PERCEPTIONS OF RAPPORT AMONG CLIENTS OF A MEDICALLY UNDERSERVED CLINIC IN WESTERN NEW YORK

By

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Abstract

Dietitians strive to provide their clients with accurate, science-based nutrition information to prevent, manage, or treat nutrition related diseases. Effective nutrition counseling is dependent on the formation of a therapeutic relationship with good rapport at the foundation of that relationship. Rapport is the connection and mutual understanding shared between a health care professional and his or her clients built on trust, respect, empathy and interpersonal communication. In the literature, rapport has been linked to improved health outcomes, quality of care, and client satisfaction. The purpose of this qualitative study was to understand the perception of rapport and rapport building from clients currently receiving nutrition counseling from a registered dietitian at an underserved, inner city health clinic. Eight patients of an outpatient dietitian participated in researcher-led, semi-structured interviews to understand the client's views of rapport. This study revealed that participants believed that their dietitian spending extra time with them beyond the scheduled class session facilitated rapport-building. Participants also believed honesty, personal connections, social support were vital to their relationship with their dietitian, in addition to trust, respect, and empathy.

Keywords: Rapport, medically underserved population, time, trust, respect, empathy.

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Chapter I

Introduction

According to the Academy of Nutrition and Dietetics (AND, n.d.b), dietitians are food and nutrition experts with specialized training to help individuals make positive lifestyle changes. Through nutrition counseling, dietitians strive to provide their clients with accurate, science-based nutrition information to prevent, manage, or treat nutrition related diseases. Effective nutrition counseling is dependent on the formation of a therapeutic relationship between a dietitian and his or her client. A therapeutic relationship is defined by "a trusting connection and rapport established between therapist and client through collaboration, communication, therapist empathy and mutual respect" (Cole & McLean, 2003, p. 44). In this way, rapport is considered the foundation of a therapeutic relationship.

Rapport is the connection and mutual understanding shared between health care professionals and their clients (Norfolk, Birdie, & Walsh, 2007). It is built on mutual feelings of trust, respect, and empathy and external expression of those feelings through communication (Barnett, 2001; Cole & McLean, 2003; Holli & Beto, 2014; Leach, 2005; Norfolk et al., 2007; Sladdin, Ball, Bull, & Chaboyer, 2017).

The ability of dietitians to develop rapport with their clients has been recognized as a key contributor to dietitians' success, and ultimately their clients' success (Vrchota, 2011). Rapport has been linked to improved health outcomes in the field of dietetics because it can lead to improvements in communication, treatment negotiation, nutrition intervention, and health monitoring and evaluation (Barnett, 2001; Leach, 2005).

A poor diet is an associated risk factor related to the development of chronic diseases such as CVD, cancer, and diabetes. These conditions are more common in underserved communities (Bryant et al., 2010; Escaron, 2009; Ruggiero et al., 2010). Understanding rapport from the perspective of an underserved client is important because rapport can influence positive behavior change. Medically Underserved Populations (MUPs) are defined by the Health Resources and Services Administration (HRSA, 2016) as "geographic areas or populations with a lack of access to primary care services" (para. 1). Some specific sub-groups identified within MUPs include populations characterized as low-income, Medicaid-eligible, populations that experience high infant mortality, and the elderly. According to the Centers for Disease Control and Prevention (CDC, 2016), in 2016 the leading causes of death in the United States (U.S.) were cardiovascular disease (CVD), diabetes, and cancer. MUPs were reported to experience higher rates of heart disease (Bryant et al., 2010) and diabetes (Ruggiero et al., 2010), coupled with higher rates of obesity (Escaron, 2009), an associated risk factor for both chronic diseases. It is for this reason that a healthy diet has been identified as an intervention to treat and prevent chronic diseases such as CVD and diabetes, along with some of their associated risk factors such as obesity (Bauer, Briss, Goodman, & Bowman, 2014). Hooker (2013) characterized the MUPs with low treatment success rates due to low treatment compliance. Therefore, a dietitian's effectiveness in nutrition counseling would be crucial for an at-risk population in need of an effective therapeutic relationship.

Statement of Purpose

This qualitative study was conducted to understand the perception of rapport and rapport building from clients currently receiving nutrition counseling from a registered dietitian at an underserved, inner city, community-based health clinic.

Theoretical Framework

My research is guided by Social Capital Theory (Hayden, 2017). Social capital represents the resources and assets that people have access to through the relationships they have with other people, groups, or institutions. These relationships provide access to additional resources, which can include knowledge, social support, and customs. Resources and networks are tools used to promote behavior change. A rich social capital is associated with a healthier and happier life. I view the relationship between a dietitian and his or her client as an exchange of social capital. The dietitian provides nutrition counseling and the client provides his or her unique perspective, which a dietitian should strive to understand.

Social Capital Theory emphasizes the power that relationships have on behaviors and attitudes (Hayden, 2017). As the constructs of Social Capital Theory are networks and relationships, these cannot be formed without trust and reciprocity. For example, the relationship between dietitians and their clients should be built on trust and reciprocity. Networks and relationships need to be maintained if they are going to remain effective for utilizing social capital. Relationships between individuals and groups of people tend to propagate specific behaviors and attitudes unique to those individuals or groups whether they are good or bad. Without a relationship, there is no motivation to adopt

those specific behaviors and attitudes. When a client forms a therapeutic relationship with a dietitian they gain access to positive behavior and attitudes. An example of this would be following a specialized diet provided by a dietitian.

There are three types of relationships included in Social Capital Theory: bonding, bridging, and linking (Hayden, 2017). Bonding relationships are those formed around similarities shared such as a family or a weight loss support group. Bridging relationships are those centered around a single purpose, which brings the group together; for instance, a sports team, students collaborating on a project, or a choir. Linking relationships are formed between a person and an institution such as that of a dietitian and a client. Linking relationships are formed around power and authority. For this type of relationship to influence behavior it must be built on a foundation of trust and mutual respect. Linking relationships can affect attitudes and behaviors because they involve a two-way exchange of knowledge and provision of emotional support. For example, a client can offer his or her nutrition history to the dietitian and the dietitian can provide nutrition counseling that facilitates behavior change. If a trusting connection was established, then the client is more likely to follow the dietitian's advice. Linking relationships like the one described have the potential to positively impact health. This is a result of the relationship formed on trust and mutual respect.

Significance and Justification

As stated above, MUPs are highly susceptible to greater health disparities. According to Social Capital Theory, if a good relationship is formed between a dietitian and his or her client, they can work together to create positive health outcomes in the

client. Therefore, it is important to understand how to effectively build relationships, by way of an established rapport, between dietitians and their clients in this setting.

This research identified factors that hinder and/or facilitate good rapport in the dietitian-client relationship. If good rapport is established, it is assumed that a dietitian can promote healthy behavior change through the power of an effective therapeutic relationship. Past research has looked at the benefit of good rapport in the doctor-client and nurse-client relationship, but there is a limited amount of information on the rapport and the development of rapport in the dietitian-client relationship. There is even less information regarding rapport in the dietitian-client relationship in an underserved population. Past research has also focused on rapport from the perspective of the health professional rather than the perspective of the client. This research added to the literature on this topic and aided in furthering the understanding of this relationship.

Assumptions

1. Truthful answers were given by participants in response to questions asked in the interviews.

2. Interview script was formulated and delivered in a way to successfully explore rapport and rapport-building.

3. The main concepts within this population were accurately reported by participants through semi-structured interview (i.e. what is rapport, how is rapport built).

Research Questions

The research question was:

1. How do clients of community-based health clinic in an underserved neighborhood narrate and reflect upon their perception of rapport and rapport-building with a dietitian?

Definition of Terms

The terms in this research study were defined theoretically and/or operationally.

1. *Dietitian* -- is theoretically and operationally defined as "a food and nutrition expert who can translate the science of nutrition into practical solutions for healthy living using their nutrition expertise to help individuals make unique, positive lifestyle changes" (AND, n.d.b, para. 1).

2. *Empathy* -- is theoretically defined as "the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts and experiences of another of either the past or present without the feelings, thoughts, and experience fully communicated in an objectively explicit manner" (Merriam-Webster's online dictionary [MWOD], n.d.). Empathy is operationally defined as displaying a desire to listen and understanding through specific communication skills such as eliciting information and reflective listening (Norfolk, Birdi, & Walsh, 2007).

3. *Medically Underserved Populations (MUPs)* – is theoretically defined as Medicaid-eligible individuals exhibiting either two chronic diseases or one serious mental illness. MUPs is operationally defined as "geographic areas or populations with a lack of access to primary care services" (para. 1). These populations include but are not limited

to low-income groups, those that are Medicaid-eligible, populations that experience high infant mortality, and the elderly (HRSA, 2016).

4. *Participant* – is theoretically defined as "a person who takes part in or becomes involved in a particular activity" (Cambridge Dictionary's online dictionary [CDOD], n.d.). Participant is operationally defined as individuals who benefit from community-based health clinic programs and services (Boyle, 2017).

