptions that might have occurred over the length of the trial. Thus all dietitians involved in the trial were invited and agreed to participate and a total of ten interviews were conducted and available for analysis. Interview data was collected by a single experienced dietitian research-practitioner from 2008 to 2010, using a semi-structured in-depth interview guide. The open-ended questions used for the

interview guide (Table 2) were informed by key literature on dietetic competency for practice (The British Dietetic Association 2008; Dietitians Association of Australia 2009) and previous research in the area of wellness and wellbeing (Cronin de Chavez et al., 2005; Smith 2005; McMahon et al., 2010). The questions were designed to allow exploration of ideas about counselling practice within a dietary weight loss trial. The interview guide was reviewed by senior researchers [LT, PW] and pilot tested with a convenience sample of clinical dietitians for understandability.

Table 2 Semi-structured interview guides for dietitians for first and final interviews

1. What you think your role might be/has been as part of the dietary trial?
2. What specific aspects of the trial protocol might be considered (as/were) important in your role as a dietitian for the study?
3. What are the perceived issues (anticipated/identified) by participants in achieving weight loss?
4. What do the terms wellness/wellbeing mean to you?
5. What aspects of the trial that you are involved in do you think are important and (might/might have) (impact/ed) on participants' feelings of wellness or wellbeing?
6. What sort of role, if any, do you think dietitians might play in communicating dietary advice in terms of wellness or wellbeing within a dietary intervention trial?

Interview analysis

Two researchers [AM, TC] were involved in all of the steps of analysis. Transcripts were checked for accuracy and examined by the researchers independently. The analysis was initially guided by a standard approach to qualitative data analysis (Qualitative Grounded Theory Approach) to ensure the emergent themes were established from the data and reflected in actual quotes (Strauss and Corbin 1990). A critical approach was also taken in that the researchers acknowledge that the identification of themes would have been

influenced by the dietitian researcher-practitioner position and experience. Initial coding was conducted by the researchers independently by reading all transcripts in full, and coding the full data set (Saldana 2009). Verification and any anomalies across the codes were discussed in-depth before codes were categorized, and agreed between the two researchers. The final themes and subcategory themes were agreed through the iterative process of coding and categorization to express the relationships found (Saldana 2009). Key quotes were identified to exemplify the relationships embedded in the themes and to present the veracity of the results (Harris et al., 2009). Comments in the interview transcripts were identified and coded into the relevant supporting themes or subthemes (Creswell 2007). The QRS NVivo 8.0 qualitative analysis software (QRS International Pty Ltd, Doncaster, Victoria, Australia) was used to manage and review themes to ensure all data was included in the analysis.

Results and discussion

Literature review

Eleven articles were retrieved from the literature search and integrated into a narrative review. There were 9 articles that specifically identified areas pertaining to patient- or client-centred care within dietetic practice (Rosal et al., 2001; Maclellan and Berenbaum 2003; Jackson et al., 2005; MacLellan 2005; MacLellan and Berenbaum 2006; Horacek et al., 2007; Maclellan and Berenbaum 2007; Whitehead et al., 2009; Henry and Smith 2010). Two additional articles were found to focus more broadly on dietetic competency and counselling (Cant and Aroni 2008; Cant and Aroni 2009) but incorporated patient-centred care (see Table 3). The limited number of articles found was surprising, given that the patient-centred or client-centred counselling approach is identified as part of the core competencies for professional practice for dietitians in the United States, Canada, United Kingdom and Australia.(Dietitians of Canada 2000; The British Dietetic Association 2008; Dietitians Association of Australia 2009; American Dietetic Association 2011) They did, however,

demonstrate that client centred practice is indeed embedded in the discipline. Authors acknowledged there were ambiguities relating to the meaning of client-centred approaches in the health system (Jackson et al., 2005; Whitehead et al., 2009), the perspectives of dietitians on the topic,(MacLellan 2005; Maclellan and Berenbaum 2007; Henry and Smith 2010) as well as how client centred practice is defined and measured within a professional counselling session (Rosal et al., 2001; Cant and Aroni 2009). Other issues raised included: ensuring dietitians have sufficient training specifically in the selection/implementation of appropriate behavioural change models and client-centred education planning(Rosal et al., 2001; Cant and Aroni 2009), and identifying appropriate outcome measures of effectiveness with this approach including more holistic aspects such as quality of life and satisfaction (Hettler 1984; Jackson et al., 2005; Cant and Aroni 2009). Further, Maclellan, one of the most prolific authors on this topic,(Maclellan and Berenbaum 2003; MacLellan 2005; Maclellan and Berenbaum 2007) noted that the evidence-based approach, also underpins practice, privileges the biomedical model, and thereby the power differential between client and dietitian (MacLellan and Berenbaum 2006). This argument provides support that implementation of the client centred practice in dietetics may be problematic.

