

Lesson I-1

INTRODUCTION AND BASIC SKILLS

Introduction to Nutrition Assessment

OBJECTIVES:

In this lesson, the student will:

1. Learn the importance and uses of nutrition assessment.
2. Identify conditions/factors affecting nutritional status.
3. List the two categories of malnutrition, their forms and/or causes.
4. Identify the four components of a complete nutrition assessment.
5. Differentiate between nutrition screening and nutrition assessment.

ASSIGNMENTS:

I. DEFINITION

Nutrition Assessment is the evaluation of the nutritional status of individuals or populations through measurements of food and nutrient intake and evaluation of nutrition-related health indicators.

Nutritional Status indicates the degree to which physiologic needs for nutrients are being met.

II. IMPORTANCE OF NUTRITION ASSESSMENT

Nutrition assessment identifies current nutritional status, nutrient requirements, and nutritional risk, if any. This information is important to:

- identify those at risk for nutritional deficiencies or excesses and promote early intervention.
- provide optimal nutritional care and counseling to clients/patients.
- provide a baseline data to monitor and measure outcome of nutrition intervention.

III. CONDITIONS AFFECTING NUTRITIONAL STATUS

A. Inadequate intake:

- inadequate calorie and protein
- lack of appetite (anorexia)
- inability to feed self
- food allergies
- treatment side effects

- B. Inadequate absorption:**
- side effects of drug therapy
 - parasites
 - surgical removal of bowel
 - chronic gastrointestinal disorders; e.g., celiac disease, regional enteritis, etc.
- C. Defective utilization:**
- metabolic dysfunction; i.e., organ failure
 - inborn errors of metabolism, e.g., PKU
 - hepatic or renal insufficiency
 - drug interference with nutrients
- D. Increased excretions or losses**
- vomiting
 - diarrhea
 - increased transit through GI tract
 - irritable bowel syndrome
 - draining fistulas/abscesses
- E. Increased requirements:**
- fever
 - infection
 - trauma
 - stress
 - pregnancy
 - growth
 - burns
 - sepsis
 - hyperthyroidism
 - malignancy
 - surgery

IV. CATEGORIES OF MALNUTRITION

Malnutrition is lack of proper nutrition. The Jelliffe monograph, published in 1966 identified four forms of malnutrition.

- A. **Undernutrition** resulting from lack of sufficient food over a period of time
- B. **Overnutrition** caused by an excess of food over time.
- C. **Specific deficiency states** resulting from lack of individual nutrients.
- D. **Nutrient imbalances** caused by disproportionate amount of required nutrients over a period of time.

There are two categories of malnutrition:

- A. **Primary malnutrition** refers to inadequacies or imbalances in the diet, in either the quality or quantity of foods eaten. This category is not related to any disease or disorder. Examples: iron deficiency anemia due to inadequate intake of foods rich in iron; overweight due to food intake in excess of energy use; overuse of vitamin or mineral supplements.
- B. **Secondary malnutrition** refers to malnutrition that results from disease or disability. It is disease-related malnutrition. Examples of conditions predisposing to secondary malnutrition include cardiovascular disease, diabetes mellitus, cancer, AIDS, mental illness, dental problems, diseases with chronic fever, drug or alcohol addiction. Secondary malnutrition results from these diseases due to one or more of the following causes:
- malabsorption
 - anorexia
 - increased metabolism (hypermetabolism)
 - metabolic dysfunction
 - organ failure
 - side effects of treatment

V. COMPONENTS OF NUTRITION ASSESSMENT

A complete nutrition assessment includes:

- A. **Anthropometric data** — measurements of the human body which indicate growth and development. Anthropometric data is most valuable when accurately measured and recorded over a period of time. These measurements include height or length, weight, head or arm circumference and skinfold.
- B. **Biochemical data** — analysis of blood, urine, and other body tissues provides useful information about nutritional status. Examples include serum albumin, hemoglobin, hematocrit, blood levels of vitamins or minerals, etc.
- C. **Clinical data** — includes a complete physical examination and a medical and psychosocial history, i.e. factors that influence nutrient intake like income, housing, family size, physical activity, use of alcohol, medications and other actors that influence nutrient utilization.
- D. **Dietary data** — includes foods and quantities eaten, eating habits, accessibility of food, cultural and socioeconomic factors that affect selection of food.

