Counselling Skills for Dietitians

Second Edition

Judy Gable
MSc (Nutrition), BACP Accredited Counsellor

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Foreword

The concept of 'patient-centred care', which is transforming the way that health care is delivered in the UK, has always been an essential element of effective practice for dietitians. The evidence shows that advice tailored to the lifestyle of an individual, as well as their clinical condition, and based on constructive negotiation is more likely to result in positive outcomes.

The importance of effective communication is reflected in the *Standards of Proficiency* for dietitians which lay down the standards for registration by the Health Professions Council. In addition to effective and appropriate skills in relation to patient care, the *Standards* also emphasise the ability to work as a member of a multidisciplinary team. This means dietitians working together with the broad range of health professionals who are involved in the prevention and treatment of the non-communicable degenerative diseases that dominate modern health care priorities.

Counselling Skills for Dietitians is an invaluable source of insight and practical guidance, which will help those who are new to the profession to develop the skills which are so vital for effective practice. In this new edition there is also plenty for the more experienced practitioner to reflect upon. Judy Gable brings her long experience as a dietitian and a trained counsellor, together with insights gained from working with student dietitians and running in-service workshops, to produce a book of unique value. This volume will enable others to share the benefits that we have been able to enjoy at King's through Judy's involvement with the teaching of our students.

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Introduction

When asked to write a second edition of *Counselling Skills for Dietitians* I was doubtful at first about undertaking such a task. However, once I had become involved in the project, I found myself engrossed. This process, I believe, mirrors that of many dietitians when faced with the prospect of learning counselling skills. I have heard a number of dietitians say 'Counselling skills are all very well, but I haven't the time'. In this book I hope to show how counselling skills can be integrated by dietitians so that the limited time they have with patients is utilised effectively and meaningfully for both dietitian and patient.

The first edition, published in 1997, stemmed from the needs and interest shown by dietitians who participated in the training courses in counselling skills and personal development that I facilitated during the 1990s. Many common difficulties emerged when sharing experiences about giving dietary advice to patients. For example, the patients who appeared not to heed the advice given, however clearly the dietitian thought she was putting it across, and the interviews when it became clear that the patients' difficulties were not diet related. In such situations frustration, helplessness and disenchantment frequently develop for the dietitian who then thinks 'What am I doing wrong?' or 'This patient is not worth bothering with'. Once the dietitian finds herself groaning inwardly at the prospect of seeing yet another patient, she is likely to find herself developing a routine 'spiel' to help her get through yet another busy clinic. Other difficulties arise from a lack of communication skills and a lack of self-confidence. As a result a dietitian is likely to be overly anxious, for example about giving up-to-date and accurate information or talking to certain people. This anxiety can be expressed as an inflated desire to help and to please, a fear of confrontation and a reluctance to be with someone who is emotionally distressed. A dietitian may experience such difficulties not only with patients but also with consultants, other doctors, nursing staff and managers.

This book explores ways in which these difficulties can be addressed. When writing I have drawn on my personal experience as a dietitian and a counsellor. The counselling theory in the book is based on the person-centred approach, which was originally the work of the late Carl Rogers, an eminent American psychologist, whose extensive research has moulded the development of counselling for decades. The person-centred approach, whether it is used in counselling, education or any other area, is more than a set of skills; it is both a philosophy and an attitude of mind. In the book, I focus on the use of counselling skills in clinical settings between dietitians and patients, because this is an area familiar to all dietitians. Those working in other areas and in management will find it equally useful as they discover how they can apply the skills in their communications with clinicians, colleagues and managers. The material includes exercises and clinical examples designed to stimulate self-awareness and encourage the reader to adopt a self-directed approach to learning. All examples and names given to dietitians and patients throughout the book are fictional and reference to any individual is purely accidental. I hope the reader finds the book thought provoking and satisfying to read. In my experience the material is valuable to students and so could also be useful to trainers who have an interest in interpersonal communication.

