Diet Therapy

Interviewing the Patient

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THE ABILITY to do a good job of interviewing patients, whether for medical, social or dietary purposes, can be an extremely valuable asset. Often the key to a diagnosis may be in what the patient tells you if he is given the opportunity under circumstances in which he feels comfortable. One of the keenest diagnosticians I have ever known when asked how he arrived at diagnoses others had missed often replied, "Why the patient told me."

Good dietary interviewing, too, can be a valuable diagnostic aid. The ability to obtain a reliable dietary history and thus appraise the dietary status of the patient and its contribution to his total nutrition may be the best way to obtain an early clue to potential nutritional difficulties. It also forms the basis for the individual instruction of the patient when special dietary treatment seems indicated.

Good dietary interviewing requires skill, time and some background knowledge of what goes into forming food habits, their significance and the factors which affect them. If dietary history or dietary instruction is worth doing at all, it is worth doing well. This article is addressed to those who believe that the diet of the individual and his nutrition are a matter of concern to his total health.

It is important to be aware that food intake and eating habits represent one of the most complex facets of human behavior. When one attempts to influence food habits he is not dealing just with physical nourishment or an intellectual matter. One is using instead an intellectual approach to a highly involved behavior pattern. Wallen[1] has said that feeding activity ranks with sexual behavior as a demonstration of that peculiar and delicate interaction of biological, psychological and cultural influences so often found in the study of human wants.

Acceptance of food is a composite of biochemical, physiologic, psychologic, sociologic, cultural and educational factors. When this is understood and appreciated one can readily understand why it is one of the most difficult aspects of human behavior to change. One can also understand why a good dietary interviewer needs to learn all he can about the person being interviewed. People cling to their customary food habits, especially when other disquieting events may be taking place in their lives, for food has far more significance to them than physical nourishment alone. This realization may cause the physician to question whether the advantage to be gained by the special diet is worth the disruption of the security the patient has in his present patterns. However, once the decision has been made in favor of such disruption every effort must be made to fit the therapy to the patient and his immediate circumstances. One should not delude himself that giving a printed diet list to an unprepared patient is a form of therapy. Unfortunately, this is exactly what the busy physician thinks he must do: pull a printed diet list from the file that is proper therapeutically to the condition of the patient, tell the patient to follow it, and then believe he has discharged his responsibility. Actually poor

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diet therapy is often worse than no therapy at all for the patient may be switched from a "not too bad" normal regimen to one which he only partially understands and can only partially follow. If a therapeutic diet is worth prescribing, it is worth presenting in such a manner and adapting to the patient in such a fashion that there is some hope he may follow the diet. Occasionally, perhaps, the limited time spent partially presenting a therapeutic diet might better be spent in helping the patient to achieve a reasonably decent normal dietary regimen.

THE PHYSICIAN

Dietary interviewing takes skill, and is dependent upon good rapport between the patient and the interviewer. Not everyone has this ability. A good physician should be an excellent person for dietary interviewing since, in many cases, he is extremely skillful at dealing with the variables of human personality that are involved in the developing of rapport. In these cases the physician should interview and instruct the patient if he can possibly take the time and if he has a real interest in diet therapy. His prestige and status with the patient adds significantly to anything he has to tell the patient. In a study among homemakers in two big cities in New York State it was found that what the doctor had told them about food impressed them more than the information given them by any other professional person.[2] Such findings indicate an opportunity, challenge and obligation for the busy physician. Furthermore, since diet and food habits are so intimately connected with many aspects of a patient's life, a good diet interview may, in an indirect fashion, give the physician excellent clues to the general emotional state of the patient, his living conditions, etc., which could be of value in the therapy as a whole. This is another reason why it is particularly desirable for the physician to interview the patient if he has the time and interest.

If, however, the physician does not have the time, interest or particular skill to interview the patient he may turn this portion of his responsibility over to someone who does: a nutritionist, dietitian, nurse or even office helper if she is the right kind of person and has been instructed properly.

THE INTERVIEWER

The interviewer should be one who recognizes and understands the needs and attitudes of the patient, i.e., his need to protect or preserve his self-respect, which may be expressed as anger, hostility, defiance or "superior" attitude; his fear, expressed as insecurity, anxiety and the various means used to cover up fear; and his need for dependency and love.[3] The interviewer needs to be aware of the various needs and attitudes of the patient, to consider each patient as an individual, and to know what such attitudes mean if she is to be more understanding when dealing with the patient. She should have the ability to put the patient at ease in a warm friendly manner backed by absolute sincerity and honesty. Behind this must be a basically sincere interest and love of all kinds of people. A relaxed manner (sometimes hard to achieve when pushed for time) and a quiet unhurried "willingness to listen" create an easy atmosphere. It is a matter of building the right climate so that the patient will feel free to talk. Too many interviewers, in their own uneasiness, tend to chatter to fill the time lapses or, worse yet, jump to conclusions or put words into the patient's mouth. It is a matter of taking time and being willing to listen. Empathy, the ability to project one's self into the role of the patient with sensitivity to his needs and feelings but without over identification, is a great help. The interviewer must have an unjudging, unchastizing attitude with the ability to appear interested in but unsurprised by anything the patient may tell her. She must be capable of great flexibility, insight and practicality, always keeping in mind the real problems of the patient.

