Chapter 3
Communication and Adolescents

Establishing Rapport: Building a Relationship of Trust Through Accessible Nutrition Education and Counseling

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Case Study

Mandy is a 17 year old who has been coming to see you for nutrition counseling and her medical provider for a year for help with behavior changes related to higher weight. She has been making gradual changes each month, but her weight has not stabilized. In fact, it has rapidly increased. You spend time speaking with Mandy confidentially at each visit. Today, after her family leaves the room, you reflected on the past year with her and all of the positive changes she has made. On review of weight trends, you ask if something may be impacting her life. Though you have asked about binge eating in the past, today you ask if she has eaten more than others around

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her and felt any guilt or shame with it. After exploring her current life stressors a bit more, she discloses that she is attracted to females and hasn't felt comfortable sharing this information with anyone. In order to cope with feelings of stress, she has been eating at night and sneaking food into her room. You encourage her to establish care with a mental health provider. She returns to see you a few months later, after seeing a therapist weekly, and updates you that she was able to come out to friends and family. Her weight trend has stabilized.

Introduction

We've chosen to work with adolescents and so can be surprised when colleagues or friends voice that they could never work with this population for a variety of reasons. Reasons may include teens are scary; teens don't talk to me; teens remind me of my own roller-coaster of an adolescence; they'll never listen to what I have to say; they are so "big"; they are confusing; etc. With these opinions in mind, we've written this chapter to provide guidance for those of you who are new to working with teens, those who currently work with teens and want to learn more, or who simply have an interest in gaining more skills in working with this unique population.

As practitioners, as women who were teens at one time and even now as mothers, we recognize and empathize with the complex landscape facing all disciplines working with teens. We've written this chapter to share the evidence-base to our approach to working with adolescents so others can have the incredibly satisfying experiences we've had watching teens and families open up, "get it" in terms of how we are supporting them, and be empowered to move forward with their lives. While there isn't a lot of evidence on effective interventions for adolescents on specific "conditions", we have gathered together what there is, along with evidence from scientific literature. We have also included "textbook" knowledge of nutrition plus anecdotal and empirical experience from our years of clinical work.

Firstly, we want adolescents and their families and caregivers to feel successful in meeting their healthcare goals, whatever they determine them to be. Additionally, we want clinicians to have the same experience we have had over the years that helps keep us engaged and growing personally and professionally. For example, we feel it is an incredibly rich experience to empower teens and have the privilege to affect and support sustainable change. This can help prevent stress and feelings of being burnt out. A physician we work with recently said at a workshop that we were co-leading that we want to provide advice about weight concerns with love and trust. While we're not prone to talking about love in a clinical setting, we realize this approach is based on the desire to provide nutrition care in a *nurturing* way – the way that the feeding process is meant to be from day one. The approach that feeding a child is *nurturing* them to grow is one we need to take after seeing so many teens and families struggle with how to understand and apply the myriad of nutrition messaging in our culture. With a constant barrage of messaging that bodies must look a certain way (see chapters on social media, eating disorders, supporting and promoting health equity, Health at Every Size, gender diverse youth), teens are influenced and may see themselves negatively. Extrapolating from an article on what an adolescent expects of their healthcare providers, we note the five over-arching themes: talk with me not at me; accept me; respect my privacy and confidentiality; show me you are a professional; and give me a trusted relationship [1]. This chapter is designed to help those providing nutrition guidance to be able feel comfortable in these five realms.

Adolescent Development

Adolescents are in the middle of the most significant change in growth since their first year of life. While this is a theme throughout the book, Chaps. 1 and 4 discuss this in-depth and provide fundamental knowledge and background on developmental aspects and milestones that the clinician needs to

constantly have in the forefront of their minds when working with and advocating for teens in any setting. In addition, we urge clinical leaders, administrators and educators to develop a similar knowledge base so that adolescents and their caregivers can have an optimal experience, regardless of the setting or diagnosis. Adolescent minds and bodies are changing rapidly, their relationship with their families is changing and their peers are very important to how they see the world. All of these affect how teens interpret and participate in the interaction with you, the clinician. Moreover, adolescents tend to view themselves as actors in an intense drama, one in which they occupy center stage and events take on a heightened importance. A calm approach, and a sense of humor, can counterbalance the urgency they feel [2].