5. *Rapport* -- is theoretically defined as "a friendly, harmonious relationship; especially a relationship characterized by agreement, mutual understanding, or empathy that makes communication possible or easy" (MWOD, n.d.). Rapport is operationally defined as the connection and mutual understanding shared between health care professionals and their client (Norfolk et al., 2007) built on mutual internal feelings of trust, respect, and empathy and external expression of those feelings through communication (Barnett, 2001; Cole & McLean, 2003; Holli & Beto, 2014; Leach, 2005; Norfolk et al., 2007; Sladdin et al., 2017).

6. *Respect* – is theoretically defined as "the expression of high or special regard or deference" (MWOD, n.d.). Respect is operationally defined as a "demonstrable attitude communicating the value and autonomy of the client and the validity of his/her concerns" (Flickinger et al., 2015, p. 254).

7. *Therapeutic Relationship* -- is theoretically and operationally defined as "a trusting connection and rapport established between therapist and client through collaboration, communication, therapist empathy and mutual respect" (Cole & McLean, 2003, p. 44).

8. *Trust* -- is theoretically defined as "confidence in the reliability of persons" (Cant, 2009, p. 113) and "assured reliance on the character, ability, strength, or truth of someone or something" (MWOD, n.d.). Trust is operationally defined as a willingness to risk vulnerability, honesty, and openness through sharing (Tschannen-Moran & Hoy, 2000).

Limitations

Limitations of this study included:

1. A selective sample of eight participants will not be fully representative of the entire underserved population.
2. This research was conducted at one site with one dietitian working at the site.
3. Relevant questions needed for data collection may not have been asked due to time constraints associated with semi-structured interviews.
4. Study results are not generalizable to the broader population.

Summary

The goal of a dietitian is to influence change in clients' lives through effective nutrition counseling. Effective nutrition counseling is dependent on the ability of a dietitian to form a therapeutic relationship with good rapport at the foundation. The ability of dietitians to develop a rapport with their clients has been recognized as a key to a dietitians', and ultimately their clients', success. This study focused on rapport between a dietitian and an individual in an underserved, community-based health clinic. This population was chosen because underserved individuals have increased risk for some nutrition-related chronic diseases and therefore would benefit greatly from effective

nutrition counseling. Social Capital Theory was chosen to guide this study because it emphasizes the power that relationships have on behavior change. This study was significant because it added to the current understanding of rapport development in an at-risk population.

This study assumed that (a) truthful answers were given by participants in response to questions asked in the interviews; (b) interview script was formulated and delivered in a way to successfully explore rapport and rapport-building; and (c) the main concepts within this population were accurately reported by participants through semi-structured interviews within the time given for interviewing. This study was limited by a small sample size and time constraints of semi-structured interviews. The next chapter reviews the literature on rapport, rapport as it relates to client change, and how to effectively build rapport with clients.

Chapter II

Review of the Literature

Introduction

According to the Academy of Nutrition and Dietetics (n.d.b.), registered dietitians (RD) "are the food and nutrition experts who can translate the science of nutrition into practical solutions for healthy living. [Dietitians] use their nutrition expertise to help individuals make unique, positive lifestyle changes" (para. 1). Dietitians strive to provide their clients with accurate, science-based nutrition information to prevent, manage, or treat nutrition-related diseases. Therefore, dietitians are trained in nutrition counseling and effective communication to provide future clients with quality care that supports behavior change and helps clients achieve their health goals. This is primarily done through nutrition counseling, which is "the process of guiding clients toward a healthy nutrition lifestyle [through] skillful assessment of the client's problem(s), the facilitation of dietary adherence and food-related behavioral change, and the provision of dietary education, information, and advising" (Fine, 2006, p. 199).

The Nutrition Care Process (NCP) is a guide for dietitians to follow to provide quality nutrition care that promotes behavior change in clients. NCP consists of four steps: nutrition assessment, diagnosis, intervention, and monitoring/evaluation. Through nutrition assessment, a dietitian gathers background information about their client from electronic medical records and client interviews. Using the data collected through nutrition assessment, the dietitian then chooses a nutrition diagnosis, which identifies a specific, nutrition-related problem along with the etiology and signs/symptoms of the

problem. A nutrition intervention is then created targeting the etiology of the problem. After implementation of the nutrition intervention, a dietitian monitors/evaluates clients' progress toward their planned goals (AND, n.d.a). NCP provides dietitians with a systematic approach to individualized care to help clients make necessary changes that will improve their health.

The ability to develop rapport with clients has been recognized as key to success, both for the client and the dietitian. A qualitative study conducted by Vrchota (2011) sought to investigate dietitian-client communication in dietetic practice. Vrchota (2011) interviewed seven dietetic professors from a didactic program in dietetics in the U.S. The professors emphasized oral communication in their curriculum. The researcher determined that interpersonal communication and associated communication skills were the basis of dietetic effectiveness. This is a critical consideration because interpersonal communication is the avenue through which dietetic professionals gather information from clients, and it is the means by which they effectively work through NCP. The data showed that the professors believed that relationships with clients are built through interpersonal communication and associated communication skills. Of these communication skills, one dietitian interviewed referred to rapport as "people skills" (p. 220).

The ability of a dietitian to build rapport and therefore relationships with clients was considered the most important part of counseling and educating patients across the participant pool. According to the dietetic professors interviewed, a dietitian's professional effectiveness is contingent upon the ability to build rapport and cultivate a

therapeutic relationship with clients. This would mean that without building rapport, dietitians would not be able to help their clients reach success through the therapeutic relationship.

I am interested in understanding what rapport is and how rapport is built. After reading the study conducted by Vrchota (2011), I reflected on the fact that as a student dietitian, it is important to know how to build rapport with my future clients. I am interested in understanding rapport from the perspective of medically underserved clients in a community health care setting. This is because underserved individuals have increased risk for some nutrition-related chronic diseases and therefore would benefit greatly from effective nutrition counseling.

In my review of the literature, I found limited research focusing on rapport in dietetics and the majority of that research presented rapport from the perspective of a health care professional, not MUPs' perspective. I also found that rapport was not well defined in the literature. It is important to be consistent in defining rapport and understand rapport building in dietetics to improve dietetic practice. Rapport has been linked to improved health outcomes because it can lead to improved communication, treatment negotiation, nutrition intervention, and health monitoring and evaluation (Barnett, 2001; Leach, 2005). While health care has shifted toward a patient-centered approach to care (Norfolk et al., 2007), much of the literature on rapport building focused on the professional's perspective of rapport (Barnett, 2001; Leach, 2005; Price, 2017; Hull, 2007; Tahan & Sminkey, 2012). Hancock, Bonner, Hollingdale, and Madden (2012) determined that research needs to focus on a patient's experience and perspective

if dietitians wish to improve dietetic effectiveness. Therefore, the purpose of this research is to understand the client's perspective of rapport development with dietitians.

Sources of Research

Major sources consulted. The literature in this chapter was chosen from the following sources: (a) CINAHL; (b) Google Scholar; (c) ScienceDirect. Search terms included: rapport, rapport building, dietitians, health care, health care professionals, therapeutic alliance, behavior change, empathy, respect, trust, communication, patient-centered care, and motivational interviewing. In order to best investigate perceptions of rapport in dietetic practice, 53% of the sources consulted for this literature review were qualitative. This is because qualitative research explores a phenomenon in its natural setting producing portraits of participants views and experiences (Pope & Mays, 1995).

Definition of Rapport

Rapport is defined by Merriam-Webster dictionary (n.d.) as "a friendly, harmonious relationship; especially a relationship characterized by agreement, mutual understanding, or empathy that makes communication possible or easy. In health profession literature, rapport is the connection and mutual understanding shared between a health care professional and his or her clients (Norfolk et al., 2007). It is widely believed that a therapeutic relationship is built on an established rapport between health care professionals and their clients (Cole & McLean, 2003; Leach, 2005; Norfolk et al., 2007; Vrchota, 2011). Rapport is built on mutual internal feelings of trust, respect, and empathy and external expression of those feelings through interpersonal communication (Barnett, 2001; Cole & McLean, 2003; Holli & Beto, 2014; Leach, 2005; Norfolk et al.,

2007; Sladdin et al., 2017). Holli and Beto (2014) believed that rapport creates a welcoming, nonjudgmental atmosphere where clients can feel free to be honest and vulnerable. They also believed that rapport is established over time through continuously reminding clients of the health care professionals support, interest, and concern for their well-being.

Building Rapport

Although rapport was frequently mentioned throughout the literature reviewed, it was rarely the primary focus of study and there remains gaps in understanding the critical value of rapport within the field of dietetics. Most of the literature described the importance of rapport from the perspective of a health care professional and some of the literature focused on a client's perception of rapport. There was no literature on building a rapport from the perspective of the clients. The literature reviewed was from the perspective of the health care professional through their own experience or their own review of rapport related literature. This leaves room for further investigations surrounding the client's perspective of rapport within dietetic counseling.