In this second edition, the basic structure of the book is unchanged. When considering what to amend and what new material to include, I realised much has progressed and much remains unchanged in the fields of both dietetics and counselling in the years since the publication of the first edition. Public awareness of counselling as an acceptable means of getting help continues to grow and counselling is increasingly widely available. Courses in counselling skills are now held in many colleges throughout the UK. Developments in the practice of health care in the past decade have placed emphasis on practitioners working in multidisciplinary teams. This means there is an even greater need for effective communication between colleagues from different disciplines if misunderstandings are to be avoided. Anxiety about roles and tasks and how these are to be performed and by whom, often leads to conflicts within teams. Meanwhile, when helping others change their eating behaviour, dietitians continue to struggle with the issue of motivation and Motivational Interviewing is a term familiar to many. Since writing the first edition there has been great interest in the use of cognitive-behavioural therapy (CBT) to help people towards changing their perceptions in the world of both counselling and dietetics. Ways in which aspects of CBT can be incorporated in patient-centred work and used for personal development are included in this edition. As the role of dietitians becomes more complex, their need for support, both

professional and personal, increases. When incorporating a counselling approach into their dietetic practice, dietitians need opportunities to engage in their own personal development in order to become competent practitioners. Those working interactively with patients who are emotionally vulnerable also need the support provided by the type of clinical supervision which attends to their emotional needs. In an increasingly demanding working environment, I believe it is even more necessary for dietitians to be able to maintain healthy boundaries concerning their role, time keeping and the extent to which they can offer confidentiality. Maintaining such boundaries supports both dietitian and patient.

As in the first edition the book is divided into four parts. Part 1 examines the counselling approach as applied to the role of the dietitian and distinguishes this from the dietitian as teacher or adviser. A key feature in counselling is the relationship between the helper and the person being helped. Therefore, in developing a counselling approach it is necessary for the dietitian to examine her approach and understand how this affects her relationship with her patients. Another key feature is understanding the process of change and the ways in which this can be facilitated. Exploring the ambivalence that underlies an inability to change is the basis of Motivational Interviewing, which is outlined in Chapter 4 of this edition.

Part 2 centres on the fundamental skills of listening and responding and introduces the reader to the skills of reflective responding. Used effectively, these skills further the development of the helping relationship. They also enable the dietitian to gain an understanding of the patient's attitude to change. In Chapter 7 I examine ways in which these skills, together with skilful questioning, can be used to make helpful interventions. The chapter now includes a section 'towards clearer thinking' which describes aspects of CBT and shows how these can be incorporated into a person-centred approach. Examples show how the skills can be used by dietitians when inviting patients to think about changing their eating behaviour.

The skills of Part 2 are applied to different settings in Part 3, which has been extensively revised in this edition. Chapter 8 describes a framework to use as a basis for the patient interview and introduces topics such as assessing motivation, contracting, tracking the helping process and reviewing the interview. Chapters 9–11 remain unchanged. In response to the general increased incidence of self-harm in the population, Chapter 12 contains a new section to help the dietitian cope in the event of her patient expressing suicidal thoughts. A new chapter (Chapter 13) illustrates the application of the interview framework and the counselling skills described in Parts 2 and 3. The three fictitious

interviews show counselling skills being used by three dietitians in different dietetic situations.

Part 4, focusing on personal development, has been revised and expanded in this edition. In response to requests by dietitians, Chapter 14 explores ways of developing assertive behaviour and handling aggressive behaviour, not only with patients but also with colleagues in the workplace. The final chapter (Chapter 15) focuses on personal support. This includes managing stress, building self-esteem and counselling. A new section is included in this chapter which introduces the subject of mutual collegial support and describes how this can be established. Finally, the appendices have been amended and updated to include details of books for further reading and contact details of organisations associated with subjects raised in the book.