Setting the Stage for a Successful Visit/ Interaction

In order to manage boundaries with patients and clients, the Academy of Nutrition and Dietetics recommends that we recognize the important position of the food and nutrition expert (or any professional working with a teen in this capacity), and the dependency of the patient/client on the care and services provided by the professional. This is a good first step in establishing boundaries in a clinical setting [3].

Recommendations for establishing solid boundaries include the following. Avoid revealing personal contact details, including social media information. Refrain from self-disclosure regarding personal issues including work-related concerns. Avoid acting or feeling possessive of a patient/client or student. Maintain an awareness of patients who have the potential to form unusual emotional attachments. Recognize when you feel overwhelmed by a potential boundary violation and seek support. Maintain a satisfying work-life balance to ensure personal fulfillment and prevent burnout [3].

Fundamental to setting professional boundaries is careful structuring of time limits in your appointments. Careful tend-

ing of time limits reminds you, the teen and family members (and team members!) that all professional boundaries are important. If you set up good time boundaries, this goes a long way in terms of setting expectations. Keep in mind, some patients will naturally respect boundaries and others will push the limit. On a note of self-preservation, don't expect gratitude, even if those who push the limit and benefit from stretching your boundaries end up getting more time or information from you. This philosophy and approach is simply part of your clinical practice. If you have a hard time setting boundaries, seek help to understand why and then improve upon what you have in place [4].

Other Considerations for a Successful Visit

- **Information prior to visit**: Develop a script for any staff that may have patient contact. This includes administrative assistants or schedulers so patients and parents know what to expect regarding visit length and importance of follow up visits. If you have written information available via your website or brochure, include information on confidentiality and health rights by age. During the first visit, be sure to review a policy on how to respond to missed appointments and cancellations. Maintain the expectation that the patient and family see all members of the treatment team.
- **Outside communication**: Communication boundaries are equally as import to set. Patients and families should know in advance, the appropriate way(s) to communicate with you between visits. For example at our institution, we avoid sharing our email address or direct telephone number and instead funnel questions through our program nurses to triage the questions or concerns. The electronic medical record has recently expanded the options for communication between patient or caregiver and provider. Age-dependent confidentiality rules may vary by state. Currently in the state of Washington, adolescents age 13 and older may have their own personal and confidential

account to communicate with medical providers. Teens can grant their legal guardians "proxy access" which allows the parent to see limited information.

- **Learners and Mentoring in Clinical Settings**: As an expert in adolescent nutrition, you may be called upon to teach and mentor others. The best way to support a positive interaction with learners is to have ground rules for any observer. For example, if a student is supposed to be observing your interactions in a clinical setting, but is trying to connect with the patient over having a similar background or being of similar age, it is important to intervene and redirect. Once you are outside of the room and in a private space, remind them of the ground rules.

Developing Rapport

Developing rapport is a necessary component of a successful visit. There are multiple components to successful development of rapport and these include: physical setting, focusing your mind, etc. The remainder of this section will expand upon these themes and how a provider can further develop rapport through clinic visits.

Physical setting The physical setting in which you conduct visits plays an essential role in rapport building. The room should be well lit and the patient should be seated in a position that facilitates discussion. Consider having armless chairs so that body habitus does not impede the adolescent's ability to feel comfortable while seated. If possible, the computer or desk should be located in a place that your back is not to the patient while typing. At the same time, be sure you have access to the door in the event a quick exit (for a quick consult or even an emergency) is necessary.

Focus Your Mind It is essential to center one's self before entering the room. Be sure to clear any expectations you may have for the session regarding how it will go, etc. Be mindful

of implicit biases you bring to the interaction (subconscious reactions or thoughts to the patient name, gender, age, body size/weight, native language, ethnicity, insurance status), and consider how they may affect your interaction and ability to provide equitable care. Spending a moment on self-care and mindfulness can bring a heightened awareness to who is in the room, how they are feeling, how you are feeling/thinking and provide insight as to how to how to proceed in the appointment. This can help ensure you interact in real time instead of relying on pre-set messages of what you think you should be saying [5].