The literature suggested that building rapport should be the goal of the first health care provider-patient meeting (Cant & Aroni, 2009: Hall, Roter, Blanch, & Frankel, 2009; Holli & Beto, 2014; Raaff, Glazebrook, & Wharrad, 2014) because it is the beginning of the therapeutic relationship. The first introduction between patient and health provider has been recognized as an important point since this is an avenue for rapport building and creating a comfortable, safe atmosphere for the patient. Tahan and Sminkey (2012) suggested breaking down the power dynamic by introducing themselves

by their first name. This would convey to the client that the health care provider is relatable, trusting, and genuine. Hull (2007) believed that a health care provider should ask the patient how he or she prefers to be addressed as a sign of respect.

With introductions completed, it has been found beneficial for the health care provider to describe the nature of the meeting and the nature of their profession in order to eliminate any confusion on what role the health care provider plays in their care (Tahan & Sminkey, 2012). There has been controversy over the role of small talk in building rapport. Some literature presented small talk as a beneficial way to build rapport in the first meeting (Holli & Beto, 2014; Leach, 2005) while others believed the transition from small talk to the actual interview can be awkward. An alternative to small talk could be having a significant conversation about the reasons for wanting a consultation (Clifford & Curtis, 2016). Beyond these steps, the continued goal of building and maintaining rapport is to support the foundations of rapport.

Intrinsic. The foundations of rapport are trust, respect, and empathy (Barnett, 2001; Cole & McLean, 2003; Holli & Beto, 2014; Leach, 2005; Norfolk et al., 2007; Sladdin et al., 2017). These are internal feelings that are expressed through interpersonal communication. The foundations are discussed in the following section.

Trust. A qualitative study conducted by Cant (2009) used interviews between dietitians and their clients as well as focus groups in order to investigate the client's perspective of trust and communication. This study is one of the few studies that focused on the client's perspective. Through the input of 46 dietitians and 34 clients, Cant (2009) found that at the beginning of a patient's relationship with dietitians, there was an implied

trust. The client felt that he or she trusted the dietitian because the dietitian was credentialed at a hospital. Patients assumed that the dietitian was competent and skilled because he or she was employed by the hospital. Patients also believed that a dietitian working in the medical field was a reliable source. Further trust in dietitians was built when patients found their dietitian to be knowledgeable, competent, and someone with whom they experienced a genuine connection. Patients appreciated when dietitians were open and honest with them, making them feel more comfortable and able to communicate their experiences with the dietitians. This study not only focused on what dietitians found built trust, but also what patients felt built rapport.

A similar qualitative study (Dawson-Rose-Rose et al., 2016) investigated how trust and respect is formed between health care providers and patients with HIV. Researchers conducted a total of 28 focus groups interviewing 135 patients with HIV and 71 health care providers. The findings of the study showed that patients trusted their health care provider because patients relied on the knowledge and expertise of the health care providers. These researchers also found that showing a client respect helped build trust between patient and care providers. Patients felt respected when their concerns and feelings were validated, and when they were treated as individuals rather than as a diagnosis. Patients also felt respected when the health care provider recognized that their experience living with the disease was a valuable asset. Patients diagnosed with chronic disease experienced living with the disease and provided unique perspective and experience to which a health care provider may not be able to relate. Patients also felt respected by their health care provider when they were seen as in charge of their care.

The providers could provide scientific information about the disease process, but the patient could provide day-to-day experiences of the disease process. Due to the patient's expertise, they wanted the opportunity to be partner with their health care provider and make decisions that would determine their care plan. In turn, health care providers also found much success partnering with patients by informing and educating them (Dawson-Rose-Rose et al., 2016).

Respect. Other literature has shown that respecting patient's autonomy and giving them the room to think and make their own decisions through collaborative care enhances mutual respect and the strength of the therapeutic relationship (Clifford & Curtis, 2016; Leach, 2005; Tahan & Sminkey, 2012). Beach, Roter, Wang, Duggan, and Cooper (2006) conducted a cross-sectional study of 30 primary care physicians and 215 of their patients to determine patient variables that influenced primary care physicians respect for them, whether or not patients could perceive the how much respect the physician had for them, and what communication behaviors toward patients were associated with higher levels of physician respect. Physicians were asked to rank on a five-point Likert scale strongly agree, agree, neutral, disagree, and strongly disagree; An example of a prompt would be, "Compared to other patients, I have a great deal of respect for this patient" (Beach et al., 2006, p. 349). Patients were asked to answer, "My doctor has a great deal of respect for me" (p. 349) on a five-point Likert scale from strongly agree to strongly disagree. In review of the recorded encounters, researchers also sought to measure information-giving, rapport-building behaviors, verbal dominance, and global affect in correlations with respect.

Researchers found trends that both the physician and patients engaged in more rapport-building behaviors when the physician reported greater respect for the patient, but these trends were not statistically significant. Rapport-building behaviors were comprised of empathy, legitimation, partnership, reassurance, and humor. This point will be discussed more fully below. Researchers also found that a physician's positive regard was higher in patients for whom they had greater respect. Positive regard was comprised of interest, friendliness, responsiveness, sympathy, and relaxed attitude. It was also noted that encounters with higher respected patients involved more information given by the primary care physician, suggesting that physicians respected the patient's autonomy by providing patients with more information enabling them to make decisions for themselves.

Flickinger et al. (2015) conducted a similar study investigating what communication behaviors were associated with respect in HIV care in a sample of 413 HIV physician-patient encounters. After each encounter, the 45 HIV physicians participating in the study were given the same questionnaire as in the study by Beach et al. (2006). Flickinger et al. (2015) also reviewed content of the encounters for communication behaviors associated with HIV physicians respect for their patients. These behaviors were socio-emotional communication, information-giving, question-asking, patient activation, rapport-building, and emotional tone. Researchers found that both the HIV physician and patients engaged in more rapport-building behaviors when the HIV physician reported greater respect for the patient, and these findings were statistically significant with the same rapport building behaviors as in Beach et al. (2006).

Researchers also found that an HIV physician's positive regard was higher in patients for whom they had greater respect, with positive regard being defined in the same way as in Beach et al. (2006). Flickinger et al. (2015), however, found that highly respected patients shared more information with the HIV physician rather than the HIV physician sharing more information with them. This could suggest that patients felt able to share openly due to the respect they were shown by their HIV physician; creating a non-judgmental atmosphere where information could be shared.

These studies would suggest that respect can be shown to clients and perceived by clients through certain rapport building behaviors and positive regard. Both above studies did find differing amounts of information given in an encounter in relation to respect. This difference could be due to the different nature of a primary care visit and an HIV care visit (Flickinger et al., 2015). Respect shown by the health care provider created an open, non-judgmental environment where clients were able to share vulnerable information and where clients and health care providers alike could engage in open dialogue. Therefore, vulnerability could be a sign of respect. These researchers also found that patients with higher respect from their health care providers were reported to share more information with their health care provider and were more engaged in communication with their health care provider. This would suggest respect between health care providers and their clients should enhance communication. In the field of dietetics, this would imply a better quality of care provided to a client and the possibility of improved health outcomes.

These two studies (Dawson-Rose-Rose et al., 2016; Flickinger et al., 2015) focused on HIV care may be valuable in dietetic practice. According to Flickinger et al. (2015), visits with HIV patients dealt with a sensitive, chronic illness. Parallels can be drawn between dietitians and their clients. Often clients in nutrition counseling need to discuss things of a sensitive nature with their dietitian (Raaff et al., 2014). Therefore, these studies are valuable resources that can aid the field of dietetics and research about how to communicate effectively with vulnerable populations.

Empathy. Empathy was identified by dietetic professors as a learned skill that builds rapport (Vrchota, 2011). Researchers explained empathy as listening to the client in order to understand and communicating with the client's needs and concerns in mind. However, according to Hancock et al. (2012), clients doubted whether a dietitian was able to empathize with them, especially if the dietitians had never experienced the same disease they had. Hancock et al. (2012) also found that empathy increases patient satisfaction of dietetic consultation. The ability of a dietitian to understand the clients' experience better can increase a client's satisfaction with dietetic consultation.

Sladdin et al. (2017) found that the ability for a dietitian to build rapport and a relationship that enabled collaboration depended on empathy. Clients who perceived that the dietitian was empathetic were more open to nutrition counseling. The perception of lack of empathy led to a negative client experience. Sladdin et al. (2017) found that a good relationship was formed between client and dietitian when the dietitian displayed empathy, along with honesty, and use of strong communication skills.

The role of empathy and communication skills in building a rapport is described by Norfolk et al. (2007). The goal of patient-centered care is to understand a client's problems from his or her point of view and then allow that perspective to guide the health care provider through the client's care plan. A health care provider's ability to accurately accomplish this is dependent on the ability to empathize. Norfolk et al. (2007) demonstrated the role empathy and communication skills play in the development of rapport. This model of empathy views empathy built on cognitive, affective, and behavioral components.