The wealth of information in the book may seem overwhelming at first. A dietitian may say 'How will I ever remember this' and 'I will forget it all when I'm with a patient'. I believe what matters most is our willingness to become better listeners more of the time, both to others and to ourselves. This involves being more skilful in the way we respond to what we hear. The skills described in Part 2 and demonstrated throughout the book are valuable life-skills. Developing, honing, polishing, and applying our listening and responding skills leads to greater understanding and opportunities for negotiation, co-operation and change. I hope this book is both useful and well used.

About the author

As a State Registered Dietitian, Judy Gable first specialised in paediatrics, where she was involved in clinical research in gastroenterology and food sensitivity. Her MSc (Nutrition) was followed by research into diet and diabetes among the Asian community. Her interest in the psychological aspects of weight management led her to training as a counsellor. As an accredited counsellor she has worked in private practice and primary care, and has taught counselling skills to dietitians and students at King's College, University of London, for many years. She currently works in Primary Care as a counsellor in a general medical practice.

How to use this book

The following guidelines are designed to help the reader make most effective use of the book.

General points

Although chapters can be read in isolation, the reader will obtain maximum benefit by reading them in order, particularly in Part 2 where each chapter builds on the skills covered in the preceding one. References are made in each chapter to other chapters, where this is thought to reinforce the reader's learning. Each chapter contains exercises, in boxes, which are designed to increase the reader's awareness and aid learning. Dialogue is designed to demonstrate the practical application of the counselling skills and to clarify the process occurring between patient and dietitian.

Dietitians who are new to counselling

You are recommended to read Chapters 1–9, followed by Chapter 13 and Part 4. Other chapters can then be read as interest dictates.

Dietitians who work in specialised areas

You are recommended to read Chapters 1–9, followed by the relevant chapter in Part 3, followed by Chapter 13 and then Part 4. Those working in either mental health or with physical disabilities are recommended to read the introduction section of Chapter 12 in addition to the section they are interested in.

Dietitians who have completed some training in counselling skills

You are recommended to read Chapters 1, 3, 4 and 13, followed by Part 4, all of which are designed to add to your understanding. Chapter 2 and Chapters 5–9 aim to increase awareness and refresh and add to skills previously learned. The different issues raised in Parts 3 and 4 provide opportunities to clarify and develop earlier thoughts.

Notes on terminology

Dietetics is still a predominantly female profession and this fact is used in delineating gender. Dietitians are referred to as 'she' throughout and those receiving their help as 'patients'. As counselling is also a predominantly female profession, counsellors are referred to as 'she' and the person with whom they are working is referred to as a 'client'.

Names given to dietitians and patients are fictional and do not refer to individuals. Examples given are either based on my personal experiences or have been adapted so that any resemblance to specific real-life situations is purely accidental.

Part 1

A Counselling Approach

In Part 1, I introduce the reader to a counselling approach. I will be:

- exploring the role of the dietitian including her personal philosophy and qualities to develop when using a counselling approach;
- explaining some of the different approaches to counselling so that the reader can gain some background knowledge;
- considering the patient's concerns, expectations, reactions and feelings;
- exploring the nature of change and the process of adapting to it;
- focusing on the relationship between patient and dietitian and the qualities of empathy, acceptance and genuineness which the dietitian can provide;
- describing what is involved in the helping process, and how the dietitian can manage the issues of time keeping, confidentiality and referral when working with patients.

Chapter 1

The Dietitian as a Skilled Helper

't'is not enough to help the feeble up but to support him after'

Shakespeare: *Timon of Athens*

In this chapter I discuss:

- Teacher, adviser, guide or counsellor?
- Continuum of control
- Developing a personal philosophy
- Portrait of a dietitian using counselling skills
- Qualities of a dietitian
- Developing a counselling approach
- Different approaches to counselling

Teacher, adviser, guide or counsellor?

In a statement taken from an information leaflet produced by the British Dietetic Association (2003) the work of dietitians is described as follows:

> 'Dietitians are skilled in taking scientific information relating to food and health, and translating it into terms that everyone can understand.'