Avoid pre-conceived agendas and messaging You may have a general sense of what topic you'd like to discuss or a plan you would like to put in place, but it is imperative you be prepared to accept the teen and caregiver where they are in regards to behavior change. We are there to support and nurture. Throughout our visit, we can ask questions and facilitate conversations around what they have been able to accomplish, even if it is the very act of getting to the appointment. Other accomplishments may include, making one incremental change in eating or activity; going to school more regularly; progress with a feeling or attitude about making a change in any of the areas you have been discussing. The acknowledgement of meeting a patient where they are is a vital part of nurturing; this is an area where the patient may have previously missed getting support from other health care professionals or family along the way.

Build trust A good and trusting relationship is built over time and cannot be expected to be accomplished in one visit [6]. Always, introduce yourself and ask about preferred names or nicknames. Try to determine intent of the visit. For example, you could say "I'd appreciate it if you can tell me what brings you in today and what you expect to get out of our visit". Try to avoid asking the patient directly about "goals" when you first meet them as it can be inferred as "pass/fail" "right/wrong" or simply put them on the spot and can diminish rapport building.

It is important to verbally outline the structure of the visit so both the adolescent and parent/caregiver know what to expect. Start the assessment together and acknowledge parents' input, but let parents know you will begin education and individualize a plan with the adolescent on their own. You may need to remind parents that you will spend time alone with the teen. This gives the adolescent space to speak freely without their parents present, helps develop a sense of autonomy over their health, and allows parents to begin the process of planning for transition to adult care.

Be inclusive Once alone with the adolescent, review and reinforce confidentiality, provider gender affirming care, and use nonjudgmental language to gain trust. Teenagers need reassurance most things discussed will be confidential. Talk with them about times when confidentiality would be breeched (such as concern for their safety). See Chap. 2 (Confidentiality) for more detailed information on confidentiality. Gender affirming healthcare supports a true sense of identity and allows the adolescent to feel fully accepted. Ask about preferred name and gender pronouns during the initial visit. When providers used non-inclusive language, adolescent participants felt unaccepted, as opposed to feelings of "relief or elation" when their chosen name or pronouns were used [7]. Please also see Chap. 26 on Gender Diverse Youth for more information on gender-affirming care.

Meet them where they are and emphasize strengths The objective of a first visit is to get to know the patient. Be prepared to make a comment about something neutral that you can both relate to – "beautiful weather out there today" or "what are your plans for the rest of the day?" If this falls flat, do not worry about it – at least you have made the effort to connect. It can be important to ask again about their hopes for the visit when you are alone. If a teen appears particularly put off by the visit, acknowledge where they may be. Did they know about the appointment? Are they upset they have missed school? Are

they missing other activities to be here today? As you continue the session, try to weave specific questions around getting to know your patient into your nutrition assessment. Be sure to ask about interests and hobbies. Use this time to probe a little further around comments that came up during your time with parent(s). Plan to reflect on teen's feelings and thoughts around their interaction with parent/caregiver. Be sure to reassure the teen that you are on their side; that you will advocate for them. As you gather more information, remind the teen it is a safe environment with no "right" answers. Let them know you are not judging their answers and only trying to better understand their day-to-day life.

Choose the language and teaching methods you use Be sure to use language the patient can understand and avoid unnecessary medical jargon. Teens do not like being talked down to because of age or difference in education levels. A nonjudgmental style conveys respect [1].

In order to create behavior change, teens need to feel educated and empowered to make changes. Spend time reviewing and discussing concepts. You can do this via pen and paper or through the internet. Work to create small achievable goals between visits. It can be helpful to write these goals down together. Some teens like using tools such as a log or journal. These should be created together and can be used to track progress. If time permits, do a summary at the end of the session with parents back in the room. This is known as a 'teach back'. Teach backs have been found to be associated with more patient-centered communication and increased affective engagement of patients [8]. Share with parents what the teen is doing well (make sure the teen knows you will discuss this ahead of time), either by letting the teen share (preferable) it or if they feel uncomfortable, you assist in doing it. Provide printout copies of the goals set forth for the next visit if you have decided it would be effective to write them out for a particular teen and/or family.