Finally, a reported key impediment to the successful implementation of the client centred approach was found to be the time constraints within which dietetic consults have to operate (MacLellan and Berenbaum 2006; Cant and Aroni 2009; Whitehead et al., 2009). A significant part of this may be related to ensuring the client is given sufficient time to identify and articulate their needs for dietary intervention as well as allow time for the dietitians to complete their assessment tasks. Ensuring the dietitians have sufficient time to conduct both full dietary and behavioural assessments, and provide relevant information to the client, is vital for the client-centred approach. In addition clients also require sufficient time to digest the complexity of the information in the context of their individual circumstances and to

articulate personal achievable and supportable goals. In practice the organisation in which the dietitians operates must also be agreeable and help facilitate this approach with procedural changes (MacLellan and Berenbaum 2006), as well as recognize the holistic nature that this care represents (MacLellan and Berenbaum 2003). Thus the literature shows that patient-client centred practice is well embedded in dietetics, but there are problems with its implementation related to clinical and contextual imperatives. To explore this perspective further the ethnographic case study of patient centred counselling in a context of a weight loss trial is examined.

Table 3 Articles from literature review on patient, client centred practice, competency and counselling

| Article | Representation of Patient/Client Centred Care | Key practice issues considered |
|--|---|--|
| Rosal MC, Ebbeling CR, Lofgren I, Ockene JK, Ockene IS HJ. Facilitating dietary change: the patient centered counseling model. <i>Journal of the American Dietetic Association</i> . 2001;101(3):332-41. | Clarification of the role of the model in practice, the underpinning theoretical frameworks and the need for a 'four-step counselling process' to deliver the model in a practice setting. | Model delivery requires empathetic cooperative patient/practitioner interaction: <ol style="list-style-type: none"> 1. Competency in behavioural assessment 2. Targeted nutrition advice 3. Supporting required skill and knowledge development 4. Facilitating appropriate follow up |
| MacLellan DL, Berenbaum S. Client-centred nutrition counselling: do we know what this means? <i>Canadian Journal of Dietetic Practice and Research</i> . 2003;64(1):12-5. | Recognition of the client centred approach as a competency for professional practice and clarification around the development of the model from its psychoanalytical heritage to current expression, its meaning and potential issues for practice. | Definition reinforces the need to work empathetically and cooperatively with client <ol style="list-style-type: none"> 1. Translation into practice can be ambiguous and difficult to teach to students 2. Trend for consumers to want to proactively manage their own health issues is acknowledged and inherent role dietitians can play in this phenomenon. 3. Can raise dilemmas for dietitians in terms of how to direct the patient to agreed care plans. |
| MacLellan D. The search for the meaning of 'patient-centred' practice. <i>Canadian Journal of Dietetic Practice Research</i> . 2005;30:1-2. | Viewpoint articulating the premise for gaining better understanding of the client-centred approach to practice | Uncovering the lack of clear definition of what client centred practice means and how this issue may confound effective practice and training |
| Jackson JA, Kinn S, Dalgarno P. Patient-centred outcomes in dietary research. <i>Journal of Human Nutrition and Dietetics</i> . 2005;18:83-92. | Review on how patient centred outcomes have been evaluated in the literature from the patients perspective provided limited findings | Outcome measures for patients need to be designed and evaluated to support effectiveness of dietetic practice. It was noted that: <ol style="list-style-type: none"> 1. Improvement in quality of life and satisfaction has been recognised in dietary research as relevant outcomes. 2. Specific measurement tools for these more holistic outcomes in nutrition setting need further research and development. |