In other words, dietitians communicate with others on nutrition matters and dietary management. They provide a service for the sick and those who live with a chronic condition, and a service for those concerned with maintaining and promoting health. Traditionally dietitians have seen their role as that of a teacher, adviser or guide. Nowadays many describe their role as one of facilitating change or of dietary counselling. As practising dietitians know only too well, fulfilling the role is not straightforward.

Dietitians may do their best to inform, educate and facilitate using the most up-to-date knowledge at their disposal, yet patients do not always follow their information or respond to their teaching. So what goes wrong? Is it the dietitian, the patient, the diagnosis or the information given by the dietitian? Much research is done into medical diagnoses and dietetic information, and dietitians undergo lengthy training to ensure their understanding of their subject. In meeting the demands of continuing professional development they endeavour to keep abreast of current developments in the field of nutrition and dietetics.

In recent years there have also been significant developments concerned with helping people change their behaviour. The model 'Helping People Change' launched by the Health Education Authority in the 1990s helps dietitians identify the stage in a patient's process (Prochaska & DiClemente 1986). Motivational Interviewing has also been adopted by many dietitians to use within the Helping People Change model (Chapter 4). Motivational Interviewing provides a framework to help explore and resolve the ambivalence people feel about implementing change, and requires the dietitian to apply a style of interviewing that draws on characteristics of client-centred counselling (Rollnick & Miller 1995). Another form of counselling is cognitive-behavioural therapy (CBT), in which patients are introduced to strategies to help them implement change (see the section 'Different approaches to counselling' later). CBT programmes have been developed for use in the treatment of obesity (Rappoport 2000). Being able to track the change process, explore and resolve ambivalence and have strategies to show people how to implement change has greatly increased a dietitian's resources. However, patients may be willing to change and know how to do this, yet the desired outcome remains elusive. The Empowerment Model, based on principles that value the patient's right to make choices about their own health and be responsible for their own well-being, is about the helper being able to empower her patient's own resources for change (Valentine 1990; Funnell *et al.* 1991; McCann & Weinman 1996). The Helping People Change Model, motivational interviewing and the Empowerment Model have all been found to be useful in dietetic consultations with diabetic patients (Parkin 2001).

Whereas the developments described above have focused on helping obese and diabetic patients change their behaviour, dietitians working in other specialities also need resources to enable them to help their patients modify their diets. Whatever their area of work, many dietitians find the following difficult:

- dealing with a patient's reasons for not changing their eating behaviour;

- handling ambivalence when a patient is unsure about changing;
- coping with the emotions expressed by a patient;
- knowing what to say or do when a patient raises a non-dietetic problem.

In addition to her own difficulties the dietitian needs to consider those of her patients. In medical practice, research into non-compliance by patients has identified a lack of satisfaction with the consultation, a lack of understanding by the patient, and a failure by the practitioner to meet expectations, as significant factors. It was concluded that patients whose expectations are met, who are listened to, who are received in a friendly manner and are not kept waiting, experience greater satisfaction with the consultation and are more likely to comply with the practitioner's advice (Ley 1988).

It would seem that patients are more likely to be satisfied and to follow the dietitian's advice when:

- they are welcomed and seen on time;
- they feel they have been heard and understood;
- they are given information they recognise as relevant to them;
- they understand what they have to do.

It follows that, in addition to being able to give information, advice and instruction, dietitians need skills in:

- demonstrating to patients that they have been understood;
- assessing and meeting patients' needs and expectations;
- working within limited time boundaries.

How can the dietitian develop these? And the skills to employ the models described earlier? Competency in using high-level communication skills is essential if the dietitian is to be able respond to her patients' emotional needs and manage appropriately the non-dietetic problems that emerge during their work together.

Counselling skills, which offer dietitians the means to provide this quality of support for patients, have been defined for the Advice, Guidance & Counselling Lead Body as 'high level communication skills used intentionally in a manner consistent with the goals and values of counselling' (Russell, Dexter & Bond 1992).