Be relaxed and pace your messaging This skill takes time to master. Remember you are the expert and this level of confidence shines through to the adolescent. Let conversation flow naturally and avoid having a set agenda. Welcome silence. Be prepared to change course multiple times throughout a visit. Leave room for spontaneity. Try to steer away from dichotomous thinking. Allow the teen to see that two opposite things can be true at the same time as opposed to thinking something is good or bad. For example, a teen may say "chips are bad" and "fruit and vegetables are good". You could rephrase this dichotomous thinking by saying "all foods work. All foods provide energy for the body". And then either at the moment it comes up or, during the education section of your visit, take the time to describe the concept of metabolism and how it applies to the patient. See the chapter on Wellness and Excessive Weight Gain for how to review metabolism during the clinical encounter.

Don't assume that patients will share ideas openly right away. Providers should be patient with their adolescent clients. When teens feel comfortable, they will be more willing to talk and open up. In the meantime, if an adolescent is not answering questions the provider should respect this and move on. Giving the adolescent space to speak freely is essential, but pushing them to talk is not conducive or necessary. It can sometimes be helpful to acknowledge if she/he is not focused on what you are talking about or simply not interested in being at the visit at all. Adolescents want health care providers with compassion and understanding, an ability to communicate with adolescents, a willingness to be straightforward and honest, and, who are competent, kind and warm [9].

Avoid changing providers within the same discipline In adolescent focus groups, participants identified that they strongly preferred a relationship with a consistent provider [10]. They feel more comfortable opening up to someone who is familiar with them. If a provider switch has been determined to be necessary by the care team, make every effort to ensure there is a warm handoff between providers.

Use of Motivational Interviewing (MI) to Develop Rapport

Motivational interviewing (MI) is an empirically supported approach to patient-provider communication that is characterized as "a therapeutic conversation that employs a guiding style of communication geared toward enhancing behavior change and improving health status" [11]. MI has recently been cited as a component of effective management for nutritional disorders in adolescence [12].

In the past several years, we've noticed that members of the inter-disciplinary team appear to be more familiar with MI after completing professional degrees though there appears to be great variability based on the institution attended. Therefore, while we will review essentials of MI in this chapter, it should be considered an introduction and then the reader should consider additional in-depth reading and training [4]. Once training is completed, it is essential to begin to weave concepts into your practice, and utilize until it becomes natural. For example, on a return visit with a patient you could ask "what do you remember from last visit" versus saying "do you remember what we talked about last visit?"

It may be tempting to skim an article on MI or attend a one-hour workshop and then begin using MI tools such as the confidence ruler or develop a list of pros and cons around making change and call this MI and feel you're "doing MI." Instead, we have found asking permission and using OARS (open-ended questions, affirmations, reflections and summary statements) are considered to be the core, and most helpful, MI skills [13]. Underlying all of this is recognizing the right of autonomy of the adolescent (as well as adults) to make their own decisions.

Asking permission Clinically, the authors of this chapter agree that the essential MI skill a clinician needs to be aware of, and be able to employ on regular basis, is asking permission (at the beginning of a session and then throughout the conversation if the patient has shown an interest in acquiring more information or indicated an interest in making changes).

Furthermore, as we've taught this to clinicians of varied professions, we've come to realize that the most important place to start is asking permission (e.g. "I'd like to take a few minutes to talk about what activity you like; is that OK?") and asking an open-ended question. Asking permission sets the stage that the patient is in charge and has ultimate control of the session. Next, being able to ask a good open-ended question will almost guarantee that the clinician will have plenty of material to affirm or reflect upon which will help develop the conversation and keep it going to help develop the relationship.

Open-ended questions An open-ended question is one that invites a person to think a bit before responding and gives them plenty of latitude on how to answer [13]. Typically, these are questions that can't be answered with a yes or no or a very short answer.

Affirmations Affirmations comment on something that is good about the person. They involve noticing, recognizing and acknowledging the positive. An affirming comment can be about something specific such as intentions or actions. It's possible to affirm by re-framing the teen or parent's actions or situation in a positive light. In general, avoid affirmations starting with I. I statements put the speaker in a one-up position and can come off with parental overtones [13].