| | | |
|---|---|--|
| MacLellan DL, Berenbaum S. Dietitians' opinions and experiences of client-centred nutrition counselling. Canadian Journal of Dietetic Practice and Research,. 2006;67(3):119-26. | Research study using Delphi survey methodology targeting Canadian dietitians who nominated their skills in advanced counselling to understand what the client centred approach meant and implications to practice | Quantitative findings reported: <ol style="list-style-type: none"> 1. Nutrition counselling skill development timing with many undertaking additional training post undergraduate and internship training. 2. Aspects helpful to implementing client-centred approach included working in a team, being autonomous in practice setting, clients' predisposition and readiness for change, and practitioner experience. 3. A key barrier highlighted the 'imbalance of power in the client-dietitian relationship' which may be compounded by the evidence based approach to practice |
| Horacek TM, Salomón JE, Nelsen EK. Evaluation of dietetic students' and interns' application of a lifestyle-oriented nutrition-counselling model. Patient Education and Counselling. 2007;68:113-20. | Research article evaluating the application of the 'life-style nutrition-counselling model' by dietetic students and interns which was developed in recognition of the holistic patient-centred approach. | Recognition that counselling skills are developed over time but it was noted that: <ol style="list-style-type: none"> 1. Sufficient exposure to appropriate tools, role modelling and feedback is required for students to become effective counsellors. 2. Behaviour model 'stages of change' was a key tool identified to improve counselling outcomes but training is required for it to be of value. |
| MacLellan D, Berenbaum S. Canadian Dietitians' understanding of the client-centered approach to nutrition counseling. Journal of the American Dietetic Association. 2007;107:1414-7. | Client centred approach meaning to a range of dietetic practitioners explored and opportunities and challenges articulated. | Challenges and opportunities identified relate to: <ol style="list-style-type: none"> 1. Clients being more autonomous and more directive about their own health management 2. Clarifying the difference between 'needs and wants' with clients in practice settings 3. Clash of Identities for both client and practitioner as 'experts' in developing nutrition care plans. 4. Barriers recognised in terms of implementation particularly related to organisational support and time constrained sessions which impacts the development of successful 'therapeutic' relationship between client and practitioner. |
| Cant R, Aroni R. From competent to proficient; nutrition and education and counselling competency dilemmas experienced by Australian clinical dietitians in education of individuals. Nutrition and Dietetics. 2008;65:84 | Research article examining the impact from training, experience and competence levels on dietitians' perspectives on educating and counselling clients in a variety of practice settings | Recognition that 'two-way' counselling as embodied in the patient-centred approach and is: <ol style="list-style-type: none"> 1. Considered the appropriate current practice for successful dietetic interventions. 2. Recognised that more extensive training at both at the graduate and practice levels is required to to support desired counselling approach and education skills are achieved. |
| Whitehead K, Langley-Evans C, Tischler V, Swift JA. Communication skills for behaviour change in dietetic consults. Journal of Human Nutrition and Dietetics. 2009;22:493-500. | Research article examining the opinions of UK dietitians about the importance of communication skills in practice and the impact their training and experience on these skills | Communication skills were recognise to be critical for effective practice particularly in terms of: <ol style="list-style-type: none"> 1. Re-orientation of health services to emphasis patient centred approach was a recognised imperative 2. Post registration training in communication skills was valued especially to manage the time challenges of client sessions and ensuring better outcomes for both practitioner and clients. |
| Cant R, Aroni R. Eleven process | Research study assessing | Patient centred planning is recognised as fundamental |

| | | |
|---|--|---|
| evaluation strategies for education of individual patients in dietetic practice. Nutrition and Dietetics. 2009;66:87-93. | evaluations methods on education strategies used by Australian dietetics in a variety of practice settings | to successful nutrition care plans and: <ol style="list-style-type: none"> 1. Dietitians do evaluate the education in real time with their clients through a variety of evaluations techniques 2. Further skill development to enhance dietitians patient centred planning would be useful. |
| Henry BW, Smith TJ. Evaluation of the FOCUS(Feedback On Counselling Using Simulation) instrument for assessment of patient-centered nutrition counselling behaviours. J Nutr Educ Behav. 2010;42:57-62. | Research study on FOCUS instrument developed to assist training of students on client-centred counselling | Training to ensure dietetic students are conversant and skilled in delivering client centred approach is recognised to be critical for their competency and FOCUS appears to be a useful tool to check skill level in standardised patient counselling. |

Ethnographic case study

Bearing in mind the researcher-practitioner positions in this research, the conclusions drawn from the literature review were relevant to the themes identified in the interviews of dietitians particularly in relation to training needs, behavioural change expertise and time constraints in practice settings. The main themes that emerged centred on acting out the professional role, and the factors that influence this activity (see Figure 1). In keeping with the qualitative methodology, there was no weighting placed on the factors (and representative quotes) underpinning the subthemes in terms of one being more important than any other. The factors represent the range of the key issues identified from the dietitians' interviews. As all dietitians who were involved in the trial agreed to participate in the interviews data saturation was achieved through ensuring all dietitians voices were heard and accounted for within the analysis of the interviews set within this specific case setting. The key theme and supporting themes are outlined in Figure 1, with the theme headings given in *italics*.