Many health professionals use counselling skills in their work, although not all health professionals are counsellors. Those using counselling skills may also use other methods such as instructing, teaching, advising and discussing. Table 1.1 highlights the differences between these methods.

Table 1.1 Comparison of methods of communication.

Method	Purpose	Skills
Instructing	To get your message across	Ordering
Teaching	To ensure others understand the material	Explaining Demonstrating
Advising	To tell others what to do	Persuading
Discussing	To exchange points of view	Expressing oneself Listening
Counselling	To understand another To help them move towards making changes	Listening Responding helpfully

Instructing, teaching and advising centre around a one-way relationship, in which the helper is in the powerful position of being the expert in control of the situation. Discussing and counselling centre on a two-way relationship. When using counselling skills, the helper supports the person being helped to gain a sense of power and control for themselves. The nature of the relationship between the counsellor and the client, and the process which occurs within that relationship, is central to counselling. The helper who uses counselling skills develops an approach that is different from the one adopted by an instructor, teacher or adviser. This difference centres around the issue of control.

Continuum of control

The continuum of control (Eweles & Simnett 2003) relates different methods of communication to the degree of control held by the health professional, as shown in Figure 1.1. Traditionally dietitians are trained to use those methods in which they have most control. The dietitian is qualified to pass on her knowledge to others and to

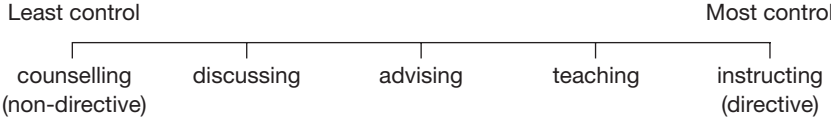

Fig. 1.1 Methods of communication related to the degree of control held by the dietitian. (Adapted from *Promoting Health – A Practical Guide to Health Education*, 5th edn, L. Eweles & I. Simnett, © (2003), with permission from Elsevier.)

provide ideas, suggestions and answers to a patient's problems with diet. She is therefore likely to be most familiar with, although not necessarily most comfortable with, methods where she has control over what takes place.

Counselling skills on the other hand require an approach in which the helper chooses to exert less control. The dietitian may feel uncomfortable with the uncertainty that this entails. However, education is of limited value when the provider has only one or two methods of delivery. The dietitian who can choose to assert her control or let go of it, depending on her purpose and the perceived needs of the patient, has a choice of approach. This enables her to be highly competent in her work.

Developing a personal philosophy

Traditionally, health professionals have been seen as experts and invested with power. This attitude is reflected in their communication with patients. Recent trends to involve patients more directly and encourage personal responsibility for health, require health professionals to examine their perception of themselves and their attitudes towards patients.

When faced with a problem, many helpers feel a responsibility to come up with a solution for the other person. Often, as the expert and the person in authority, they take this responsibility on themselves. Once the helper thinks of a solution, they see it as their job to persuade the other person to adopt and implement this.

The dietitian who thinks she should be the one to provide the solution to a problem is also likely to associate compliance by the patient with her own effectiveness. This attitude is reflected in the way in which the dietitian communicates. For example, if a patient does not follow her advice she may persuade the patient to comply in the future not only 'for their own good' but also in an attempt to feel better about herself. She is likely to use methods which allow her to be in control, such as lecturing the patient on the importance of modifying their diet or by allowing the patient to think that she also has difficulty in restraining her intake, as a way of inviting them to disclose indiscretions with their diet.

The dietitian who perceives herself as someone who knows what is best for the patient reflects a different attitude from the dietitian who thinks of herself as someone who is available to share her professional knowledge with her patients in order that they may make use of this if they choose. The latter will endeavour to provide, to the best of her

ability, an environment in which a patient can feel safe, acknowledged and supported as a worthwhile human being (Chapter 3). She is likely to recognise the value of counselling skills in:

- encouraging a patient to make the choices that are best for them;
- helping a patient explore thoughts and feelings about changing their eating behaviour;
- providing a supportive relationship in which the patient feels able to make small changes for themselves.

