Chapter 5

NUTRITION EDUCATION AND COUNSELING

Jamie Stang and Mary Story

One of the keys to effective nutrition education and counseling of teenagers is a good understanding of normal adolescent psychosocial development (see Chapter 1). Adolescents are striving to achieve independence yet they are highly influenced by the beliefs and behaviors of peers. They are developing abstract reasoning skills, however they may revert to more concrete cognitive skills when faced with new challenges or perceived stressful situations. These aspects of adolescent development need to be integrated into all nutrition education and counseling efforts, whether they occur as classroom nutrition education presentations or individual counseling sessions.

The capacity for more abstract thinking coupled with the changing psychosocial milieu of adolescence provides both challenges and opportunities for health professionals when providing nutrition education. Adolescence is an opportune time to train students to assess their own eating behaviors and set goals for dietary change. Nutrition education has generally not taken advantage of the social and cognitive shifts of adolescence that could be built upon to promote the adoption of more healthful behaviors.

GENERAL CONSIDERATIONS FOR NUTRITION EDUCATION AND COUNSELING

Nutrition education involves teaching the client about the importance of nutrition, providing educational materials that reinforce messages about healthy eating, teaching adolescents skills essential for making dietary change, and providing information on how to sustain behavior change. Information gathered during nutrition screening or assessment will provide the necessary information on which nutrition issues need to be addressed during nutrition education and counseling sessions. Prior to beginning the education process, it is helpful to assess what the adolescent already knows about nutrition, how ready they are to adopt new eating behaviors, and if there are any language or learning barriers that may need to be addressed in order to facilitate the nutrition education process.

Motivation to make behavior changes can be easily assessed using a 0 to 10 scale (see Chapter 4). Once a teen's motivation to make behavior change has been assessed, nutrition educators must determine the best course of action to facilitate dietary change. Table 1 provides a model for nutrition education and counseling based on stages of change. This model provides strategies for advancing clients to the next level of readiness to change.

TABLE 1
Stages of Change: A Model for Nutrition Counseling

Stage	Description	Goal	Strategies
Precontemplation	Is unaware of problem and hasn't thought about change. Has no intention of taking action within the next 6 months.	Increase awareness of need for change. Personalize information on risks and benefits.	Create supportive climate for change. Discuss personal aspects and health consequences of poor eating or sedentary behavior. Assess knowledge, attitudes, and beliefs. Build on existing knowledge.
Contemplation	Intends to take action within the next 6 months.	Increase motivation and confidence to perform the new behavior.	Identify problematic behaviors. Prioritize behaviors to change. Discuss motivation. Identify barriers to change and possible solutions. Suggest small, achievable steps to make a change.
Preparation	Intends to take action within the next 30 days and has taken some behavioral steps in this direction.	Initiate change.	Assist in developing a concrete action plan. Encourage initial small steps to change. Discuss earlier attempts to change and ways to succeed. Elicit support from family and friends.
Action	Has changed overt behavior for less than 6 months.	Commit to change.	Reinforce decision. Reinforce self-confidence. Assist with self-monitoring, feedback, problem solving, social support, and reinforcement. Discuss relapse and coping strategies.
Maintenance	Has changed overt behavior for more than 6 months.	Reinforce commitment and continue changes/ new behaviors.	Plan follow-up to support changes. Help prevent relapse. Assist in coping, reminders, finding alternatives, and avoiding slips/relapses.

Source: Adapted from Glanz K, Rimer T. Theory at a glance: a guide for health promotion practice. Bethesda, MD: National Institutes of Health, National Cancer Institute; 1995 and Sandoval WM, Heller KE, Wiese WH, Childs DA. Stages of change: a model for nutrition counseling. Top Clin Nutr 1994;9:65-69.

Adolescents often enter nutrition education and counseling at the precontemplation stage. They are often not aware of the potential health risks associated with poor eating habits and have not thought about making dietary changes. The initial goal of nutrition education and counseling therefore, will be to increase the client's awareness of risks associated with current eating habits. In situations such as the diagnosis of diabetes mellitus, adolescents may be aware of the need to change dietary habits but may show resistance toward change. Identifying potential barriers to change and providing small, achievable goals along with concrete strategies to facilitate necessary dietary modifications are often the initial stages of nutrition education.

A variety of methods of nutrition education are used successfully with adolescents. Individuals learn in a variety of ways and each individual responds differently to various methods of education. In general, adolescents learn best when they are actively involved in nutrition education.