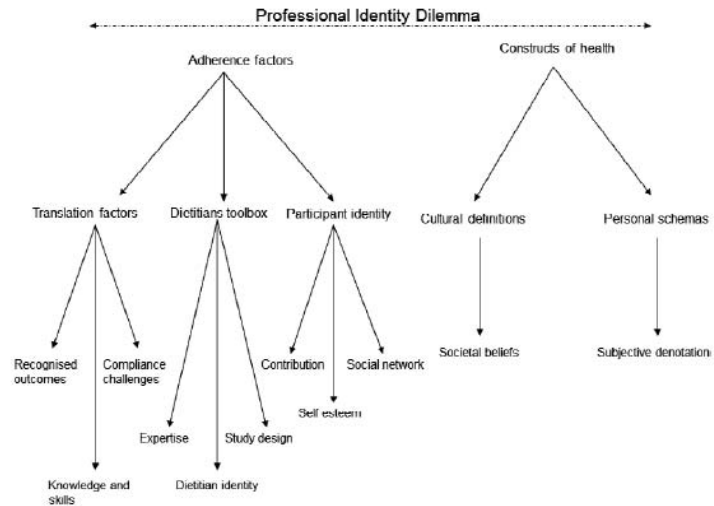


Figure 1 Schematic of thematic relationships connecting to the overarching theme *Professional Identity Dilemma*.

Main theme - Professional Identity Dilemma

The main theme identified for early-career research dietitian practitioners in this case study context related to acting out their roles as professionals and the tension they experienced in being confident with their own professional identity (experts in nutrition) while ensuring optimal health outcomes within a supportive nurturing environment. For instance as one dietitian noted:

“it’s not enough just to tell someone to, here, this, eat this food. I think we need to help people and help them eat the food they like, help them become healthier and rather than just telling them to eat.” (D2 no. 2)

The dietitians needed to work within the constraints of the clinical trial, which required them to have significant expertise to communicate appropriate food choice options to meet the study outcomes but at the same time limited their ability to meet individual patient preferences. Hence the *Professional Identity Dilemma* as ‘nutrition expert’ collided with the need to be more open with the patients’ perspective on alternative food choices. This was

particularly the case in a clinical trial when the diet was pre-determined, as exemplified in the following quote:

‘It’s really hard to apply a diet prescription to each individual and they (clients) are all so different’ (D2 no.2).

While the constraints of a trial context may be exaggerated due to the strict controls that must be met, they are likely to be similar to constraints felt by dietitians in other practice areas. For instance there is a common need to address specific health outcomes with a patient who may have very specific food preferences which do not align well with the client’s preferred dietary pattern. In this case, the dietitians interviewed recognized their limitations in terms of their skills to nurture patient-driven goals, as shown here.

‘We might need more, a bit more training on like actually motivating people...like we learn a lot (of that) along the way’ (D4 no.2).

This concern did not seem to change at different time points of the trial, and the need for skill development was reported by all dietitians who were involved in the entire length of the intervention trial. Maclellan et al (Maclellan and Berenbaum 2007) has also previously reported that dietitians want more extensive training as they are concerned about how to prioritise expert knowledge within a client-centred counselling environment driven by clients’ needs and wants. A dichotomy may be seen to emerge where both dietitians and patients are recognized as ‘experts’. Dietitians are the ‘experts’ in dietary assessment and the translation of nutrition and health science into dietary prescriptions whereas patients may be seen as the ‘experts’ in their food rules and preferences appropriate for their lives. This tension was previously recognized by Canadian dietitians in developing nutrition care plans with clients (Maclellan and Berenbaum 2007). That is, the dietitians’ expertise centers on their training and experience, whilst the patients’ expertise most likely comes from other

socially derived knowledge and life experiences. Different knowledge bases (epistemologies) that the dietitian and the client may draw upon would affect the value both parties place on proposed changes that may be required in the overall diet, and ultimately the goals they both see as important.