Portrait of a dietitian using counselling skills

Sally is a dietitian who encourages her patients to take control and responsibility for themselves. She sees herself as someone whose role is to enable the patient to make their own choices. She believes that human beings are unique, that each one knows best how they feel and what they think and believe, and that although these values may not be in accord with her own, they are worthy of her respect. The respect she has for herself and others enables her to trust that her patients are able to use her information in whatever way is best for them.

In doing this she is neither naive nor irresponsible in her attitude. She is realistic and able to respond to her patients. She accepts that each individual has difficulties which are unique to them. Some of these are known to her and others are unknown. Likewise, she knows her patients are aware of some difficulties themselves and unaware of others. She sees her role as one of offering support in helping her patients understand and deal with the difficulties they have with regard to their diet (see Exercise 1.1).

Exercise 1.1

How would you describe your philosophy about helping your patients? Thinking back to the continuum of control, which methods do you feel most comfortable with?

Method	*Colleagues*	*A patient*	*A group of patients*
Instructing			
Teaching			
Advising			
Discussing			

Qualities of a dietitian

Dietitians frequently describe the qualities of someone who is effective in their role of helping others as someone who is:

- trustworthy;
- honest;
- reliable;
- a good listener;
- caring;
- knowledgeable;
- competent.

These are qualities which come readily to mind to most people working in the caring professions. Someone who is trustworthy and honest is thought of as someone who can be believed and relied on to do what they say they will. We trust someone and consider them honest and reliable when we experience them as being authentic, real and genuine (Rogers 2004). Genuineness (see Chapter 3) is a quality that counsellors strive continually to develop. It is demanding to be honest with oneself and to trust oneself. However, the more able we are to be this way with ourselves the more able we are to be this way with others. Openness and honesty are key characteristics of the person who is perceived to be trustworthy and reliable.

Many actions are taken which are said to be caring because they are thought to be in the best interest of another. In truth, these actions are often in the best interest of those giving the 'care', and as a result the recipient feels unheard, manipulated and disempowered. We demonstrate true caring of another when we feel empathy towards another (Chapter 3) and are willing to place ourselves at their service. We show caring by:

- giving time and attention to another;
- being fully present when listening to another;
- doing what is needed to meet the needs of another;
- helping another in their process of resolving their difficulties.

Caring is demanding yet empowering of oneself and the other person. Our ability to be available to another in this way is closely linked with our ability to establish our own boundaries, which in turn is dependent on knowing our own limits in terms of competency, and physical and emotional availability.

Developing a counselling approach

Acquiring information and monitoring competence are continual requirements for any health professional. Usually these are thought of as keeping up to date with technical and scientific developments. It is also the responsibility of the professional to develop her interpersonal and self-management skills, for without these she is unable to provide true quality care for her patients.

A dietitian who wants to develop the qualities mentioned earlier will be concerned with developing *self-awareness*. This is the key to developing genuineness and empathy (Chapter 3). Increasing self-awareness enables us to learn how we respond emotionally. This is a prerequisite if we want to help others effectively. With self-awareness we can learn to recognise our own feelings and those of another. In doing so we are less likely to attribute our own emotional response to the person to whom we are listening. In other words, we are less likely to become angry, fearful or confused by the other person and will be more able to take in what they are saying without interpreting and distorting this.

Developing self-awareness is about becoming more wholly ourselves. As Verena Tschudin (1995) succinctly says in *Counselling Skills for Nurses*: 'when we can hold the doubtful and the certain, the strong and the weak sides of ourselves in balance, then we can use ourselves positively'. She goes on to say, 'what matters is not so much that we have been "good" or "skilled helpers" but that we have been real people'.