Reflections The essence of a reflective listening response is that it makes a guess about what the person means. The reason for responding with a statement rather than asking a question is practical: a well-formed reflective statement is less likely than a question to evoke defensiveness and more likely to encourage continued exploration [13].

Summary statements Summaries are essentially reflections that pull together several things that the person has told you. They can be affirming because they imply "I remember what you tell me and want to understand how it fits together."

Summaries also help clients to hold and reflect on the various experiences they have expressed. They not only hear themselves describing their experiences, but they also hear you reflect what they have said in a way that encourages them to continue [13].

A simple rhythm is to ask an open-ended question and then reflect upon what the person says, perhaps two reflections per question but do avoid using a rigid formula. The key is to rely more on reflections than questions [13].

Remember, all of these skills will require courage to try and then practice because they are essentially different from the traditional medical model of asking questions to get needed information to make a diagnosis or tell a patient what they need to do. We have provided Table 3.1 for your reference so that you can review where you are and then try a new approach using MI principles (adapted from [13]).

Rolling with Resistance A less-mentioned concept in MI that is important to keep in mind is rolling with resistance. Resistance is a natural response by patients to the idea of change and is seen by those of us working with adolescents and parents as common and certainly not full of malevolence. On the provider side, we need to be aware of and cautioned against using one's own righting reflex. The righting reflex is natural reflex to try and "fix" or make something better for the patient and set them on a better course [13]. The righting reflex is natural and while not intended by providers to be top down yet can get in the way of identifying desire for change and developing rapport.

Time Concerns It may seem to you that using an MI-informed approach this will add a lot of time to your clinical sessions. We have heard this from providers we are training in MI. We encourage you to keep open to the idea of trying OARS or even an element of OARS such as open-ended questions in your clinical conversations. As you become more practiced, it will feel more natural and take less time.

Table 3.1 Description and Practice of OARS

Techniques	If you currently say or do…	Try this…	Practice
Open-ended questions – Cannot answer yes or no – Creates impetus for forward movement to help individual explore change	Closed-ended – Did you… – Can you… – Will you… – Is it…	– Rephrase so that the answer provides more information – Get them to tell you more – how often, to what extent – Explore what they think – Tell me about, why might you want to make this change? – See what they already have in mind – How might you go about it, in order to succeed? What are three reasons to do it?	Try re-writing these as open-ended questions: – Are you making sure your child is physically active every day? – Do you fix your child breakfast every morning? – Do you have professional goals for this year? – Can you stop spending money?

Affirmations – Ask open-ended questions in order to uncover something positive & then affirm it. – Statements of recognition about individual strengths – Helps individual feel change is possible – Be aware of "cheerleading" – can be patronizing	– Were you successful or unsuccessful? – Were you able to follow the plan? – Did you do anything this week? – I'm so worried about you – You don't seem to be making any progress – I know you can do it	– Point out strengths where the person only receives failure – Consider effort, intentions, partial successes – Be genuine – Be specific and personal – Use resistance as the source for affirmation	– I see that you were able to eat breakfast this week. Nice work! – Sounds as if you were able to get in by 8 AM several times this week. – The last time we met, you talked about classes that might interest you. You must have done some research – that's a good first step. – Sounds like you are delaying your remodel to save money.

(continued)

TABLE 3.1 (continued)

Techniques	If you currently say or do…	Try this…	Practice
Reflective listening – Listen carefully to patient – Vary level of reflection. Avoid only comments at the emotional surface. – If you are right, emotional intensity of session will deepen. If wrong or patient not ready to deal with, the patient corrects you and the conversation moves forward	– Clearly, you're not doing well. – Everyone seems really mad about something in this room. – I'd like you to work on … – Uh huh (looking around the room) – Eye rolling, sighing heavily – Looking at the clock, phone or computer – Multi-tasking	– Statement, not question – Voice should go down – Takes hard work to practice – Starts with: So… Sounds like… You… So, one hand…but on the other…	– It sounds like you are feeling tired in the morning and can't get up to make breakfast. – So, you are saying you are having trouble understanding the bus schedule. – So, you're saying that you are confused about how to develop a savings plan.