NOTE: The components of nutrition assessment can be easily remembered by the acronym, “ABCD”.

VI. NUTRITION SCREENING VERSUS NUTRITION ASSESSMENT

Nutrition Screening (also referred to as screening for nutritional need) is the process of recognizing the presence of factors known to be associated with nutrition problems for the purpose of identifying individuals who are at nutritional risk. Nutrition screening can be done by any member of the health care team, such as the dietitian, dietetic technician, nutrition assistant, or nurse.

Characteristics of the Nutrition Screening Process:

- can be completed in any setting, e.g. clinic, hospital, meal sites, etc., through personal interview and/or using data in client's chart,
- facilitates completion of early intervention,
- includes the collection of relevant data on risk factors and the interpretation of data for intervention and treatment,
- determines the need for a more in-depth nutrition assessment, and is cost effective.

(Refer to examples of nutrition screening forms.)

Minimal nutrition screening done in some clinics or other facilities include height, weight, change in appetite, hemoglobin, hematocrit, blood pressure, cholesterol and smoking/alcohol habits. This information is used to screen for medical/nutrition risks such as overweight, underweight, anemia and cardiovascular disease. Data for the individual are compared to standards to classify the level of nutritional risk: low risk, moderate risk, or high risk.

Individuals determined to be at moderate to high nutritional risk are referred to the registered dietitian for nutrition assessment to determine severity and causes of nutritional problems so appropriate intervention/treatment can be planned and implemented.

In summary, screening for nutritional need is used to:

- determine client's eligibility and priority for program services,
- plan effective nutrition education and counseling,
- decide if the client should see a dietitian/nutritionist,
- determine if the client needs referral to other agencies and programs for special help.

Lesson I-2

INTRODUCTION AND BASIC SKILLS Documentation of Nutrition Care The SOAP Format

OBJECTIVES:

In this lesson, the student will:

1. Identify the rationale for documentation.
2. Comprehend the confidential nature and legal issues of documentation.
3. Practice charting progress notes using the SOAP format.
4. Learn commonly used medical terminology and medical chart abbreviations.

ASSIGNMENTS: Read teacher-developed supplementary materials, *Documentation of Nutrition Care, Medical Terminology, and Medical Chart Abbreviations*.

MATERIALS: Activity work sheet (1)
Handouts: *Documentation of Nutrition Care, Medical Terminology, and Medical Chart Abbreviations*.

I. RATIONALE FOR DOCUMENTATION

The client's *medical record* or *chart* is an ongoing collection of information which documents a client's care. It includes a complete assessment of the client's health/nutrition status, a care plan, and progress notes monitoring the implementation of the care plan and the client's response to it.

A. The purposes of the medical record are:

- document care or services rendered,
- facilitate communication between members of the health care team,
- serve as basis for the evaluation of the health care delivery, and
- comply with laws, regulations and accreditation requirements.

B. Legal Issues of Documentation:

The medical record is legal evidence of care given and therefore, must be accurate. Clients have the right to see their medical records. The medical record is also classified as a confidential document.

II. GUIDELINES FOR DOCUMENTATION

- A. Entries in the progress notes should contain: client name, medical record number, the date, health care team service (or the department), signature and title of the staff writing the notes.
- B. If notes are handwritten, write legibly using black or blue ink dark enough to be photocopied.
- C. Describe information accurately but briefly and to the point.
- D. Be specific—avoid unclear statements. For example, instead of “Client lost weight,” write “Client lost 5 lbs. in two weeks.”
- E. Write objective notes, i.e., facts, not conclusions. For example, write, “Client’s weight is below the 5th percentile” instead of, “Client is malnourished.”
- F. Use correct medical terminology and medical abbreviations.
- G. Use short sentences or phrases. Complete sentences do not have to be used all the time.
- H. Do not use personal pronouns. For example, “Client needs counseling on iron-rich foods”, not, “I will counsel my client on iron-rich foods.”
- I. Always time and date entries—never back date. Sign every entry with name and title.