As self-awareness grows so does 'a greater openness to and acceptance of others' (Rogers 2004). During this process we question and clarify our beliefs and experiences. These form our 'frame of reference' or the position from which we view our world. Each of us holds a different frame of reference. Using counselling skills necessitates being able to step into the frame of reference of another in order to provide empathy with someone whose experience and beliefs are different from our own. We do not have to be widowed, for example, before we can empathise with someone whose spouse has died. What is important is that we can draw on our experience of loss and suffering for the benefit of another.

Developing self-awareness is closely related to developing self-worth. An ability to value and respect oneself leads to self-acceptance and trust in oneself. As a result self-confidence grows. Patients will place greater trust in someone they sense they can rely on to be open and honest with them. Relating in this way develops a mutuality. As the dietitian's trust in herself grows, so does her willingness to trust her patients.

Imagination and intuition develop with self-trust. To be able to empathise and step into another's world requires the dietitian to use her imagination. As an ability to be empathic and genuine develops, so also does an ability to sense or intuit. Hunches provide potent material when used in an appropriate way. It is important to distinguish between hunches and assumptions, and to be aware when we are sharing a hunch, and when we are making an assumption and treating this as a fact.

An important part of building self-worth, self-value and self-respect lies in learning to care for and about oneself, in mind, body and spirit. Caring for others stems from being able to care for ourselves. If we do not feel cared for we look to others to fill our needs. Caring for the carer is therefore essential, otherwise the carer, as much as the person seeking help, is in need of receiving the care outlined earlier.

Those who are considering using a counselling approach in their work face the challenge of examining their reasons for choosing to be a member of the caring professions. Is it the hope that in providing for others they will fill their own needs? If so what are these? Is it a need for acknowledgement and recognition? Is it a desire to be thought of as 'kind' 'helpful' and 'doing something worthwhile'? A dietitian's professional practice is in question if her needs are mainly fulfilled by her patients. Yet if she has a commitment to her work and her patients is this not going to be the case? An integral part of a counsellor's training involves exploring their commitment to their own personal development. Dietitians who are thinking of using counselling skills in their work also need to explore their commitment to themselves. Part 4 outlines some aspects of personal development for the dietitian to consider.

Different approaches to counselling

Within counselling there are many different approaches based on varying beliefs about human nature. These can be broadly categorised under three headings: psychoanalytic, behavioural and humanistic.

Psychoanalytic approach

Psychodynamic counselling comes under this heading as it is based on Freud's belief that unconscious motives and drives lead us to behave in certain ways. Past experience, of which we are unaware, is relived when we encounter a similar experience in the present. Psychodynamic counselling encourages the client to explore their past in relation to

the present problem. Anxiety is reduced when clients are able to make sense fully of their patterns of behaviour. The principles and practice are clearly explained by Michael Jacobs (2004) in his book *Psychodynamic Counselling in Action*. This approach is useful in health care when the patient has long-term emotional problems, suffers anxiety and talks of an unhappy childhood (Burnard 1999).

Behavioural approach

The behavioural approach is based on the belief that all behaviour is learned and so can be unlearned. The first step is to identify the undesirable behaviour and to replace this with desired behaviour by a scheme of positive reinforcement. The focus is on the behaviour and not on exploring the reasons behind the patterns of behaviour. This approach could be applied in health care with long-term behaviour problems such as those which may occur in children (Burnard 1999), and is the approach recommended by Hunt and Hilsdon (1996) in their book *Changing Eating and Exercise Behaviour*.

Cognitive approaches are frequently combined with behavioural therapies and this has led to the development of CBT, which studies have shown to be helpful for patients suffering from a range of emotional disorders including depression (Beck *et al*. 1987). CBT is based on the principle that our perception of ourselves and the world around us, that is, our point of view, shapes our thoughts (opinions, beliefs, ideas) and feelings and by learning to change our thoughts we change how we feel and behave (Beck 1989). In Chapters 7 and 15 there are examples of how aspects of CBT can be used by dietitians. The potential for CBT to be misused in a coercive way has provoked criticism (Stickley 2005). Therefore in describing how dietitians can apply the principles I have carefully considered their integration within a person-centred approach.