Summary statement – Communicates interest in individual and helps develop rapport – Can shift direction if necessary	– I gotta get going, see you next time. – Gosh, you have a lot to do but it's going to be fine. – So that's it. – You've got everything you need, right?	– Begin with announcement that you are about to summarize – Be selective and concise – Note ambivalence – Invitation to correct anything – End with an open–ended questions	– I see you want to use teach backs to help your patients demonstrate what you've shared, yet I hear that you are struggling with the time it takes away from giving them more info. What could you eliminate? Can you try it once later today? – To summarize, you're going to start by setting aside $50/week and see how that impacts your budget. How will you know if that feels okay for you?

When Providing Information is Imperative Our experience and the literature indicate that using OARS helps develop rapport, trust, and ultimately develop a relationship from which the adolescent will benefit. We recognize that initial visits and return visits are designed to check progress, labs, and provide additional support in terms of problem-solving and goal-setting. That being said, the patient may need information right away. For example, at a return visit, if a teen says, "I am going to cut carbs to lose weight" it will be important to provide information and educate. As with OARS, start by asking permission. "I hear you have an idea of what you would like to do to feel like you have more energy. Are you okay if I ask you a couple of questions to understand this more?" Then, utilize Elicit, Provide, Elicit (EPE) [14].

- Elicit: Ask an open-ended question to focus your informing. What do you already know about "carbs"?
- Provide: "Carbs" (carbohydrates) are your body's main energy source. They help your brain, heart, lungs and muscles work. Without them, you break down muscle that gives you strength and shape. (This example provides information in simple, easy to understand terms).
- Elicit: Elicit the patient's response to the of information you just provided. "What might this mean for you?"

Promoting Satisfaction/Preventing Burnout

In addition to some of the guidance listed above and below to help promote satisfaction with your work and thus prevent burnout, it is important to develop self-compassion and show grace to self and others. Allow time for self-care, in the type and amount that works best for you. Burnout can manifest in different forms: emotional fatigue, cynicism, lack of empathy, etc. Recognize your limits and signs that you may be emotionally fatigued. Another important aspect of care to consider is our own implicit biases. Many times, having a different perspective and goals than the patient can lead to emotional

exhaustion. Our own implicit biases may be involved when this occurs. It is important to recognize bias so that we can work to remove it. For more information please see the Chapter on Supporting and Promoting Health Equity.

Additionally, experts have written about how to cope with challenging interactions and suggest that recognizing the physical or emotional responses triggered by challenging patients/families may allow the provider to effectively partner with, instead of confront, the patient or the family [15].

Reflection is a key competency in working with adolescents and it can be used clinically or in leadership [16]. In order to work with teens and their families it important to be aware and reflect upon one's own experience as an adolescent and in family/caregiver interactions. This way, you can be prepared for reactions you may have in a session and then be able to reflect upon them further either on your own, with a trusted confidant or one of your team members. These reactions are normal and can be considered countertransference. Counter-transference is defined as the complex of feelings of a psychotherapist toward the patient [17].

Working with an inter-disciplinary, inter-professional team has many benefits that can promote satisfaction and prevent burnout. The team allows the sharing of responsibility of caring for teens. As a provider, you can obtain perspective and guidance on next steps via care conferences and team meetings. You can use case management to work through complexes case and identify recommendations for next steps. A team allows providers to relay a unified message. One way to ensure consistent messaging amongst team members is a warm hand-off. A warm hand-off helps set expectations for the next clinician's interaction and reinforces the importance of the team approach. It also can instill confidence in the family that the team is working together.

Supervision and mentoring can also provide support to help promote satisfaction and ultimately prevent burnout. Meeting regularly (realistically no more than once a month) with a trusted colleague, manager or mentor is suggested and

can provide perspective. Additionally, supervision is the perfect place to get validation that you are still providing value for patients even when there appears to be little or no change taking place [4].

Food and Nutrition Approach

While the authors have been working with adolescents for many years using the approach outlined below, we were pleasantly surprised to get support for our approach when the Academy of Nutrition and Dietetics (AND) published a new position paper stating that the total diet or overall pattern of food is the most important focus of healthy eating. Focusing on variety, moderation and proportionality in the context of a healthy lifestyle, rather than targeting specific nutrients, foods or calories can help reduce consumer confusion [18]. Additionally, the Society for Adolescent Health and Medicine (SAHM) recent new position paper [12] takes the following position that furthers this approach: providers should have a balanced and unified approach for counseling all adolescents with nutritional disorders – regardless of weight – about healthy patterns of eating and activity.