III. THE SOAP FORMAT

After completing the nutrition screening/assessment of a client, the assessment data, plans for care and needs for further assessment must be documented as progress notes. One format commonly used for writing progress notes is the SOAP format.

S: Subjective Data

- client's thoughts and feelings,
- client's complaints, history, "quotable" significant information, description of his/her problems, statement of needs,
- information obtained by talking with client or client's family.

O: Objective data

- facts, findings that can be verified, observations,
- physical findings, signs and symptoms,
- anthropometric data,
- laboratory or biochemical data,
- factual information regarding background, history, environment, progress or problems.

A: Assessment

- interpretation of client's nutritional status, needs or problems based on data given under S and O,
- estimate of client's calorie, protein and other nutrient needs.

P: Plans

- plans of action for the problem identified, including:
 - Dx (diagnosis): Plans to obtain more information about.
 - Rx (treatment): Plans for client care/services, problem management.
 - Ed (education): Plans to counsel/educate the client.
 - F/U (follow-up): Schedule of return visits; referrals to other agencies, services and/or R.D.

IV. MEDICAL TERMINOLOGY

The nutrition assistant must acquire basic medical vocabulary to function effectively. Although this may seem overwhelming at first, there are some tools to promote easier and faster learning. One such tool is to analyze the component parts of words: root words, prefixes, and suffixes. For example, prenatal has a prefix, *pre-*, meaning "before," and a root word, *natal*, meaning to do with "birth." Therefore, "prenatal" means prior to birth. In some cases, the analysis cannot be taken literally but can be used to suggest the meaning.

NOTE: Discuss the handouts (Appendix A): *Medical Terminology* and *Medical Chart Abbreviations*.

SAMPLE OF PROGRESS NOTES IN **SOAP** FORMAT

NUTRITION SERVICE

6-3-02, 1000 hr

Problem I: Excess Body Weight

S: Diet history shows usual intake of 3,000 kcal/day with high intake of sweetened soft drinks. No c/o, 1,500 kcal diet.

O: Ht. 5 ft, 2 in. Wt. 160# (bed scale), IBW 110-120#. Diet Rx-1500 kcals.

A: Prescribed diet is acceptable to client. Needs ed. on wt. reduction diet.

P: Dx: Weigh weekly.

Ed: 1. Reviewed concept of exchange lists with elimination of sweetened foods.
2. Gave client exchange list booklet with 1500 kcal meal plan to study.
3. F/U next week.

Rx: Maintain flow sheet of client's weekly weights to be kept in chart.

Mary Smith, R.D.

ASSIGNMENT I-2 - SOAP PROGRESS NOTES

DIRECTION: Observing all the guidelines, write a SOAP progress note for the given client under Problem #2.

Problem #2: Inadequate Growth.

P.J. is a 24-month old girl seen at the clinic for the first time today. According to her birth record, she was born at 40 weeks gestation, weighing 6 lbs (slightly above the 10th percentile), and her length was at the 10th percentile.

Her mother brought P.J.'s growth record, which showed that both her weight and length progressively dropped percentiles since birth, and the latest measurement at 18 months reads well below the 5th percentile for both weight and length. Today, her weight is 19½ lbs. (Well below the 5th percentile), and her height is also below the 5th percentile.

Her mother noted that P.J. has been a very picky eater but loves Kool-Aid. The mother complained that her baby daughter is sick a lot.