- For general nutrition education topics such as making healthy food choices at fast food restaurants, classroom presentations or group education sessions are an efficient and effective way to reach a large audience of teens.

- Small groups can be used to provide nutrition education to adolescents who are found to be at nutritional risk and would benefit from modifying eating behaviors. Weight management, vegetarian eating and sports nutrition are topics that can effectively be addressed in small groups.

- An individualized approach, such as one-on-one counseling, will be required for adolescents who need a high level of nutrition guidance. Initial education related to diabetes, adolescent pregnancy, hyperlipidemia or hypertension is best provided in an individualized setting.

- Peer education on an individual level or in small groups can provide peer support for teens who have undergone initial individualized nutrition education and may benefit from continued nutrition education and support to improve compliance with dietary recommendations.

The initial component of the counseling session should involve developing a positive rapport and getting to know the adolescent. Key aspects of an initial nutrition counseling session include:

- Describe the role of the nutrition educator. Teens may be apprehensive about nutrition education if their previous health education experiences have been negative or their perceptions are that they will be told what not to eat and will not be offered choices or a chance to provide feedback regarding dietary modifications. These concerns can be addressed if the health professional provides a detailed overview of the events of the counseling session, including what specific nutrition topics will be discussed.

- Ask about any personal health or nutrition-related concerns that the teen would like to discuss. Adolescents should be actively encouraged to add their own nutrition concerns to the list of topics to be discussed during the education session.

- Gauge the psychosocial development of the teen, in an effort to determine which types of education and counseling methods may be most effective.

A complete nutrition assessment should be performed prior to nutrition education and counseling (see Chapter 4). Upon completion of the assessment, the health professional and teen should work together to establish goals for improving dietary intake and reducing nutrition risk based upon the findings of the nutrition assessment.

It is important to involve adolescents in decision-making processes during nutrition counseling. Allowing teens to provide input as to what aspects of their eating habits they think need to be changed and what changes they are willing to make achieves several important goals during the counseling session.

- The importance of the adolescent in the decision-making process is stressed and she or he is encouraged to become involved in making personal decisions about health

- A good rapport is established between the health professional and the teen, which may lead to more interaction during the remainder of the counseling session

- Behavior change is more likely to occur when adolescents have identified specific behaviors that they feel need to be changed, thus expressing a willingness to change.

One or two goals during a counseling session are a reasonable number to work toward. Setting too many goals in one session reduces the probability that the adolescent can meet all of the goals and may seem overwhelming. For each goal that is identified and mutually agreed upon, several behavior change strategies should be developed. These strategies should be concrete in nature and should be initiated by the teen. The adolescent and the health professional should also work together to decide how to determine when a goal is met. Follow-up sessions should be scheduled frequently in order to provide feedback and monitor progress toward individual goals. The use of behavior change contracts should be used with caution when working with teens. If the teens feel they have failed to meet their goals, they may not return for follow-up nutrition education sessions.

PEER EDUCATION AND COUNSELING

Peer influence is very strong during adolescence. This aspect of psychosocial development can be utilized to promote behavior change through the use of peer education and counseling sessions. In peer education, teens who have mastered the skill of making dietary change and are willing to share their experiences and knowledge provide nutrition education to other teens under the supervision of a health professional.

Peer education is generally well received by adolescents and has many advantages:

- Teens may be more willing to adopt suggestions provided by a peer than by a health professional as they may perceive the suggestions to be more relevant to their personal lifestyle and needs.

- Peer educators are able to teach concepts using terminology and language to which other adolescents can relate.

- Peer educators can provide personal examples of changes that they have made and how they were able to overcome perceived barriers to behavior change.

- Peer education provides social support to teens. For issues such as overweight or diabetes, where extensive changes in dietary habits may be required, peer support can help adolescents overcome feelings of isolation and being overwhelmed by new information.

- Practical suggestions and encouragement by older peers can help teens to feel empowered to make behavior changes, while group support can help to sustain behavior changes through positive reinforcement.

It is important to choose peer educators carefully. Characteristics to look for in peer educators include:

- good communication skills

- a mastery of skills that are being taught

- an interest in working with other teens

- the ability to identify teens who may need referral for more in-depth nutrition education

Because adolescents tend to look up to older teens, peer educators should be the same age or slightly older than the individuals with whom they are interacting. All peer educators should have basic training related to utilizing effective verbal and visual teaching methods, how to facilitate group discussions, and how to identify individuals who may need referral for depression or chemical dependency issues. On-going mentoring of peer educators is necessary to be sure they are providing accurate information to teens as well as to maintain their interest in the peer education process.