Make It Accessible and Individualized

In order to help make nutrition education accessible for the teen and caregivers, make sure the information and conversation is:

- Developmentally appropriate and based on normal adolescent development [12]. Consider the developmental stage for each individual you see. As stated in the chapter on adolescent development (Chap. 1), younger teens are more concrete in thinking about ideas and older teens are more capable of abstract thinking.
- Limited in technical language and jargon – use scientific terms but be prepared to explain them and use a more

appropriate word using the teen's vernacular. If a teen is not responding or is looking worried, blank, or overwhelmed, reframe your language to simplify words and try again. Conversely, try to avoid public health "bullet points" messaging because they aren't tailored to the patient's needs. Our clinic's youth advisory board is requesting clinicians provide even more in-depth science-based education about how the body responds in various conditions such as anxiety, etc.

- Strengths-based and grounded off a good nutrition history and informed by Motivational Interviewing (MI) [12]. Additionally, be sure to base education on what the teen is already doing well. It may be a change in practice for the provider to emphasize what is going well but it is essential to build trust.
- Based on a thorough nutrition history – (please see the chapter on Bulimia Nervosa, for an excellent review of how to do this). If a patient is restricting (regardless of weight status), they may not have the glucose on-board in their brain to be able to understand and process your input. Simplify input if needed and make sure the patient has return visits scheduled so that you continue to build on topics. This can take multiple visits until the patient demonstrates understanding and is applying it to their behavior. Of note, sometimes a full history will take several visits to obtain if the teen is compromised nutritionally or if the psychosocial situation is complex.
- Informed by team input (or your own observation) regarding emotional status. As you communicate regularly with team members, if you hear that the teen is overwhelmed by pressing social issues, it is okay to slow down the rate at which you are imparting information.
- Individualized for each adolescent. It can be tempting to make assumptions based on too little information or even a visual assessment in the interest of time available in clinic, standard work, etc. See Chaps. 8, 10, 11, 12, 26 etc. for why assumptions are counter-productive and even damaging to the teen.

Ground Nutrition Advice in the Science of Nutrition as Well as Evidence in Order to Avoid Promoting Dichotomous Thinking ("Good vs. Bad")

As stated earlier, the total nutrition approach has been suggested by the Academy of Nutrition and Dietetics and provides a much-needed paradigm from which to base recommendations [18].

We've identified and woven together evidence-based key themes to offset negative messaging about food, body image and weight bias in our culture. Moreover, our aim for these themes is they support non-judgmental messaging that normalizes balanced eating and promotes growth and development. They can be used as nutrition education or as part of a clinical treatment. This approach includes three guiding principles:

- Food works to support the body;
- Restriction doesn't work to support the body;
- A supportive environment helps support the body.

Our goals for nutrition sessions are to promote self-regulation so that a child/teen grows and attains his/her genetically determined body type; establish or reclaim (through education, counseling, and experimentation) self-regulation to normalize weight, body composition, food relationship; and enjoy food and eating– eat when hungry and stop when satisfied, most of the time [19].

Nutrition Education Tools

While non-nutrition professionals can introduce the concepts (e.g. eating breakfast or adding a snack mid-afternoon), the nutrition professional is essential to be able to effectively provide the appropriate level of information based on a thorough nutrition assessment. A certified nutrition professional

has both a breadth and depth of understanding of the sciences behind nutrition – physiology, biology, anatomy, chemistry, food science, etc. to provide these tools and concepts.