If the doctor does assign the dietary interviewing responsibility to someone else then he must give this person and her function prestige value in the eyes of the patient. He should make provision for keeping informed on what is going on and for receiving a report from the therapist or the patient. It is just as impor-

tant that the physician be aware of this aspect of therapy so that it can be tied in with the other therapy of the patient. Again we urge that no one tamper with the eating habits of the patient unless he intends to carry the therapy through and make it a constructive part of the total program.

TECHNICS

How one carries out the dietary interview depends upon the patient and the therapist. There are no uniform or standard procedures which should or could be laid down as applicable to all patients in the hands of all therapists. The method should be adjusted to the needs and conditions of the patient at the moment the instruction is being given and to the particular skills of the therapist.

One factor is certain, adequate dietary interviewing takes time. Little can be accomplished in most initial interviews during the ten or fifteen minutes often allotted. Sufficient time must be provided either through a longer initial interview or through closely timed follow-up interviews. Often there may be an advantage in the latter since initially the patient may be so confused and anxious that he absorbs far less than his intelligence might indicate.[4] If someone other than the physician does the interviewing she should introduce herself and make her role quite clear to the patient.

A climate should be built in which the patient feels relaxed and at ease so that he may talk more freely, remember better and receive instruction more easily. One wishes to know all he can about the patient: from his record, from other therapists and most especially from the patient himself. This can be accomplished by helping the patient to talk freely and then "reading between the lines." If the physician does the interviewing he probably has the advantage of an already established rapport as well as the knowledge of the background of the patient. Others may start by asking such general questions as height, weight, age, family composition, what he does, where he lives, etc. Often the extraneous conversation which these inquiries may produce (including either too profuse or too inhibited response) may be of more use than the answers to the specific questions in informing one about the patient. More specific questions with regard to food intake and habits may then be covered quite quickly: where he eats; with whom he eats; when and under what circumstances; who prepares the food; what preparation and storage facilities are available; shopping facilities; money available for food; the regularity of eating patterns; the usual (if any) eating pattern, as to what, amount and variations; between meal eating, what, when, under what circumstances; and, finally, a cross check of the information on actual food intake.

INDIVIDUALIZATION

Diet therapy should be built on the present food habits of the individual since these are already acceptable to him. Hence it is desirable to change them as little as possible. It has been said that the acceptability of food to the patient is the largest single factor in effecting changes in food habits. The advice given needs to be something which the patient can reasonably hope to adapt to his usual pattern of living. I believe a printed diet list should be avoided as much as possible since it is important for the patient to think that the plan is developed for him and his particular needs, as indeed it should be.

Dietary information should be summarized on the general clinic record of the patient and in addition, in detail on a card in a place set aside for it. Often this second record may contain a running report on subsequent visits as well which will help in re-establishing rapport and in finding the solution to continuing problems.

Dietary interviews usually should be followed by subsequent, perhaps briefer, visits. In certain cases too much information should not be given during the first interview for fear of overwhelming the patient in his anxious state. Often the patient can not absorb all the information given him during his first visit or he has no questions at the moment. However, when he tries to carry out the instructions he may find he has many questions. It is important that these be dealt with carefully

and not disregarded. Small practical points may make a difference in whether or not instructions will be followed. Also, the willingness of the interviewer to help on fine points may impress the patient with the importance of his diet to his general welfare. If the inquiry is brushed off, the patient interprets it as "can't be very important anyhow." If one does not know the answer to a question it is better to tell the patient so, to treat his question with respect and to try to find the answer. In many cases, it may be useful to talk not only with the patient but also with the person responsible for his food planning, purchase and preparation. If, during the dietary interview, one is primarily concerned with obtaining a reasonably accurate picture of present food intake, it may be advantageous in certain cases, to check the diet picture again later after the person has been sensitized to "being aware" of what he is eating. Most normal people, unless they have some food responsibilities, give little thought to their food habits, hence the value of the information may be greater after the person has been geared to think of what he eats.

Dietary interviews are best carried out in a quiet, calm place with some degree of privacy. This may exist in the office of the physician; however, if someone else is doing the interviewing it is particularly important to remember this need. Food habits are personal matters which deserve some privacy; also recall is much better when there is some freedom from distractions.

Any materials used in interviewing should be patient-centered. There is merit to brevity, simplicity of language, practicality, accuracy, logical sequence and factualness (which is what the patient is looking for when he actually begins to understand the material presented). Graphic presentation is particularly important if there are any language or numerical handicaps.

Interviewing can be rewarding if carried out with skill and interest and allowed sufficient time.

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