Maclellan (MacLellan and Berenbaum 2006) notes that dietitians recognise these differing goals as significant barriers to effective counselling, and they need to engage in ‘therapeutic relationships with patients and actively respect the knowledge and skills that they bring to the relationship’ (pg1416) (Maclellan and Berenbaum 2007). This may present a challenge, particularly for relatively new dietitians as they need to be confident with their own professional identity as dietetic experts, and be competent in their skill base to navigate their way through client-directed counselling sessions. The interviews conducted in this study provided an appropriate lens to expose this issue, suggesting specific areas for mentoring of new graduates. The dietitians interviewed were early career dietitians who had recently completed basic tuition in client-centred practice to meet their competency requirements. Their expressed interest in undertaking further skill development in behaviour change techniques to improve their confidence in practice also aligns with findings identified in a study of UK dietitians (Whitehead et al., 2009) where respondents emphasized the need for additional training to improve communication skills over their career lifetime to ensure competent practice in the client centred approach (Whitehead, Langley-Evans et al. 2009). Learning to appreciate alternative constructs of health embodied in the concepts of wellness and wellbeing could be a valuable part of this training.

Supporting Themes – *Adherence Factors and Constructs of Health*

Adherence Factors

In the interviews, factors that could impede or support dietary advice were identified, and these were termed *Adherence Factors*. They included attributes that clients bring to the interview such as *knowledge and skills* (termed *Translation Factors*). This supporting theme also included the tools dietitians deploy in the interview (termed *Dietitians' toolbox*) which in turn exposed other factors such as professional *expertise*. For instance one dietitian noted how reflective listening by both parties enabled more appropriate strategies to be developed for *Adherence* to dietary plans.

“she (the client) came back to me the next time, she said ‘yes, I, um, I realised that I am just eating out of habit or for, for another reason’. And we came up with, um, suggestions of, of non-food reward, you know..., what would make you happy, um, you know, a book, a new lipstick all those sort of things...keeping away from food, but food is such an instant response” (D3 no.2)

Another factor was *Patients' identity* which related to the clients' personal conditions such as how their *social network* (including significant others) could influence their commitment to deliver upon agreed changes. For instance one dietitian noted the struggles of their clients in relation to delivering to others needs and meeting their own.

“Normally it (challenges to meeting the dietary plan requirements) comes with ...family or people around them, say they have a, a child that they have to, um, deliver to...child care, they can't have much time, um, doing cooking....and sometimes they have to rush to pick up the kid after they finish work. So they might feel a little hungry at those times so they might provide them, um, let say a piece of biscuit at that time (and themselves)” (D4 no.2)

All these factors especially social connectedness and responsibility are linked to concepts of wellness and wellbeing which have been acknowledged as having multiple dimensions within the social, psychological, and intellectual domains(Hettler 1984).

The importance of the wellness and wellbeing concept was further emphasized in the observations reported by interviewees that very often the patient's compliance to agreed dietary changes took second place to other aspects of their lives. This is exemplified in one dietitian reporting that:

‘The people that didn't do well tended to say ‘oh you know I'm really busy with the kids or I've got work issues’ (D6).

Being able to deal with conflicting priorities is one of the great challenges dietitians face in delivering effective counselling. This is recognised in the literature and has been emphasized by the reported number of strategies that can be utilized in practice (Rosal et al., 2001; Cant and Aroni 2009). Limited formal training in improving counselling skills and behavioural techniques pre- and post-registration or accreditation has been noted in the literature on dietetic training in Canada, USA, Australia and the United Kingdom (Rapoport and Nicholson Perry 2000; Rosal et al., 2001; MacLellan and Berenbaum 2006; Cant and Aroni 2008). A lack of clarity about what needs to be incorporated in this approach in dietetic practice may be part of the reason why dietitians feel they have not had adequate training prior to registration/accreditation (Rapoport and Nicholson Perry 2000). Understanding how important wellness and wellbeing is for individual clients may be a relevant part of this training. Specifically it could be useful to learn to frame client goals in the vocabulary of wellness rather than illness; using terms such as vitality, comfort, independence, increased capacity, vigour, appearance, energy and control.

To take this point further, the dietitians interviewed were quite open about what they saw as gaps within their own current skill base, as exemplified in this statement:

'I always think...that dietitians should all have psych degrees ... cause you know there're so many issues that surround...behaviours and eating...we have such a limited training on that aspect' (D2).