Empathetic understanding starts with empathetic motivation, the health care provider's desire to completely understand the client's experiences (Norfolk et al., 2007). This motivation is driven by interest (cognitive component) in the patient as a person and warmth (affective component) toward them through caring. When both cognitive and affective motivation to understand a patient are lacking, a health care provider's responsibility as a health care provider takes over as motivation because it is an implied professional duty to gain an understanding of the client. The next step in empathetic understanding is empathetic attention. In this phase, a health care provider puts a concentrated effort into identifying the client's thoughts, feelings, and expectations. The next stage involves empathetic skills giving the health care provider the ability to identify the client's thoughts and feelings through observation of their verbal and non-verbal communication. The final component of empathetic understanding is that communication skills convey the health care provider's empathetic understanding to the client through verbal and non-verbal communication. This communication allows a health care provider

to express his or her empathetic understanding to the client. Communication aids the health care provider in attainment of clients' thoughts and feelings as well as confirming the accuracy of their empathetic understanding. A health care provider's skill in verbal and non-verbal communication aid in the attainment of information from the client. Verbal skills include open-ended questioning, active listening through reflection and summarizing, providing verbal cues, as well as clarifying and summarizing. Non-verbal skills include voice tone and speed, body language, facial expression conveying interest such as smiling and nodding, eye contact, etc. The strength of rapport established is dependent on the depth of empathetic understanding gained.

Extrinsic. Interpersonal communication is a loop of messages and feedback sent between a sender and receiver. The interpretation of messages between communicators is greatly influenced by context, the sender, and the receiver. The receiver is going to interpret the message through their own context. The message is influenced by age, gender, culture, and each person's background (Holli & Beto, 2014). A large component of this interpretation to consider is cultural differences. Not every culture communicates the same way through verbal and non-verbal communication. For example, some cultures view eye contact differently. Gable and Herrmann (2016) suggest using mirroring to match client's non-verbal behavior to ensure the message communicated is not offensive.

Good interpersonal communication between health care professionals and their clients can increase client satisfaction and positive care outcomes (Norfolk et al., 2007). Interpersonal communication is necessary for building rapport with clients (Barnett, 2001; Norfolk et al., 2007) and enables a client to feel understood (Holli & Beto, 2014),

respected, and cared for. It provides a way for dietitians and other health care professionals to verbally and non-verbally express these internal feelings of empathy, respect, and interest to their clients. Cant and Aroni (2008) believed interpersonal communication to be the crucial to dietetics because it is the skill that aids dietitians in accomplishing their professional purpose. A dietician needs to be able to not only empathize and respect a client but possess the ability to express that respect and empathy with clients in order to build rapport (Norfolk et al., 2007).

Verbal Communication. Verbal communication is the communication that happens through words and sounds. Motivational interviewing is a patient-center care counseling style making a move in the field of dietetics due to its ability to enhance long term client adherence. The four main communication skills used in motivational interviewing- are open-ended questions, affirmations, reflections or reflective listening, and summaries (OARS). These communication skills can be utilized by a dietitian in order to build rapport with his or her clients (Smart, Clifford, & Morris, 2014). Open-ended questions aid a health care provider in uncovering a client's opinion through unpacking his or her experiences (Clifford & Curtis, 2016) and enables the health care provider to understand the client's problems while evoking a client's trust and expressing acceptance to the client (Holli & Beto, 2014). Affirmations are reinforcements of a client's strengths or positive behaviors. These can express to a client the health care providers understanding of their past failures and successes (Holli & Beto, 2014). Reflective listening is a use of paraphrasing or repeating statements the client has expressed with the goal of not only to gauge the health care providers understanding of

what the client has shared (Holli & Beto, 2014), but also to convey empathy and curiosity to the client (Clifford & Curtis, 2016). Reflective listening also enables the dietitian to unpack a client's deep thoughts and feelings (Clifford & Curtis, 2016). Finally, summaries are similar to reflective listening in that a summary paraphrases what the client has expressed. The difference is that a summary is a paraphrase of more than just a statement; it sums up an entire client experience (Holli & Beto, 2014). Leach's (2005) review of the literature also supports the influence that listening, reflecting, summarizing, and open-ended questions have on building a rapport. Ultimately using these tools can express to a client a desire to understand their experiences through listening. Vrchota (2011) found that dietetic professors believed rapport building not to be a skill, but a bond built through communication skills, such as active listening.

Nonverbal Communication. Nonverbal communication is encompassed by behaviors and actions that convey a message. Nonverbal messages are important to be aware of because nonverbal communication is responsible for 65% of a message sent in communication (Cant & Aroni, 2008). Nonverbal messages include eye contact, facial expression, posture, gestures, touch, proximity, and appearance (Cant & Aroni, 2008; Gable & Herrmann, 2016). Leach (2005) found that health care providers, who exhibited a warm and friendly demeanor to their clients, built a better rapport with them. Gable and Herrmann (2016) believed that the following things conveyed interest in a client. Health care providers should have an open and relaxed posture, slightly leaning forward to indicate interest. Occasional head nodding can also indicate interest and acceptance and encourage the client to continue sharing. Maintaining eye contact can also communicate

interest and attention. Smiling can impart warmth and friendliness. Interest can also be communicated through facial expression.

Mirroring is another powerful non-verbal communication tool used by health care professionals in order to create a trusting environment where clients can feel comfortable (Mclean, 2008). Mirroring is using similar body language, voice, and breathing patterns as the client. The professors interviewed by Vrchota (2011) also believed that matching a client's non-verbal behaviors through mirroring is an important behavior that helps dietitians build rapport.

Barriers to rapport. It has already been established that trust, respect, and empathy are at the foundation of rapport. Therefore, any barrier to these three things could be seen as a barrier to building a rapport with clients as well. Barriers to trust that were identified in the literature were a lack of integrity and professionalism from the health care provider (Cant & Aron, 2009). Some studies have shown that a client's race/ethnicity can influence the relationship with health care providers. Flickinger et al. (2016) found that 78% of patients reported to be highly respected were non-white patients. In another study, physicians were found to be more verbally dominant in their consultations with African American patients compared to White patients rather than engaging in more patient-centered communication (Johnson, Roter, Powe, & Cooper, 2004). This study shows that health care providers have a potential to communicate with their patients differently depending on race. Another study found that health care providers, exhibiting stronger implicit bias, had poorer interactions with their clients (Maina, Belton, Ginzberg, Singh, & Johnson, 2018). Therefore, a health care provider's

implicit biases toward a client could be a barrier to respect. In the same regards, Gudzane, Beach, Roter, and Cooper (2013) found that physicians built less rapport with obese clients. This again could have been due to negative personal attitudes held by health care providers toward their clients. Barriers to empathy included the health care provider's ability to communicate a desire to understand the client perspective to the client (Norfolk et al., 2007). Holli and Beto (2014) felt that rapport could be hindered if a dietitian seemed too informal with their client. For example, addressing a client by their first name could be interpreted by the client as informal and disrespectful. Another example of this would be a dietitian referring to his or herself by surname and addressing the client by his or her first name. This example could establish a power dynamic, which the authors believed to be damaging to rapport as well. How to address clients is a cultural consideration and should be handled case by case (Holli & Beto, 2014).

Price (2017) found that rapport was difficult to build when nurses left clients expectations unfulfilled. This manifested through expected tasks left incomplete by nurses or when clients felt that nurses were not explaining the things clients expected to be told about. It is expected that not only nurses, but other health professions as well, would take the time to gain a certain level of understanding of their clients' attitudes, thoughts, and expectations for the care they will receive. This not only aids in better quality of care but also conveys interest and concern for the clients. One barrier to this would be the time it takes to obtain this information. In summary, Price (2017) presented that rapport development can be hindered if a client feels unknown or not heard. This is supported by a study conducted by investigating counseling strategies among a diabetic

population (Brown, Pope, Hunt, & Tolman, 1998). This study viewed rapport as the client feeling known by a dietitian. Rapport development is a continual process and needs to be maintained throughout the therapeutic relationship (Price, 2017).

Importance of Rapport

Dietitians consider rapport to be an important aspect of nutrition counseling due to its influence on quality of care provided. A literature review conducted by Leach (2005) found that an established rapport led to better client outcomes and increased client success related to stronger adherence to treatment plans as well as increased client satisfaction. Hall et al. (2009) also found that an established rapport led to increased client satisfaction. An established rapport also aided health care providers in gaining more useful information through an interview as well as a more accurate client history, thus improving the quality of care provided. A similar literature review conducted by Barnett (2001) found that clients provided their health care providers with in-depth information in an interview. This was due to the health care providers expressing a desire to know clients' specific beliefs, values, attitudes, and preferences through a continually developed rapport. From this review, it can be determined that rapport development led to clients sharing personal information, affording the health care providers with deeper insight into their clients and enabling the design of an individualized intervention. Much of the literature names rapport as the first step to forming a therapeutic relationship (O'Connor, Gaylor, & Nelson, 1985). It is for these positive health care outcomes that behavior change models of care value the use of rapport to influence long term behavior change.

