1. Clinician details
Profession: Dietitian Role: Clinical dietetic consultations Type of program/practice context: DVA (Department of Veterans Affairs) referral Type of organisation: Private Practising Clinician

2. Client demographic details (de-identified)
Fictitious name: Bob Age Group (5 year range): 60-65 years Gender: Male Other: Vietnam Veteran; married; recently relocated to a new regional area after retiring.

3. Presenting issues & relevant lifestyle and treatment categories
Referral issues: Referred by GP for IGT (OGTT: 9.1mmol/L 2 hours pp); Obesity: BMI range: 35-38 (specific height unknown) weight 118kg. Client-identified issues: Hypertension: 140/90 mmHg (recently started medication); Gout (recent 'flare up'); post traumatic stress disorder (PTSD). Relevant lifestyle and treatment categories: Increase exercise/general activity levels, improve nutrition (quality/quantity), alcohol management, stress management, medication management.

4. Initial lifestyle or treatment category selected to work on	
Selected category: Increase exercise/activity levels	Decisional Balance Conducted? **Yes**
Initial RICk® scores/descriptions: R= Medium ('so-so') I= 6 C = 4 k: Client showed knowledge about the effect of exercise on preventing Diabetes.	Subsequent RICk scores/descriptions: R= High ('very ready') I= 9 C = 5 k: no extra education required during decisional balance.

5.Client or other barriers to health behavior change identified in consultation (BEST)
Main Barrier/s: Situational: Bob resented being told what to do in a didactic manner by previous health professionals. He was told to attend a diabetes education program and was advised to make many changes in a short period of time i.e. increase exercise, cut out alcohol, eat a palm size portion of meat. My analysis: obvious resistance during the initial consultation from observing Bob's body language and listening to his reflection about the situation. "I have to eat tiny portions to lose weight"; "I was not asked, just told to follow a diet and exercise plan." Emotional/thinking: Bob became angry in response to being told what to do and to do too much. He felt like he had no choice or control over managing his health. "I've been told what to do all my life and I've had enough of it." Bob reported a history of poor anger management and admitted that his habitual anger reaction to didactic advice from health practitioners led to an avoidance of taking any actions that were recommended to him. Secondary Barrier/s: Bob had recently moved town and had not integrated into the community yet. He had no mates and needed to establish his social circle in order to play golf.

6. Client facilitators for health behavior change identified in consultation (BEST)

Intrinsic motivators identified: In the consultation, Bob was given the opportunity to consider his health condition and how to manage it in a non threatening manner that did not leave him feeling overwhelmed. This enabled Bob to reflect on his own reasons for change i.e. a better quality of life with his wife. "I just want to get on with life and enjoy my retirement with my wife." This was the primary motivator in Bob's top level decision to engage in managing his health (it increased his level of personal importance in managing his health).

Client facilitators identified to address barriers:

Social contact: Bob identified and was motivated by the idea of making new friends at the local golf club. This encouraged him to work on increasing his exercise.

Enjoyment of golf: Bob enjoys exercise with a purpose that involves friendly competition in a pleasant environment. "I don't like exercise for the sake of it."

Autonomy: Bob felt like he had choice and was able to make up his own mind about what specific actions to take to manage his health. This helped him to overcome a significant psychological barrier.

7. Techniques used by clinician to identify and address barriers and improve RICk

Above the line techniques:

Explaining clinician role: Bob's previous experience with health professionals led to his negative perception that he was going to be told what to do in a didactic manner. Within the first five minutes, I explained my role and how his experience would be different this time. This helped to reduce resistance and build trust.

Prioritizing: exploring the options and asking Bob to prioritize his health goals. This reduced the sense of being overwhelmed and increased self efficacy.

Asking RICk: Bob was ambivalent about working on diabetes prevention. Asking RICk guided me to stay above the decision line and work on finding an intrinsic motivator. His low confidence level prompted me to discuss the '1 thing, 1 step, adding up over time' and the 'trial and error' principles and to invite Bob to start working on small changes chosen by him.

Decisional Balance: working through decisional balance questions allowed Bob to reflect on his own reasons for change and identify an intrinsic motivator. Bob made the decision to prioritize his health because he wanted to enjoy his retirement with his wife. Identifying and addressing his reasons for not changing i.e. barriers, helped to increase his confidence. Bob realized that making changes did not have to be so overwhelming and, therefore, unachievable.