Lesson I-3

INTRODUCTION AND BASIC SKILLS Interviewing and Counseling Skills

OBJECTIVES:

In this lesson, the student will:

1. List effective ways of establishing rapport with the client.
2. Identify the steps in interviewing and counseling.
3. Demonstrate correct interviewing and counseling skills through role-playing.

ASSIGNMENTS:

MATERIALS: Videotape: *Gaining Collaboration in Nutrition Counseling*, DGH Productions, 1992.
Activity work sheets (2)
Handouts: *Interviewing and Counseling*

I. ESTABLISHING RAPPORT

A. DEFINITION

Rapport is a sympathetic, friendly and trusting working relationship. The establishment of rapport between the nutrition staff and the client is essential to the success of interviewing and counseling.

B. SUGGESTIONS TO ESTABLISH RAPPORT*

1. Greet the client, being polite, friendly and personal, using name, if possible.
2. Express interest and desire to help with the problem, e.g. evaluating the diet, regulating weight, etc.
3. Encourage the client to express fears and concerns about the problem or changes. Be sure to listen thoughtfully, be accepting and non-judgmental. Examples: Is the client afraid to make changes? Worried about cost?
4. Let the client know that you understand the situation, have helped others with similar problems, and will help the client do what must be done.
5. Express confidence that the client can handle problems and progress toward a solution. Point out expected benefits.

*SOURCE: Obert, J. C. *Community Nutrition*, 2nd Edition, 1986, page 196.

II. INTERVIEWING

Many of the nutrition assistant's interactions with clients will consist of interviewing or counseling. It is therefore important that techniques for both are learned.

A. DEFINITION

Interviewing is a guided communication between a nutrition staff and a client for the purpose of gathering information that can be used to help the client. Interviewing is necessary before counseling is planned and conducted.

B. STEPS IN THE INTERVIEW

1. Starting the Interview

- a. Prepare for the interview by obtaining pertinent background information about the client. Main source is the medical record or medical referral form. Make sure the interview takes place in an environment that is comfortable, private and as free as possible from distractions; allow adequate time.
- b. Use client's name with appropriate title, except children who can be called by their first names. This serves to identify the client and personalize the interview.
- c. Introduce self by stating name and appropriate title. E.g., Mary Jones, the Nutrition Assistant.
- d. Make initial effort to put client at ease and establish rapport. Suggestions: Inquire about client's comfort, inquire about client's purpose in coming, stand as the client enters office.
- e. Explain the purpose of the interview.
- f. Determine client's knowledge/attitude about the purpose of the interview. A client who is in denial about the condition/problem needs help with this attitude before the interview can proceed successfully.

2. Implementing the Interview

- a. Begin with non-directive (or open-ended) questions. This allows the client to talk about his/her concerns. Later in the interview, use direct and behavioral questions to obtain information needed. Avoid closed or leading questions. (Refer to Table I-3.1 for different types of questions).

- b. Use language that is appropriate for the client; clarify any dialect or slang the client uses.
- c. Listen with interest using verbal and non-verbal responses. Examples: non-verbal - leaning forward, frequent eye contact, nodding occasionally; verbal - "yes", "I see", "Uh-huh", "Go on". AVOID: "Very good", "Excellent", or "Fine", to indicate you are listening because these can be taken as acceptance or praise, in turn encourages client to report what you want to hear.
- d. Be non-judgmental. Be careful not to judge behaviors as good or bad but simply use the information to plan care and counseling. Avoid evaluative responses such as, "Oh, no!" or frowning. Praise may be given to reinforce a positive activity.
- e. Gather information specific to the purpose of the interview by encouraging client to provide only pertinent data. (See Table I-3.2).
- f. Allow client to talk without unnecessary interruptions. If the interviewer talks excessively, the client will begin to withdraw.
- g. Be sensitive to the client's anxieties, attitudes and emotions.
- h. Do not hurry the interview. Keep it on track but be willing to listen and spend time with the client.
- i. Check for understanding, e.g. restating and clarifying responses.
- j. Summarize the information gathered.