Rapport building is linked to improved patient outcomes and is the hallmark of patient-centered care (Hall et al., 2009; Sladdin et al., 2017; Smart et al., 2014). The patient-centered care model of health care and other patient-centered models have become the focus of not only nutrition care, but also health care in general. This movement has taken the health care provider from the head of care and made clients equal partners in care. Health care is shifting toward a patient centered approach to counseling because of its ability to influence long lasting behavior change (Smart et al., 2014; Sladdin et al., 2017; O'Connor et al., 1985; Whitehead, Langley-Evans, Tischler, & Swift, 2009; Madson, Loignon, & Lane, 2008; Rosal et al., 2001). This shift in health care is supported by clients valuing their right to be involved in decision making surrounding their care (Dawson-Rose-Rose et al., 2016; DiMatteo, 1994).

Patient-Centered Care. Patient-centered care is a model of health care that focuses on the individuality of each client and involving each client in their care (Whitehead et al., 2009). This model of health behavior change is based on several cognitive behavior theories, including the Health Belief Model, Stages of Change Model, Social Cognitive Theory, and Behavioral Self-Management. These cognitive behavior theories emphasize tailoring intervention and increasing intervention adherence through client involvement (Rosal et al., 2001). The review of patient-centered care performed by Rosal et al. (2001) focused on the importance of a nutrition intervention tailored to a client's individual needs. In order to achieve this, a dietitian must be able to assess the client's readiness to change, assess personal concerns about change, feelings, past experiences with dietary change, and barriers to change. This information is crucial for

effective use of patient-centered care as well as emphasizes a need for a strong relationship, interpersonal communication skills, and a strong rapport (Rosal et al., 2001; Sladdin et al., 2017). Smart et al. (2014) recognized the use of patient-centered care in nutrition care and practice for its positive effects on long-term adherence to nutrition intervention and facilitating dietary change. Utilizing patient-centered care enables a health professional to create a tailored intervention that is designed on a patient's unique experiences, beliefs, and specific needs. Some key features of this model include patient and health professional partnership and collaboration, respecting patients, encouraging autonomy, good communication, trust, and a strong relationship (Sladdin et al., 2017).

An integrative review by Sladdin et al. (2017) of dietetic care literature, found that patient-centered care is linked with greater care effectiveness. Emerging themes from the literature reviewed reflected building rapport as an important part of building the dietitian-client relationship and an important part of patient-centered care. Research on patient-centered care has found that creating an individual care plan with the input of patients will increase their likelihood of following the plan and ultimately improving patient outcomes (Whitehead et al., 2009). Patient-centered care was also found to increase patient satisfaction in terms of quality of care (Barnett, 2001; Rosal et al., 2001; Sladdin et al., 2017; Whitehead et al., 2009).

The results of the above information are supported by DiMatteo's (1994) literature review on patient adherence to medical treatment. DiMatteo (1994) showed that patients want to be involved in their treatment decisions and collaborate with their health care providers. Studies from 1988 to 1994 showed that when patients were more

involved, they felt greater responsibility for their own health, had increased self-efficacy, adhered to the treatment plan, and expected their health to improve. Including patients in their own care and treatment decisions increased their adherence. Similar qualitative research found that patients saw dietetic consultations as a chance to work with the dietitian and that partnership made enhanced the effectiveness of those consultations (Hancock et al., 2012). Collaboration with clients is highlighted in patient-centered care (Rosal et al., 2001; Leach, 2005; Madson et al., 2009; Cant & Aroni, 2008). Sladdin et al. (2017), found that dietitians understood the impact that building rapport had on a building a positive relationship with their clients and sought to build rapport with clients in order to enable collaboration with them.

Motivational interviewing, a patient-centered care model counseling style (Madson et al., 2008; Martins & McNeil, 2009), focuses on motivating change from within an individual through empathy, identifying and resolving ambivalence, identifying a need for change, and self-efficacy. As mentioned above, health care and nutrition care, the primary focus of this study, has shifted toward patient-centered care. This includes motivational interviewing (Smart et al., 2014). A critical review of motivational interviewing in health care literature (Martins & McNeil, 2009) was conducted in the areas of diet and exercise, diabetes management, and oral health. Motivational interviewing was found to be effective in producing positive behavior change in patients. The use of motivational interviewing produced greater feelings of self-efficacy, reduced caloric intake, increased fruit and vegetable intake, decreased BMI, better glucose control, dietary changes, increased control over diabetes, and increased physical activity.

According to Tahan and Sminkey (2012), building a rapport with clients is the first step of the motivational interviewing process, and the step of motivational interviewing that creates a safe place where clients feel free to explore potentially vulnerable areas of their life without feeling threatened or judged. The rapport built enables the clients to fully navigate ambivalence toward change and move toward readiness to change.

Patient Perspective of Rapport. Hancock et al. (2012) conducted a qualitative study in which they interviewed dietetic clients in focus groups and individually. This research investigated patients' experiences in dietetic consultations in order to find areas within a dietetic consultation for improved effectiveness. Patients associated certain behaviors with positive consultation experiences, including good communication and rapport. Patients felt that negative consultations were dissatisfying and ineffective citing that they did not meet their expectations, needs, or goals toward improved health and individualized care. Dietetic consultation effectiveness was judged by patients as well as the researchers as the ability to meet patients' needs, goals, and expectations as well as utilizing individualized care and resulting in improved health. According to this study, patients felt that positive consultations resulted from the above-mentioned factors of effectiveness and negative consultations lacked these characteristics. Rapport, or the lack there of, was identified by patients as a contributing factor when assessing consultation experience.

Summary

Rapport is the connection and mutual understanding shared between a health care professional and his or her clients. Rapport is built on mutual internal feelings of trust,

respect, and empathy and external expression of those feelings through interpersonal communication. Rapport has been linked to improved health outcomes in the field of dietetics because it can lead to improvements in communication, treatment negotiation, nutrition intervention, health monitoring and evaluation, quality of care, and client satisfaction. Dieticians consider rapport to be an important aspect of nutrition counseling due to its influence on quality of care provided. Rapport building is linked to improved patient outcomes. As seen through behavior change models such as patient-centered care and motivational interviewing. Nutrition care has shifted toward these client centered approaches to care due to its ability to enhance long term client adherence to treatment plans. Without an established rapport, these methods of behavior change would be ineffective. Building rapport has been discussed superficially throughout the literature providing general guidelines, but a more in-depth review of the foundations of rapport can be found in the literature. Any barrier to the foundations of rapport can be seen as a barrier to building rapport itself.

Chapter III

Procedures

Introduction

The purpose of this qualitative research study was to investigate how clients who received nutrition counseling with a dietitian in an inner city, community-based health clinic in western New York, narrate and reflect upon their perception of rapport and rapport-building with a registered dietitian. Eight to ten participants were desired for researcher-led semi-structured interviews. Recorded interviews were transcribed, and inductive coding techniques were employed order to determine common themes and subthemes.

Role of the Researcher

According to Glesne (2011) a qualitative researcher has two roles. The first is as a researcher. This includes an understanding that a researcher's behavior has an impact on data collection. The second role is that of a learner and therefore a listener. A qualitative researcher takes the role of a listener rather than expert. It is a researcher's duty to be informed and learn from the research.

As a qualitative researcher and the main research tool, I acknowledged that my values, beliefs, and perspectives had the ability to influence what I heard, saw, and recorded during data collection. Therefore, I reflected on things I thought I would find through my data collection in an effort to minimize their effect on data analysis (Draper & Swift, 2010). Based on my experience with rapport and through the process of literature review, I assumed people would have a vague understanding of what rapport is

and how it is built. I also had preconceptions of how interviewees felt rapport was built. I assumed they would want to feel that their dietitian cared for, took interest in, respected, and listened to them.

My role as the researcher also extended into the interview process. As a student dietitian, I have had some training in communication skills, and some experience in interviewing, but certainly not as much as more experienced qualitative researchers. The ability to guide a conversation, elicit information, and dig deeper into meaning, while remaining engaged are important factors in qualitative research. As a qualitative researcher, I was also responsible for analysis of my own data. This can be a difficult and time-consuming process. Qualitative research allows for exploration of phenomena in their natural settings (Pope & Mays, 1995). However, because qualitative research is subjective by nature, data can be influenced by the researcher's values, beliefs, and preconceived opinions regarding the study subject (Draper & Swift, 2010).

Setting

This qualitative study was conducted at an inner city, community-based health clinic that serves underserved communities in western New York. Participants of the study were interviewed in-person and on-site.

Population and Sample

This study used a purposive sample of participants from a community-based health clinic in western New York. Participants were contacted through recruitment flyers posted at the research site. In the event that adequate participation was not achieved through flyers, the facility assisted in recruitment by speaking with potential participants

and forwarding the patient's information to the researcher if they expressed an interest in learning more and/or participating. Inclusion criteria for this study included: (a) Participants needed to be at least 18 years old, (b) participants needed to be able to understand and speak English, and (c) participants were currently receiving nutrition counseling from the dietitian. A minimum sample of eight participants was desired for this study. Additional participants were interviewed above the minimum number in the event that consistent data was not obtained.