Below the line techniques:

Acknowledging client as expert: Brainstorming options increased Bob's hope that there were many ways to increase exercise. It encouraged Bob to talk about options that would suit his needs and preferences i.e. exercise that served a purpose and was social.

Teaching BEST to identify barriers and facilitators: including Bob in action planning helped him to actively think about how he was going to achieve his goal. This increased Bob's confidence when he was able to address all of the barriers and leave with a workable action plan.

Cognitive change technique: ANNTs and PETs were used in an informal way (verbally walked through BEST to identify a thinking barrier/facilitator). Bob was able to make the connection that if he talked himself out of joining the golf club, he would feel guilty and, therefore, more likely to avoid. Bob's confidence increased when was able to identify a thinking strategy i.e. remind himself of his intrinsic motivator.

Active listening: allowing Bob time to respond to questions by using the WAIT 'til 8 principle.

Client First technique: Bob had prior knowledge about diabetes prevention after attending a group education program. Asking Bob what he already knew about IGT rather than providing a lot of education helped to build a positive clinical relationship. It also saved time and allowed us to work on the 'real barriers.
Inviting Bob to do the writing: increased Bob's feeling of having choice and ownership.
Positive emotion: Using appropriate humour to create positive affect and increase cognitive flexibility.
Explaining techniques used in the process: Bob was used to the medical model approach. Explaining rationale behind each health behavior technique increased Bob's understanding and, therefore, acceptance of engaging in the process e.g. 'Often life can get in the way of achieving our goals, even if we have the best if intentions. Would it be worth coming up with an action plan on how you might go about playing golf?'
Solution focused: focused on solutions rather than problems to assist with building self efficacy.

8. Outcome from initial session

Specific goal/s: To play at least 9 holes of golf, twice per week, starting next week (didn't need to track it). To review progress at next consultation (4 weeks).

Action plan:

- Register at new golf club and pay membership fee (this week)
- Contact neighbour (who plays golf) to join him at the next golf match to meet his friends
- Nominate days to play golf (when neighbour and friends play)
- Charge up golf buggy the night before
- Put golf clubs in the car in the morning before breakfast
- PET: "This is for me. I want to enjoy life and make new friends
- (Bob didn't feel that he needed any memory prompts)

RICk Scores/categories:
R= high
I= high
C= 'pretty good' (7)

9. Number, Frequency and Time Frame of Sessions

Number and Frequency of Sessions with Client: 8 sessions. First (initial) consultation was 1 hour; review sessions booked for 30 minutes but only need 15 minutes. Review sessions scheduled monthly, then bimonthly. No other contact needed between consultations.
Time frame from 1st to last session: 9 months
Future Follow-up: Bob is being reviewed bi-monthly for 15 minute sessions.

10. Additional Issues and Goals Addressed in Review Sessions

- **Reduce alcohol intake:** Bob's alcohol intake was discussed during the third consultation. He was drinking at least 4 beers, most nights of the week. Bob worked on reducing his beer intake gradually to a maximum of 2 beers, five nights per week.
- **Reduce cholesterol levels:** Despite reaching 101kg, Bob's cholesterols increased to 6.5 mmol/L. After being told by his GP to lower cholesterol levels, Bob investigated dietary strategies independently and discussed this at the next consultation. He read about the benefits of soluble fibre and started to eat an oat/barley based breakfast cereal. This was reviewed during a consultation along with ways to increase mono/polyunsaturated fats.

- **Reduce saturated fat intake:** Bob's lunch and snack option when playing golf was a sausage roll and snickers bar. Bob worked on reducing saturated fat by choosing a healthier option that was easy to carry i.e. a sandwich and piece of fruit.

- **Cognitive change strategy:** Bob was told by his GP that he did not need to see a Dietitian any more, particularly when his weight reached a plateau. Bob reported that he reacted by getting angry and defensive. He discussed this at a review consultation. Bob realized that reacting like this was not going to help him. Bob worked on how to interpret the situation differently (i.e. when receiving unsolicited advice from health professionals). Bob realized and accepted the fact that telling patients what to do was part of the medical model approach. However, he could control the outcome of the situation by choosing to react differently (curbing his anger and recognizing that his GP had not intended to upset him). He thought that this would help him to keep on track with achieving his health goals rather than engaging in avoidance behavior.