3. Closing the Interview

- a. End the interview when the objective or purpose has been achieved or when you notice the client is tiring. Verbal ways to bring the interview to a close: ask if the client has any questions; or say "when I see you again on your next appointment ...".
- b. Make a referral if necessary. Inform the client why this is recommended. Assist in scheduling an appointment.
- c. Write down for the client time, date and place of next appointment. Indicate what you have planned for next appointment.
- d. Summarize items or goals to be accomplished by the client by next appointment, e.g. forms to be completed, a three-day food record, etc.
- e. Give the client a phone number where you can be reached for questions.

TABLE I-3.1 Different Types of Questions

Open or neutral questions - require a narrative or explanatory response; allows the client to talk about information that he/she feels is important. Start with *what*, *how* or *when* or an open statement.

“Tell me about your favorite foods.”

“What is the first thing you have to eat or drink in the morning?”

Closed questions - require only a *yes* or *no* answer and provide no additional information. Can be used to ask for specific information but fail to reveal anything else about a client’s attitude. Start with *do you* or *have you*.

“Do you salt your food at the table?”

“Have you tried to lose weight before?”

Leading questions - the interviewer makes suggestions about the desired or expected answer, therefore information gathered may not be accurate.

“You don’t drink whole milk, do you?”

“What do you eat for breakfast?”

Behavioral questions - In order to help the client change undesirable eating habits, it is important to find out what he/she *eats*, not what he/she *knows* about choosing foods. To accomplish this, behavioral questions are more useful for future counseling efforts than knowledge questions. Behavioral questions use verbs that describe *doing* rather than knowing something.

Examples:

Knowledge question: “What do you think about losing weight?”

Behavioral question: “What methods have you tried to lose weight?”

TABLE I-3.2 Strategies for Re-Focusing the Interview

Controlling Statement

Asking open or neutral questions may result in storytelling or other deviations from the purpose of the interview. In this case, the interviewer must develop a strategy for re-focusing the interview to the question asked and for the client to provide only pertinent data. Here's an example:

INTERVIEWER: How often do you eat out?

CLIENT: Oh, my kids and I love this little Mexican restaurant down the street. They serve the best enchiladas. My mother used to fix the kids' favorite Mexican dishes until she suffered a stroke. Now of course, she ...

In a storytelling response such as this, the interviewer must use a controlling statement to focus the client to the question at hand. For example:

INTERVIEWER: I'm sorry to hear that; but remember we were discussing how often you eat out.

or

INTERVIEWER: You must really like that Mexican restaurant. How *often* do you eat there?

Question-framing

This strategy is needed for clients who are reluctant or uncomfortable to reveal their true habits/behaviors. When the interviewer senses this in a client, it is best to ask a series of "framed" questions. Framed questions allow the client to hypothesize about an imaginary situation and therefore remove himself from a negative disclosure. For example:

CLIENT (overweight): I never eat sweets. In fact, I seldom eat any dessert.

INTERVIEWER: Let us for a moment imagine that you were at a friend's party and the only desserts being served were cheese cake, chocolate mousse, and pecan pie. Which would you choose?

Another example:

CLIENT (a reluctant child): I don't have favorite foods.

INTERVIEWER: Let us pretend you were invited to spend a day at the beach with some friends. When asked to bring your own food, which foods would you bring?

III. COUNSELING

A. DEFINITION

Counseling is the process of providing individualized professional guidance to assist a client in adjusting his/her daily food choices to meet his/her health needs. Data gathered from the interview is the basis for counseling. The purpose of nutrition counseling is to change food practices so that all necessary nutrients are provided, or to modify the food intake for special needs. As much as possible the client and the person who prepares the family meals should both be present for the session(s).

The emphasis in counseling is *on the client* and *actual skills* he/she is able to achieve. For this reason, the goals of counseling should be written as behavioral objectives clearly identifying the skills that should be acquired at the end of counseling. A well-written behavioral objective will clarify for the counselor and the client the expected skills or behavior to be achieved. Achievement of a skill/behavior is only possible if the client is asked and given time to practice the skill/behavior during counseling.