Data Collection Method

After receiving permission from the D'Youville College Institutional Review Board (IRB) (Appendix A) to conduct this study and permission from the community-based health clinic, potential participants were contacted through recruitment flyers (Appendix B). Recruitment flyers included general information about the study and researcher contact information. Interested individuals responding to the flyers were contacted to schedule an interview at a convenient date and time for the participants and took place at the health clinic.

Enrolled subjects participated in researcher-led, semi-structured interview. Each interview was anticipated to last between 45 and 60 minutes. Participants received no direct benefit from participation. Prior to each interview, an informed consent (Appendix C) was reviewed with each participant and enough time was given to participants to ask any questions. A signed consent form was given to each participant to keep and a copy was kept in a locked filling cabinet on D'Youville College campus. Interviews were audio recorded. In order to navigate participants perception of rapport and rapport

building and facilitate a flowing conversation, participants were asked a series of open-ended questions (Appendix D) (Draper & Swift, 2010). A research journal was also kept in order to reflect on perceived nonverbal cues, thoughts, and any possible preconceptions influencing data collection (Draper & Swift, 2010).

Protection of Human Subjects

Full approval by the Institution Review Board (IRB) at D'Youville College was sought prior to the collection of data. Participants were vetted to ensure eligibility and to protect the time of prospective participants. Participants information remained confidential and any identifiers were deidentified at the time of transcription. Each participant read and signed an informed consent prior to the interview process. Each participant was reminded that he/she could drop out of the study at any time during the interview and that his/her confidentiality would be protected. Participants were informed that involvement in the study was voluntary and that they could withdraw at any time without consequence. Transcribed interviews were kept in a locked file on a password protected computer. Audio recordings and the research journal were kept in a locked filing cabinet.

Tool

A semi-structured interview script was designed by the researcher in order to learn more about perceptions of rapport and rapport building. Topics addressed through the interview script included aspects of the dietitian-client interaction during a session, trust, respect, and empathy. Interviews were anticipated to last between 45 and 60 minutes. Probing questions were asked in order to gain additional information from

participant responses. The interview script was reviewed by fellow dietetic students, dietetic professors, and the community health center dietitian in order to pilot test the questions. Feedback was given on a pilot tested feedback form (Appendix E).

Treatment of Data

Inductive thematic analysis was used to analyze data collected through researcher-led interviews. Analysis was completed by the researcher. To increase credibility of evolving themes, data were reviewed by a seasoned qualitative researcher in a process known as interrater reliability. Analyzed data were also validated through follow-up interviews conducted with study participants in a process called member checking. This process ensured that data were analyzed and interpreted by the researcher (Liamputtong, 2005).

Analysis. Inductive analysis was used for this study. Inductive analysis means that codes are developed through review of data rather than fitting data into preexisting codes (Braun & Clarke, 2006). For this study, raw data were approached through thematic analysis in order to establish codes, subthemes, and themes. Thematic analysis starts with becoming familiar with the data. Initial codes are then generated by noting data that seem to stand out. Codes are arranged together according to overarching theme or subtheme. Themes are then reviewed checking for continuity. This step was done using a thematic map. Finally, themes and subthemes are named according to contents of that theme (Braun & Clarke, 2006).

Research Question 1. How do clients of community-based health clinic narrate and reflect upon their perception of rapport and rapport-building with a dietitian? The

interview script was designed in a way to enable participants to navigate their perceptions of rapport and rapport building with a dietitian. Topics investigated included aspects of the dietitian-client interaction during a session, respect, trust, and empathy.

Summary

The purpose of this study was to investigate how clients who received nutrition counseling with a dietitian in a community-based health clinic in western New York narrate and reflect upon their perception of rapport and rapport-building with a dietitian. Semi-structured researcher-led and designed interviews were used to gain data. In person interviews were conducted on site. Participants were selected through purposive sampling of the underserved community receiving nutrition counseling from the dietitian at the community-based health clinic. Qualitative data were transcribed verbatim by the researcher, coded and organized by themes and sub-themes.

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Chapter IV

Journal Article

Perceptions of Rapport among Clients of a Medically Underserved Clinic in Western New York

Authors: Faith M. Bastian, BS/MS Dietetic Student; Megan Whelan PhD, RDN, CDN; Naheed Ali-Sayeed MS, RD, CDN; Renee Cadzow PhD.

ABSTRACT

Background Dietitians strive to provide their clients with accurate, science-based nutrition information to prevent, manage, or treat nutrition related diseases. Effective nutrition counseling is dependent on the formation of a therapeutic relationship with good rapport at the foundation of that relationship. Rapport is the connection and mutual understanding shared between a health care professional and his or her clients built on trust, respect, empathy, and interpersonal communication. In the literature, rapport has been linked to improved health outcomes, quality of care, and client satisfaction.

Objective The purpose of this qualitative study was to understand the perception of rapport and rapport building from clients currently receiving nutrition counseling from a registered dietitian at an underserved, inner city health clinic

Design This study used researcher-designed, semi-structured interviews to understand the client's views of rapport.

Participants/Setting Subjects included eight women participants of dietitian led nutrition group classes at a community-based health clinic in western New York. Participants completed interviews via telephone.

Analysis Inductive thematic analysis was used to analyze data and organize it according to codes and themes that would emerge.

Results This study revealed that participants believed that their dietitian spending extra time with them beyond the scheduled class session facilitated rapport-building. Participants also believed honesty, personal connections, social support were vital to their relationship with their dietitian, in addition to trust, respect, and empathy.

Conclusions Members of an underserved community in western New York desired to feel cared for by their dietitian. They also desired trust, respect, and empathy from their dietitian.

INTRODUCTION

According to the Academy of Nutrition and Dietetics (AND, n.d.), dietitians are food and nutrition experts with specialized training to help individuals make positive lifestyle changes. Through nutrition counseling, dietitians strive to provide their clients with accurate, science-based nutrition information to prevent, manage, or treat nutrition related diseases. Effective nutrition counseling is believed to be dependent on the formation of a therapeutic relationship between a dietitian and his or her client. A therapeutic relationship is defined by "a trusting connection and rapport established between therapist and client through collaboration, communication, therapist empathy and mutual respect" (Cole & McLean, 2008, p. 44). In this way, rapport is considered the foundation of a therapeutic relationship.

Rapport is the connection and mutual understanding shared between health care professionals and their clients (Norfolk, Birdie, & Walsh, 2007). It is built on mutual

feelings of trust, respect, and empathy and external expression of those feelings through communication (Holli & Beto, 2014; Leach, 2005; Norfolk et al., 2007; Cole & McLean, 2003; Barnett, 2001; Sladdin, Ball, Bull, & Chaboyer, 2017). The ability of dietitians to develop rapport with their clients has been recognized as a key contributor to dietitians' success, and ultimately their clients' success (Vrchota, 2011). Rapport has been linked to improved health outcomes in the field of dietetics as rapport has been associated with enhanced communication, treatment negotiation, nutrition intervention, and health monitoring and evaluation (Leach, 2005; Barnett, 2001).

According to the Centers for Disease Control and Prevention ([CDC], 2016), in 2016 the leading causes of death in the United States (U.S.) were cardiovascular disease (CVD), diabetes, and cancer. A poor diet is an associated risk factor related to the leading causes of death. These conditions are more common in underserved communities (Bryant et al., 2010; Ruggiero et al., 2010; Escaron, 2009). It is for this reason that a healthy diet has been identified as an intervention to treat and prevent chronic diseases such as CVD and diabetes, along with some of their associated risk factors such as obesity (Bauer, Briss, Goodman, & Bowman, 2014). Medically Underserved Populations (MUPs) are defined by the Health Resources and Services Administration (HRSA, 2016) as "geographic areas or populations with a lack of access to primary care services" (para.1). Some specific sub-groups identified within MUPs include populations characterized as low-income, Medicaid-eligible, populations that experience high infant mortality, and the elderly. MUPs were reported to experience higher rates of heart disease (Bryant et al., 2009), an associated risk factor for both chronic diseases. Hooker (2013) characterized

the MUPs with low treatment success rates due to low treatment compliance. Therefore, a dietitian's effectiveness in nutrition counseling would be crucial for an at-risk population in need of an effective therapeutic relationship.

This research identified factors that hinder and/or facilitate rapport in the dietitian-client relationship through the lens of Social Capital Theory (Hayden, 2017). According to Social Capital Theory, if a positive relationship is formed between a dietitian and his or her client, they can work together to improve health outcomes in the client. Therefore, it is important to understand how to effectively build relationships, by way of an established rapport, between dietitians and their clients. If rapport is established, it is assumed that a dietitian can promote healthy behavior change through the power of an effective therapeutic relationship. Past research has looked at the benefit of good rapport in the doctor-client and nurse-client relationship, but there is a limited amount of information on rapport and the development of rapport in the dietitian-client relationship. There is even less information regarding rapport in the dietitian-client relationship in an underserved population. Past research has also mainly focused on development of rapport from the health professional's perspective rather than the client's perspective. This research added to the literature on this topic by exploring the meaning of rapport and rapport-building from the client's perspective.