Rosal (Rosal et al., 2001) recognises that training in behavioural modification techniques delivered within pre-registration/accreditation programs may be limited and has outlined a four-step framework to ensure effective dietetic counselling. Step one includes full behaviour assessment requiring confidence and skill in multiple behavioural theories and models. Step two is changing eating behaviours and personalising to clients' needs, which requires interpreting the behavioural assessments appropriately. Step three is providing advice and skill development customized to the patients' needs, and step four is supporting client based goal setting (Rosal et al., 2001) Whilst this framework provides a useful pathway it is recognized that the dietitian's individual approach to applying behaviour change theory in counselling sessions can also influence outcomes.(Lok et al., 2010) Post graduate training and mentoring, focused on client-centred practice, may be required to ensure more skill development as well as awareness about the implications of applying techniques differently.

Constructs of health

The environment in which dietitians were transmitting their messages also appeared to be a major factor in being able to counsel effectively, and this included the way in which the environment has an influence on knowledge and beliefs about health. This finding relates to the more encompassing concepts of wellness and wellbeing. Reference to broader concepts of health (*Cultural definitions*) and to belief systems (*Societal beliefs*) were made that linked health with other meaningful outcomes such as emotional outlook. These relationships are demonstrated in the following exemplary quote:

‘I think in modern culture it’s sort of a bit less clear...wellbeing I think is more like...absence of disease...and also like...physiological health and social health...just kind of more well rounded’ (D7).

This sense of a social construct of health suggests there may be much more to the interview than the medical imperative. It goes beyond concerns for meeting measurable physiological or biochemically defined health outcomes. This perspective is also supported by other authors who call for broader multi-layered definitions to be used in health practice (Randall 1996; Bourne 2010; Ashcroft 2011). Through this case study analysis an appreciation of the concepts of wellness and wellbeing arguably can enable an acknowledgement of more expansive notions of health that are meaningful to clients including the social, physical, subjective and emotional dimensions of their lives. Dietitians are increasingly challenged to be more than translators of scientific facts. They need to be excellent counsellors providing motivational dietary prescriptions which embody food patterns based on an individual’s lifestyle and knowledge/skill base. This requires a familiarity with social trends and an ability to identify environmental factors that enable or hinder food choice recommendations.

Psychological processes to implement appropriate behaviour change interventions as outlined in Rosal’s four step counselling process (Rosal et al., 2001) are useful constructs, but a broader understanding on the current social constructs of health has to be considered (NICE 2007). Hence social constructs embodied in the concepts of wellness and wellbeing may be a useful adjunct to broadening the dialogue between practitioner and client (McMahon et al., 2013). This has been recognised by other authors concerned about how the pervasive biomedical perspectives on health seen to be limiting the traditional medical health research and education sector more broadly (Saylor 2004; Hettler 1984).

As with all exploratory research these findings are limited by design - in this case the search strategy used for the narrative review of the literature, the context of the case study and the inherent bias of the researcher-practitioner typified in ethnographic studies. The constraints of the intervention trial did however enable stronger exposure to the challenges that may be found in everyday practice. The arguments formed through this analysis however, may be further tested in different contexts, with different sets of constraints on practice to see how the problems may be mediated.

Conclusion

An understanding of the concepts of wellness and wellbeing is useful for dietitians delivering a client-centred counselling approach within the current environment, a core competency of practice which is embedded in current dietary practice. Referring to these concepts can build bridges between biomedical and more client-oriented health paradigms. Behavioural modification techniques may provide the impetus for this to occur, bearing in mind issues of time constraints in the professional consultation noted in the dietitians interviews and identified within the literature review in this pilot research study. These behavioural techniques would strengthen dietitians' confidence in their identity as experts in nutrition while building skills in client centred practice. However, a number of barriers can impede this process, such as the amount of time available for the consultation, and other constraints on the counselling context which may limit flexibility. This was exemplified in this case study of a clinical trial context which is a highly defined setting for dietary counselling, driven by biomedical imperatives. In Australia the Accrediting Practising Dietitians (APD) program assures that all dietitians maintain their professional competency (Dietitians Association of Australia 2010). In this framework, structured courses in areas such as behavioural modification using a client-centred approach and utilising concepts of wellness and wellbeing may form a useful part of planned continuing professional development programs.

Developing skills in these areas may enable practitioners to embed clinical targets (representing biomedical imperatives) within client defined perspectives on health. Appreciating the concepts of wellness and wellbeing from a client perspective may be central to this process.

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