Examples of behavioral objectives:

1. The client will plan an adequate diet for pregnancy using the foods and recommended number of servings in the Food Guide Pyramid.
2. The client will select from a list of foods those foods she likes to eat that are allowed on a low-sodium diet.

B. GUIDELINES IN SETTING GOALS & INITIATING DIETARY CHANGE

1. Set reasonable expectations about what changes should be made, the extent of change and timeline.
2. Goals are best set by the client guided by the counselor.
3. Goals should be specific, measurable, reasonable, and attainable.
4. Short-term goals of 1 to 2 weeks are more effective than long-term goals.
5. Build client's commitment to achievement of goal(s) through a written self-contract. (See Figure I-3.1 for an example).
6. Help promote maintenance of behavior change by using rewards.

FIGURE I-3.1 Self Contract

_____ NAME	
_____ PERIOD OF TIME	
_____ DESCRIBE SPECIFIC BEHAVIOR GOAL	
_____ REWARD UPON ATTAINMENT OF GOAL	
_____ CLIENT'S SIGNATURE	_____ DATE
_____ COUNSELOR'S SIGNATURE	_____ DATE

C. STEPS IN COUNSELING

The steps may proceed in a different order or some may be combined.

1. Evaluate the food record gathered from the interview or supplied by the client.
2. Help the client to see how the same basic foods can be used by the whole family. Identify and encourage continuation of good practices.
3. Help the client identify practices needing improvement, e.g., food groups for which intake is low.
4. Help the client to suggest acceptable ways to improve the diet and that can be obtained within available budget.
5. Help the client decide on one or two changes to be made and write the suggestions on the food record.
6. Time should be allowed during counseling session for the client to practice the changes or skills to be achieved from the counseling. For example, if you expect a client to plan a day's food intake, then allow time to practice this skill during the counseling session or as an assignment to be completed and returned.
7. Give the client the food record with changes to make and suggest it be hung in the kitchen for frequent reference.

8. File a copy of the food record and recommended changes with the medical chart and/or nutritionist's file.
9. In subsequent visits, follow up on progress. Suggest further changes as needed.
10. Take another food record when changes have been implemented to see whether further counseling is needed. Counseling should continue until the client has made the recommended changes or until it is clear the change will not be made. Client should be praised/congratulated on successful change. The unsuccessful client can be invited to return at a later date when possibilities of success may be greater.

D. EFFECTIVE INTERVIEWING/COUNSELING TECHNIQUES

Some recommended interviewing and counseling verbal skills to gain rapport and cooperation from the client are given in Table I-3.3.

E. FACTORS WHICH CAN INFLUENCE THE COUNSELING SESSION

Various factors in the client, the counselor and the environment can either positively or negatively affect the outcome of the counseling session. For a list of these factors refer to Table I-3.4.

TABLE I-3.3 Effective Interviewing/Counseling Techniques

1. *Exploratory response* – acknowledges that the counselor is listening, usually used after a pause in the client’s narration.

Example: “I see,” “Go on,” “I’d like to hear more about that.”

2. *Probing response* – used in an attempt to gain additional information.

Example: “So you think the diet doesn’t work. Could you tell me a little more about that?”

3. *Paraphrasing* – ensures that the information is clear and correct by repeating, summarizing or rewording what the client said. It also demonstrates that the counselor is listening and trying to understand.

Example: Client: “There seems to be no reason for me not to have lost a few pounds.”
Counselor: “You don’t see any reason why you did not lose any weight.”

4. *Empathetic response* – involves relating back to the client the feelings the counselor perceives in the client’s response; particularly effective when client’s response has significant emotion attached to it.

Example: Client: “There are so many things to learn. I just don’t know if I can possibly stay on this diet plan.”
Counselor: “You seem to be pretty discouraged about your diet.”