METHOD

Setting and Population

This qualitative, phenomenological study was conducted at an inner city, community-based health clinic that cared for an underserved community in western New York. This study used a purposive sample of participants enrolled in a wellness program at a community-based health clinic. The wellness program, open to both men and women, ran five days a week and consisted of rotating group nutrition education or cooking classes followed by open gym time. A Registered Dietitian provided group nutrition education and cooking classes. Participants of the wellness program could attend the rotating group nutrition education and cooking classes every day during the week if they chose. The classes were held in a large room with seating for participants and a cooking demonstration area. This was the space that the dietitian worked in. The dietitian did not have a private office space.

The staff at the facility assisted in recruitment by speaking with potential participants and forwarding the patient's information to the primary author if they expressed an interest in learning more and/or participating in the study. In order to enroll in the study, participants must have been: (a) at least 18 years old, (b) English speaking, and (c) receiving nutrition counseling from the clinic dietitian. Eight participants were recruited through this process. All participants were women enrolled in the wellness program run by the health clinic.

Data Collection

After receiving permission from the D'Youville College Institutional Review Board (IRB), potential participants were contacted by the primary author. Enrolled participants, who signed an informed consent participated in researcher-led, semi-structured interview. A semi-structured interview script was designed by the researcher in order to learn more about perceptions of rapport and rapport building. Topics addressed through the interview script included dietitian-client interaction, trust, respect, and empathy. The interview script was reviewed by fellow dietetic students, dietetic professors, and the community health clinic dietitian in order to pilot test questions before the study began.

Participants of the study were interviewed by phone. Each interview lasted between 10 and 25 minutes. Interviews were audio recorded. In order to navigate participants' perception of rapport and rapport building and facilitate a flowing conversation, participants were asked a series of open-ended questions (Draper & Swift, 2010). A research journal was also kept in order to reflect on perceived nonverbal cues, thoughts, and any possible preconceptions influencing data collection (Draper & Swift, 2010).

Treatment of Data

Inductive thematic analysis was used to analyze data and organize it according to codes and themes that would emerge (Miles, Huberman, and Saldana, 2014). Audio-recorded data were transcribed verbatim. Participants were given pseudonyms to maintain confidentiality. Transcribed interviews were then read and re-read in order to produce codes and assign them to blocks of data. In the first round of analysis, preliminary descriptive codes such as "easy to understand", "open"," honest", and "time" were

assigned to blocks of data without trying to fit emerging data in to an existing framework or thought pattern. In the second-round of analysis, larger blocks of data were reduced, and codes were merged with similar concepts to form themes according to an existing framework and thought pattern. The data was analyzed through the lens of Social Capital Theory (Hayden, 2017), and through the definition of rapport and rapport-building as described in the literature, and the notion that rapport is the foundation of the therapeutic relationship (Cole & McLean, 2008). In the third-round of analysis, the themes were read and agreed upon with a seasoned qualitative researcher. This process aided in credibility of the evolving patterns. After transcripts were concentrated, preliminary themes were also narrowed down to include only those pertinent to the dietitian-client relationship. Example themes included extra time and respect.

RESULTS

Participant Characteristics

The study sample consisted of eight women. They ranged in age from approximately 40 to 65 years of age. All women were active participants in the wellness program and frequently attended the dietitian-led group nutrition education and cooking classes at the health clinic.

Semi-structured Interview Results

Throughout the interviews the participants consistently shared that they were positively affected by the dietitian-led nutrition classes provided by the health clinic. All participants strongly agreed they were finding success and reaching their personal health goals. Not only were participants pleased with the success they found through nutrition

classes, but participants were also very pleased with their dietitian and their relationship with her. When asked, 100% of interviewees said they would not change anything about their experience with the dietitian, followed by impromptu praise of the dietitian.

Each question prompted the interviewee to reflect on rapport and rapport building as defined by the literature. Trust, respect, and empathy have been determined as the foundations of rapport, and by extension, the foundations on which a strong relationship is built. Questions such as: "*how do you define trust, respect, and empathy?", "how does one show you respect?", "how does one gain your trust?", "how does one show you empathy?", "how do you think a strong relationship is built?"* were used to prompt discussion. According to the women interviewed, honesty, personal connection, and social support were vital to their relationship with their dietitian. A theme that was identified that is not commonly used to understand rapport was the importance of extra time. All the women in the study described how the dietitian spent additional time to talk with each participant outside of class sessions. This was an important component the women believed to be essential to building rapport. The following section will discuss how the interviewees defined rapport and rapport building.

The importance of spending time: "We know she loves us cause she wouldn't take time to do the things she do if she didn't." (Sue, personal interview, 11/26/18)

Participants in this study all believed that their dietitian cared for them. Each participant articulated that they felt cared for because the dietitian spent extra time with them beyond the scheduled class session. When asked, "*what do you think your dietitian feels about you?"* or *"Do you feel your dietitian cares about you and is sensitive to your*

concerns?," the participants all brought up the importance of time. When their dietitian spent extra time taking care of them, they felt that she cared for them. Interviewees felt time was important mainly because they felt it was something she did not need to do, since it was additional time spent beyond class time. For example, Elizabeth felt the dietitian went above and beyond to help her when she gave her extra time after class. Elizabeth shared "[the dietitian spending extra time with me shows me] that she really cares about us, and our health, and the things we need help with. She puts her time and effort into helping us out, which you know, she really don't have to do but she takes that time out to do it" (Elizabeth, personal interview, 12/19/18). In this quote, Elizabeth recognized that the dietitian spends extra time with her clients because she cares.

The dietitian, Juliet (pseudonym), took extra time with the participants in different ways. For example, participants explained how she would take time to answer questions after group classes. Mary said it made her feel that Juliet was interested in her when she answered her questions. Mary said "she takes her time and at the end she answers any questions… to me that means that she really cares… she shows the interest in every last patient she gets" (Mary, personal interview, 12/18/18). In this quote, Mary recognized that Juliet might not have time to answer questions after class, or may not have to stay to answer questions, but does because she cares.

The participants also recognized the dietitian helped with concerns that were not related to nutrition showing, that she cared for them as a person, not just as a patient. For example, Holly believed that Juliet cared about her because Juliet would help her with day to day problems. Holly said, "She will make sure that I get my medicines when I'm

having a hard time getting it… we are important to her you know, and she helps" (Holly, personal interview, 12/18/18). This quote provided an example of how the dietitian devoted extra time to the women that went beyond the class expectation.

The dietitian spent extra time with participants in the following ways: answering questions after class, talking about personal matters after class, and making sure things were explained thoroughly enough for understanding during class. It was well established throughout interviews that the women appreciated when Juliet would spend extra time with them. It did not matter if it was just answering questions or talking, this made the women feel cared for.

A few women expressed how important it was to be cared for by Juliet and other staff at the health clinic. It established a social support that some women believed they did not experience anywhere else. They were receiving love and attention they did not get from family. Joy described how she does not feel cared for at home, so she turned to her relationships at the health clinic because that was where she felt cared for. Joy said,

> There's couple of people there that I feel that care about me. And that has never happened so often for me before, that somebody actually care about me. Because I'm telling you even my own family don't care about me right now, they don't. But that's why I go there every day. (Joy, personal interview, 11/26/18).

Mary shared similar feeling to Joy. Mary shared that the relationships she built with the providers at the health clinic are as strong as a family bond. It is a strong bond because the providers took time to care for her in her community. Mary said,

> You know some of us don't have family and some of us don't have a closeness with our families and stuff but when you come here to the health clinic, they make you feel like a family. Cause you know they gotta love and care to even create a program like this (Mary, personal interview, 12/18/18).

The participants in this study all believed their dietitian cared for them. Each participant articulated that they felt cared for because the dietitian spent extra time with them beyond the scheduled class session.

Foundations of rapport: "She don't sugar coat it. She lets us know the truth and I appreciate that" (Sue, personal interview, 11/26/18)

According to the women interviewed, honesty, personal connection, and social support were vital to their relationship with their dietitian, in addition to trust, respect and empathy. The qualities listed reflected the definition of rapport.