GROUP EDUCATION METHODS

Group education can provide an effective means of reaching many adolescents with common nutrition messages. Nutrition issues that are especially amenable to group education methods include fast food and snack choices, vegetarian diets, sports nutrition, prenatal nutrition, and overweight. In general, groups should be kept small when possible. Keeping groups to no more than 5-15 people provides more opportunity for each member to participate and provide input. When larger groups are necessary, utilizing small group activities that allow 2-3 individuals to work together encourages participation by each adolescent.

Group education should begin with the identification of what nutrition concepts teens already know. This can be accomplished by beginning an interactive discussion (not a lecture) about the topic to be discussed. The inclusion of questions can assist group facilitators in determining the level at which education should begin.

Group education should be as interactive as possible. It is important to build in opportunities for the group leader to model desired behaviors or to demonstrate procedures in addition to verbally describing them. It is also important to allow adequate time for group members to practice the skills or behaviors they are being shown. Small groups can be effectively utilized for this purpose. One scenario that works well with adolescents is to have them work in groups of 3. Two individuals in each group can roleplay the desired behavior (such as how to choose low fat fast food choices when they are with peers who they think may tease them about such choices) while the third person

provides feedback. Allowing adolescents to practice a behavior as well as to assist others in learning the behavior reinforces key concepts and empowers them.

It is important to provide each teen an opportunity to provide input during group education activities so that he/she feels ownership in the group ideas. If 1 or 2 individuals dominate the conversation, group leaders should ask each member of the group to provide an answer or personal reflection on the issue being discussed. Alternatively, a group nomination process can be used. In this process, each adolescent is asked to write down 1-2 suggestions or comments on a piece of paper. The group then takes turns reading one of their suggestions as the group leader records each of them. Once all of the suggestions have been read, and each person has provided at least one or more suggestions, the group works together to group related suggestions together. The resulting groups of suggestions are then discussed as potential ideas to facilitate dietary change.

Once the main points of a particular topic have been covered and desired behaviors have been practiced, the group leader can introduce more detailed information that is tailored to the interest level of the small group. Health professionals should remember that adolescents may only be able to learn a few concepts at a time. Therefore information in initial sessions should be limited to what is most necessary to know, while "nice to know" information should be added only when appropriate.

EFFECTIVE NUTRITION MESSAGES AND MATERIALS FOR TEENS

Health professionals need to give careful consideration to the types of nutrition messages that are presented to adolescents. Many teenagers perceive that good nutrition means eating foods that don't taste good and that eating healthy foods means not eating from vending machines or at fast food restaurants.[1] However, focus groups of teens have also found that many adolescents believe that healthy eating gives them energy and helps them grow.[1] More effective nutrition messages should capitalize on these concepts and convey the idea that eating well will help the teen to have the energy to do what s/he wants to do and to become the person s/he wants to become.

Most adolescents are present-oriented, which means they are generally not concerned about how their current eating habits will affect their future health status, but are concerned about their physical appearance, maintaining a healthy weight, and having plenty of energy. While teenagers should give consideration to the potential long-term risks of an unhealthy diet and the likely benefits of healthy eating habits, focusing on short-term benefits is more likely to make a lasting impression on adolescents and facilitate dietary change.

Educational materials should be written using the style of language in which a person would speak. Some key concepts to think about when developing education materials or messages include:

- Use an active rather than passive voice when presenting information.
- Use common language, phrases and words in place of medical terminology.
- Provide illustrative examples for all key concepts presented. Remember, many adolescents are concrete thinkers and cannot easily apply new concepts to current behaviors or situations.
- Keep the reading level of written materials to the 5th – 6th grade level.

- Be specific and concrete in examples. Avoid using value judgment terms such as “too much” or “not enough”. These terms may be interpreted in many ways and are not valuable to concrete learners.
- Use many short sentences instead of a few long sentences.
- Keep paragraphs short in written materials.
- Include interaction whenever possible. Utilize concepts such as fill-in-the-blank worksheets, open-ended questions, or checklists and quizzes whenever possible.

It is imperative that all educational materials and messages be pilot-tested with the population for whom they have been developed. Ask several teens from a variety of grade levels to provide feedback on educational materials or ideas for group counseling sessions. Peer educators can provide feedback about nutrition education materials and messages or can help you to locate individuals who would be willing to pilot test materials.

REFERENCES

1. Croll J, Neumark-Sztainer D, Story M. Healthy eating: what does it mean to adolescents? J Nutr Educ 2001;33:193-198.