5. *Confrontation* – useful if used carefully to deal with client resistance. The counselor shares with the client how the counselor sees the client’s problem.

Example: Client: “I’m not interested in staying healthy.”
Counselor: “I heard you say earlier you cared about being well. I think there is some conflict in what you’re telling me.”

TABLE I-3.4 Factors Which Can Influence Counseling Session

	POSITIVE FACTORS	NEGATIVE FACTORS
CLIENT	<ul style="list-style-type: none"> - has made the choice to see the counselor and has arranged the appointment - awake, alert - free from pain (emotional and physical) 	<ul style="list-style-type: none"> - emotional stress (recent operation; stress of diagnosis) - physical or mental handicap - quiet, resistant to share feelings - has been told to see the counselor
COUNSELOR	<ul style="list-style-type: none"> - is relaxed; self-confident - speaks in a patient, pleasant tone - is well prepared and organized - maintains good eye contact - encourages client to speak openly and honestly - listens attentively - instills confidence in the client - uses appropriate body language - minimizes note taking - maintains control of the counseling session - observes client's attitudes and expressions and uses them to guide the session - provides clear, concise answers to questions - elicits client's goals and concerns - uses teaching tools effectively - is accepting and non-judgmental 	<ul style="list-style-type: none"> - disorganized; unprepared - accusatory - judgmental - closed minded - has not allotted appropriate time for interview, appears rushed - does not guide interview - asks too many closed ended questions - does not speak on the client's level: either talks down or speaks in terms or jargon which are too complex
ENVIRONMENT ¹	<ul style="list-style-type: none"> - quiet, private setting - presence of supportive family members - orderly, uncluttered desk - availability and appropriate use of teaching aids 	<ul style="list-style-type: none"> - noisy area - distractions from other patient/staff - presence of non-supportive or controlling family members - large imposing desk arrangement

¹ Some of these factors may be related only to the in-patient or the out-patient setting.

ACTIVITY I-3 – INTERVIEW QUESTIONS

A. Indicate if each question given is open or closed. If a question is closed, rewrite it as an open question.

1. Do you eat anything between meals?
2. How often do you eat eggs?
3. Have you started feeding cereal to your baby?
4. Do you drink a fruit juice for breakfast?

B. In the next set of questions, indicate whether the question focuses on knowledge or on behavior. If a question focuses on knowledge, rewrite it as a behavioral question.

1. What kinds of breakfast cereals do you eat?
2. Do you know what foods are rich sources of iron?
3. What do you think about losing weight?
4. What do you do for your morning sickness?

ASSIGNMENT I - 3 – ROLE PLAYING OF TECHNIQUES

Group activity (40 points):

In groups of 3, plan and role-play one of the following scenarios, observing all guidelines and using as many of the verbal and non-verbal skills for interviewing and counseling. One will play the role of the counselor, another the client, another the husband or parent, and the last will be the narrator/observer. Allow 5-7 minutes for the interaction.

1. A pregnant client is being interviewed about her food intake and the use of alcohol. You have some evidence that the client regularly drinks alcoholic beverages, but she says she drinks only fruit juices and milk.
2. A diabetic child is being interviewed about after-school snacks. He says he eats only fruits and vegetables, but you have reason to believe otherwise.
3. A seven-year old girl who has iron-deficiency anemia is being interviewed along with her mother on her usual intake of iron-rich foods.
4. A 28 year old overweight pregnant client in her first trimester is being counseled on healthier food choices to control the amount of weight gained.
5. An underweight pregnant teenager in high school is being counseled on food choices for pregnancy and weight gain.
6. A pregnant 35 year old client in her second trimester who is below recommended rate of weight gain is being interviewed on her usual food intake.
7. A 70 year old widower is being interviewed because of a weight loss of 7 lbs. in two months. He lives by himself after the death of his wife a few months ago. His wife has done most of the food shopping and preparation.