Humanistic approach

The aim of a humanistic approach is to 'increase the range of choices and encourage and enable the client to handle this successfully' (Rowan 1998). It is concerned with a client's thoughts, behaviour and feelings, and it is useful with problems concerning self-image and when someone believes they are powerless to change their circumstances (Burnard 1999). The humanistic approach is based on the existential philosophy that people are unique individuals essentially able to be responsible for the choices they make in their lives, rather than their actions being determined by their unconscious as in the psychodynamic approach,

or learned mechanically as in the behavioural approach. In the period from 1940 to 1970, Carl Rogers formulated his theory of person-centred counselling based on his knowledge of psychoanalytic and behavioural theories, his clinical experience and a vast amount of research (Thorne 1992). A fundamental tenet of the person-centred approach is the realisation that a move towards change will occur when the qualities of empathy, acceptance and genuineness are present in a relationship (Rogers 2003).

For a more detailed exposition of the humanistic approach the dietitian is recommended to read John Rowan's (1998) account in his book *The Reality Game – a Guide to Humanistic Counselling and Therapy* and Philip Burnard's (1999) account in his book *Counselling Skills for Health Professionals*. There are many schools of therapy within each approach and many of these are concisely described in *Who Can I Talk To?* (Cooper & Lewis 1995). Many counsellors describe themselves as having an *eclectic approach* and draw on aspects from several approaches in the belief that no one approach suits every situation and that individuals benefit from the approach that most suits their needs at the time.

The *person-centred approach* forms the foundation of the counselling skills described throughout this book and is concerned with:

- enabling patients to make appropriate choices;
- helping patients express their thoughts and feelings;
- demonstrating to patients that they have been heard and understood;
- enabling patients to feel valued and respected;
- supporting patients in the actions they choose to make.

Transactional analysis, founded by Eric Berne, is another humanistic approach used in this book. Berne developed the concept of ego states calling these 'Parent, Adult and Child' (Stewart & Joines 1987). Understanding and recognising ego states can be useful as a framework for analysing an interaction when there are difficulties in communication. For example, a dietitian in Parent ego state may say to a patient, 'You shouldn't go without your breakfast.' The patient may respond from a Child ego state with, 'Well, I've never had breakfast up to now so I don't see why I should start at my age.' This conjures up an impression of a rebellious child. Alternatively, the dietitian when in Adult ego state may say, 'It is generally recognised that having some breakfast is a healthy way to start the day.' The patient who replies, 'I understand that it is healthier for me to eat something in the morning rather than start the day on an empty stomach', is then also responding from an Adult ego state.

Material is drawn from two other models where appropriate. Concepts from *family therapy* are described in Chapter 10. The aim of family therapy is to look at a family as a dynamic system and help the family members deal with their difficulties in a different way. It is not concerned with apportioning blame to an individual within the family, but rather with enabling family members to explore together the ways in which communications between them are unclear. They learn to recognise mixed messages and develop other ways of behaving towards one another. The aim of therapy is to help family members develop a different perspective on their problems and discover alternative strategies for coping.

Techniques from *neuro-linguistic programming* (NLP) developed by John Grinder, a linguist, and Richard Bandler, a mathematician and therapist (Bandler & Grinder 1979) are applied in this book where these can clarify communication. NLP includes skills such as mirroring, which can be used to great effect in creating rapport (Chapter 5). A practitioner of NLP pays great attention to detail and observation. NLP focuses on treating problems in the present without recourse to the past, and changing specific aspects of behaviour related to clearly defined problems. For example, a patient who has a phobia about heights is asked to describe in minute detail their experience of heights, including taste, smell, sight and sensation, and is then helped to change the experience by a technique called 'reframing'.

This chapter has examined the role of the dietitian and introduced some aspects of counselling. The next chapter focuses on the thoughts, feelings and behaviours associated with being a patient.

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