- Describe metabolism verbally and visually – please see the chapter on Wellness, for an excellent description on how to do this.
- If needed, put the concept of calories in perspective – define a calorie for what it is and then put the caloric value of a food into perspective in terms of a portion of the total value that is needed to keep a person alive, growing and active.
- Describe foods and the nutrients they provide, including micro and macronutrients.
- Visualize patterns of eating that support a person.
- Describe energy use during various types of activity.
- Keep guidance positive and realistic – resist the temptation to provide a long list of to-do's. Through an MI-informed approach, determine 1–2 steps the teen is willing and able to take over the next 1–2 weeks!
- Provide a written meal plan for visual guidance only after 3–4 visits of discussing the above and if you do, be sure it is based on what the patient is already doing well and is individualized based on their history and preferences. Be sure to let the patient and family know that this is only a road map and not intended to add rigidity to eating. Help them know that eventually they will be able to plan, prepare and eat meals more intuitively.

Concluding Thoughts

Never underestimate the value of a team in supporting adolescents and emerging adults. Putting in the time and energy towards developing an approach to support evidence-based food and nutrition messaging amongst all types of providers presents many opportunities. These include but aren't limited to: strengthening the roles of a multi-disciplinary team members; decreasing the burden that one provider type is solely

responsible for nutrition messaging and behavior change; developing new interdisciplinary working relationships; strengthening health messaging for adolescents and families, and ultimately our patients and the public.

We hope this chapter has provided you with insight on how to communicate with adolescents. From our experience, we have found these approaches to be satisfying and helpful for teens. We encourage you to work on applying some of these strategies in your own work, recognizing that it takes courage to try these practices, themes and messaging. Be patient. At the core, remember we are trying to provide nutrition care in a *nurturing* way – the way that the feeding process ought to be for every child. Let this message guide your work.

References

1. Daley AM, Polifroni EC, Sadler LS. Treat me like a normal person! A meta-ethnography of adolescents' expectations of their healthcare providers. J Ped Nursing. 2017;36:70–83.
2. Deering CG, Cody DJ. Communicating with children and adolescents. AJN. 2002;102(3):40.
3. Peregrin T. Maintaining professional boundaries in the practitioner-patient/client relationship. J Acad Nutr Dietet. 2018;118(11):2174–7.
4. Kellogg M. Counseling tips for nutrition therapists, practice workbook, vol. 1. Philadelphia: Key Press; 2006.
5. Vo D. Staying present: Mindfulness in health care. http://med.ubc.ca. March 17, 2017.
6. Cooper A. A reflection in practice: communication with a teenager. Dermatol Nurs. 2018;17(1):9–12.
7. Brakman A. Gender-affirming healthcare: how providers can do better. Contracept Technol Update. 2016;37(12):1–4
8. Badaczewski A, Bauman LJ, Bland AE, et al. Relationship between teach-back and patient-centered communication in primary care pediatric encounters. Patient Educ Couns. 2017;100:11345–52.
9. Ferri R, Veroneau P. Initiating a dialogue with the adolescent patient. Am Nurse. 1998;30:6–7.

10. Schaeuble K, Haglund K, Vukovich M. Adolescent's preferences for primary care provider interactions. J Ped Nursing. 2010;15:206.
11. Carcone A, Jacques-Tiura A, Brogan Hartlieb KE, Albrecht T, Martin T. Effective patient-provider communication in pediatric obesity. Pediatr Clin N Am. 2016;63:525–38.
12. Kumar MM, AlBuhairan F, Galagali P, Dixon Docter A, Weiss A, Keough L. The society for adolescent health and medicine. Addressing Nutrit Disord Adolesc. 2018;62:120–3.
13. Miller WR, Rollnick S. Motivation interviewing, helping people change. 3rd ed. New York: Guilford Press; 2013.
14. Rollnick S, Miller WR, Butler CC. Motivational interviewing in healthcare, helping patients change behavior. New York: Guilford Press; 2008.
15. Breuner CC, Moreno M. Approaches to the difficult patient/parent encounter. Pediatrics. 2011;127:163–9.
16. Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration, (HRSA), US Department of Health and Human Services, MCHB competencies: https://www.mchnavigator.org/trainings/competencies.php, extracted 22 Oct 2019.
17. https://www.merriam-webster.com/dictionary/countertransference; extracted 8 Aug 2019.
18. Academy of Nutrition and dietetics, position of the academy of nutrition and dietetics: total diet approach to health eating. 2013, 113(1):307–17.
19. Satter E. Your child's weight… helping without harming. Madison: Kelcy Press; 2005.