11. Results over time

Behavioral:

Bob increased the frequency of his golf games from twice per week up to three to four times per week.

Bob achieved his goal of drinking a maximum of two beers, five times per week. By the fifth consultation, Bob had eliminated alcohol entirely and now only drinks on special occasions. He reports that he can only manage one drink. Bob's reflection: "If you had told me to cut out alcohol, I'd probably be drinking more."

Bob has increased soluble fibre by eating an oat/barley based breakfast cereal and other plant based foods e.g. legumes, fruit and vegetables/salad.

Bob has increased fish from once per fortnight to twice per week and is now using olive oil.

Physiological:

Weight and BMI:

March: 118kg BMI range: 35-38

July: 110kg

December: 101kg BMI range: 32-35

Waist Measurement:

March: 131cm

July: 120cm

December: 112cm

OGTT:

March: 9.1mmol/L (2 hours pp)

March (following year): 7.1mmol/L (2 hours pp)

Blood Pressure:

March: 140/90 mmHg

December: 120/80 mmHg

Motivational:

Bob is now proactive about health and seeks to find solutions independently. He brings topics to our consultations for discussion and is more positive about taking action.

Psychological:

Since our discussion, Bob reports that he is now less likely to react to health professionals by getting angry and actively avoiding. He is using a cognitive strategy to help overcome a habit that he has struggled with since his military days. He reports to feel better in himself, particularly because he now feels that he has some control back in his life.

12. Spontaneous changes (behavior changes not planned in consultations, but enacted by client)

Walking: Bob started to walk with his neighbour most days. He started at 30 minutes per week in April and is now (December) walking 45 – 60 minutes, including some hills.

Bob cut down his **ice cream intake** from most nights to twice per week. To assist with portion control, he is now eating a single ice cream (ice cream on a stick) rather than a large bowl of ice cream.

13. Describe how you have adapted your professional practice to include health behavior change principles and techniques
To increase my confidence in using health behavior change principles and techniques, I worked on making gradual changes to my practice. **Documentation:** Assessment: I no longer follow a traditional form of assessment with every client i.e. a 30 minute assessment followed by 30 minutes of education. Depending on what suits the client I conduct either a full dietetic assessment (when a client is not aware of the main issues), partial assessment (client has made some changes, therefore, only one to two areas are selected to assess) or an informal assessment (client has good knowledge and therefore is aware of the main issues and nominates the area they wish to address). This area is then assessed. I have changed my paper work from a 3 page structured assessment to one page. What I record on this page largely depends on the client and what I need to assess. Reports: I have changed my letter template to GP's to include health behavior change education and recommendations. This has helped to educate GPs and other health professionals about how I practice and the rationale behind it. For example, I now include RICk scores and client barriers (other than knowledge) to explain client non adherence. **Consultation structure**: I have changed the structure of my practice. I now base it around the HCA 10 step decision framework and use this to weave in dietetic advice and recommendations where relevant. This has changed the consultation timings. Using the 10 steps as a framework to follow has cut down the length of my consultations. Most of the time I no longer require 1 hour for an initial consultation (unless a full dietetic assessment is conducted). **Resources**: I have taken on the 'menu of options' approach and use this when offering advice. I have created education materials in the form of options and ask the client to choose. Resource folder: I have electronic and paper copies of selected resources from the HCA website and use these whenever needed. **Consultation environment**: I have changed the structure of my office to reflect my new way of practising. I have replaced medical pictures and scales (these are in the cupboard and used when needed) with landscape pictures, plants, box of tissues, pen and paper for writing and chairs alongside the desk rather than opposite each other across the desk and acting as a barrier.
14. Please provide a one paragraph summary of your case – to be used as a description for posting on the HCA website for viewing by other practitioners
A patient was referred by his GP to a private practising Dietitian for treatment of IGT and obesity. He had previously attended a diabetes prevention education program where he was told to make many changes in a short period of time. He became angry in response to being told what to do. This led to behavioral avoidance and obvious resistance during the initial consultation. Building the therapeutic alliance and identifying an intrinsic motivator helped the patient feel that he had choice and control back in his life. This acted as a precursor to many motivational, behavioral and physiological outcomes including: improving anger management in response to health practitioners, increased exercise levels and improved nutrition, normal OGTT and controlled blood pressure.
Thank you for contributing to the collective knowledge of health coaching health practitioners!