Trust. Trust was highly appreciated by the women interviewed. Joy expressed throughout her interview that without trust, a relationship is not going to be built, "If you can't trust [somebody], you aren't going to deal with that person" (Joy, personal interview, 11/26/18). The participants initially trusted the dietitian independent of any conscious efforts to build trust. This initial trust was attributed to the dietitian's title and the health clinic she worked for. Women felt that Juliet's information could be trusted because she is a dietitian and was educated. For instance, Mary found solace in Juliet's diploma hanging on the wall. This showed Mary that Juliet's information was to be trusted because of the education she went through. Mary said,

> I like the way Miss Juliet shows her credentials on the wall or nearby or whatever because that means a lot. When we walk in and we see her accomplishment, that wow she worked hard to get that. And that she knows something because she can teach us something because she studied hard (Mary, personal interview, 12/18/18)

They also expressed that they trusted her because she worked for the health clinic and the interviewees trusted other providers from the health clinic. Joy expressed this feeling in her interview, "So, for me, I trust everybody there at the health clinic because so far everything in this corner, I'm going to be what, two and a half years that I been with them and they never give me nothing to not trust them about" (Joy, personal interview, 11/26/18).

Women also felt they could trust the dietitian when they saw that she practiced the nutrition principles that she taught in class. They felt that Juliet was not just telling them what to do because it was what she learned in school, but because her advice worked for her. Mary expressed that Juliet was a role model and practiced what she taught. This increased the amount of trust she placed in Juliet. Mary said, "She's living it. She's not just telling us and teaching us, not just study, but she lives it. It's like she's an example to us. And like she's doing it right with us… somebody like that, I trust." (Mary, personal interview, 12/18/18). The dietitian as a role model for health established trust among participants.

Confidentiality was also a factor that built trust in the dietitian-client relationship. Juliet was seen not only as a reliable source of information, but also as a reliable person that could be confided in. The relationship between Juliet and the interviewees was

strengthened because they could trust that their personal information was safe. Mariam expressed that sentiment in her interview, "trust would be for me is that a person is reliable, that I can confide in them… [and] I trust that will stay confidential" (Mariam, personal interview, 12/20/18). Maintaining confidentiality of personal information was viewed as vital to establishing rapport and maintaining trust and showing respect for the participants.

Respect. Respect was also described outside of the context of confidentiality. Mariam best described respect as, "open-mindedness, and respecting people's life experiences and their opinions" (Mariam, personal interview, 11/26/18). Participants of this study believed that open communication, the opportunity for dialogue, ability to openly express their opinions was vital in the dietitian-client relationship. For example, Elizabeth felt respected when she was able to join in on the conversation, "being able to participate and not just sit back and listen sometimes express yourself and talk with the person that's explaining things to you." (Elizabeth, personal interview, 12/19/18).

Participants noted that the dietitian knows when to stop asking questions. For example, Noel felt respected when she was not forced to talk about something if she chose not to, "it's when no one don't invade my privacy. If I don't want to speak on something, they won't push me to speak on it" (Noel, personal interview, 11/26/18). Women were also shown respect when their opinions were valued. Joy felt her opinions were valued when the dietitian would ask her opinion on subject matter in class, "they'll ask me about doing something and ask my opinions about stuff and everything." (Joy, personal interview, 11/26/18). Finally, respect was communicated through honesty about

health-related matters. Sue appreciated that when she went to Juliet for health-related advice, Juliet was straightforward with her, "she just really lets us know the truth about everything, she don't sugar coat it, she lets us know the truth and I appreciate that" (Sue, personal interview, 11/26/18).

Empathy. Most of the participants who gave an answer for "*what does empathy look like to you?*" mentioned that they believed it was displaying concern for an individual. The participants wanted to feel that their dietitian not only tried to understand their feelings, but also displayed concern for them through action. Carol explained it this way, "[empathy is] general concern for someone and to do something about it" (Carol, personal interview, 11/26/18). Participants also said that listening and helping could be a display of concern.

For some women, they felt their dietitian could show concern for them by talking to them in order to understand their situations. Mariam was looking for her dietitian to sit with her and hear her thoughts and feelings. Mariam shared, "empathy for me is to be able to put ourselves in someone else's shoes where we may have not been but to have compassion for their situation and their thoughts and what they may be feeling" (Mariam, personal interview, 12/20/18). Joy shared a similar feeling. "it's like relating… actually, come sit with me and talk with me and ask me questions about things" (Joy, personal interview, 11/26/18). Women also appreciated when their needs were known and when their dietitian tried to help meet those needs. For example, the health clinic had a plan to bring in a local farmer to provide participants of the wellness program with free fruits and vegetables. This action conveyed to Elizabeth that the health clinic cares for her and her

wellbeing. Elizabeth said, “they have a [food] program that helps us with getting our vegetables and fruits. They saying they appreciate you and they try to make it easy for you and help out with things” (Elizabeth, personal interview, 12/19/18).

DISCUSSION

Rapport is the foundation of a therapeutic relationship and is often linked with improved client outcomes but is not largely talked about in the field of dietetics within a medically underserved population. The findings in this study identified that women felt rapport was built on honesty, personal connection, and social support as well as trust, respect and empathy. This study also revealed that women of the underserved community appreciate their dietitian spending extra time with them. Women identified this extra time when the dietitian spent extra time with them after class to answer questions, explain material, or discuss personal matters. Another aspect of trust that was independent of the dietitian’s actions was what is known as impersonal trust. This is discussed in a study conducted by Cant (2009) as a trust that just automatically exists due to the professional title held.

Research has shown that clients trust their health care provider because of their credentials and their knowledge base (Dawson-Rose et al., 2016; Cant, 2009). Findings from this study supported that notion. Many of the women followed the dietitian’s advice because they needed the dietitians help to get healthier. Much of the current literature on respect shows that clients wish to be respected. The ways they are respected are due to their provider being honest with them and providing them information, as well as respecting their thoughts and feelings (Tahan & Sminkey, 2012; Leach, 2005; Clifford &

Curtis, 2016; Dawson-Rose et al., 2016; Beach et al., 2006). Women in this study supported that view of respect. They desired open dialogue and honest.

The results of this study showed that members of a medically underserved population perceived extra time spent with them as vital to establish and build rapport. The literature on rapport building has not addressed extra time as found in this study. Most references say that building rapport takes time and needs to be maintained over time (Holli & Beto, 2014). Previous studies only recognize that limitations on time often make rapport building a difficult task when there are other clinical tasks to be done (Gudzune, Beach, Roter, & Cooper, 2013; Price, 2017; Barnett, 2001). This study provides evidence that spending extra time with clients is necessary to build and maintain rapport.

Limitations

This study recruited participants from one health clinic with one dietitian, thus the results are not generalizable. A larger study of multiple health clinics with multiple dietitians may help to further understand rapport and rapport-building from a client perspective. Also, all interviewees were women. A study of men and women would be beneficial to further explore perceptions of rapport. Participants were enrolled in dietitian led group classes. Rapport building may be different in a one-on-one patient counseling setting. Participation for this study was voluntary. It is possible participants who volunteered for the study may have been more eager to share positive feedback. In addition, individuals enrolled in the wellness program who had negative feedback may not have chosen to participate. Finally, the primary author spent time working at the health clinic with the dietitian on staff and had a professional relationship with some of

the participants in the study. This relationship may have influenced positive feedback from participants.

CONCLUSIONS

Members of an underserved community in western New York believed a dietitian-client relationship is built on honesty, personal connection, social support, trust, respect, and empathy. The members of the community interviewed appreciated when their dietitian spent extra time caring for them. Rapport in itself is not a skill, but is the result of learned skills (Vrchota, 2011) such as spending extra time with clients, building trust, showing respect, and being empathetic toward clients. Building rapport through these means can be practiced and implemented in education or training programs. Future studies could investigate rapport in one-on-one counseling settings to determine if learning environment and group interactions impact perceptions of rapport and rapport-building. Future studies could also investigate dietitian-client encounters in varied to better understand rapport and rapport-building.

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Appendix A

IRB Full Approval Letter

IRB Full Approval Letter

D'Youville COLLEGE
320 Porter Avenue
Buffalo, New York 14201-1084

TO: **Faith Giamberdino**

FROM: Dr. Julia Hall JH/EB
Institutional Review Board

DATE: October 26, 2018

SUBJECT: **IRB FULL APPROVAL**

Thank you for submitting the materials requested by the D'Youville College Institutional Review Board in regard to your IRB application that was previously granted Approval with Conditions.

I am pleased to inform you that you have met the conditions specified and your application to the D'Youville College Institutional Review Board entitled: *"Perceptions of Rapport Among Clients of a Medically Underserved Clinic in Western New York"* has now been granted **FULL APPROVAL** with respect to the protection of human subjects. This means that you may now begin your research unless you must first apply to the IRB at the institution where you plan to conduct the research.

Please note that you are required to report back to this IRB for further review of your research should any of the following occur:

1. a major change in the method of data collection
2. unanticipated adverse effects on the human subjects
3. unanticipated difficulties in obtaining informed consent or maintaining confidentiality
4. the research has not been completed one year from the date of this letter

Congratulations and good luck on your research!

eb

cc: Director of Graduate Studies
Dr. Megan Whelan
file

(716) 829.8000
fax: (716) 829.7790
www.dyc.edu

Appendix B

Recruitment Flyer

Recruitment Flyer

ARE YOU RECEIVING NUTRITION COUNSELIING FROM A DIETITIAN? THEN I WANT TO HEAR FROM YOU!

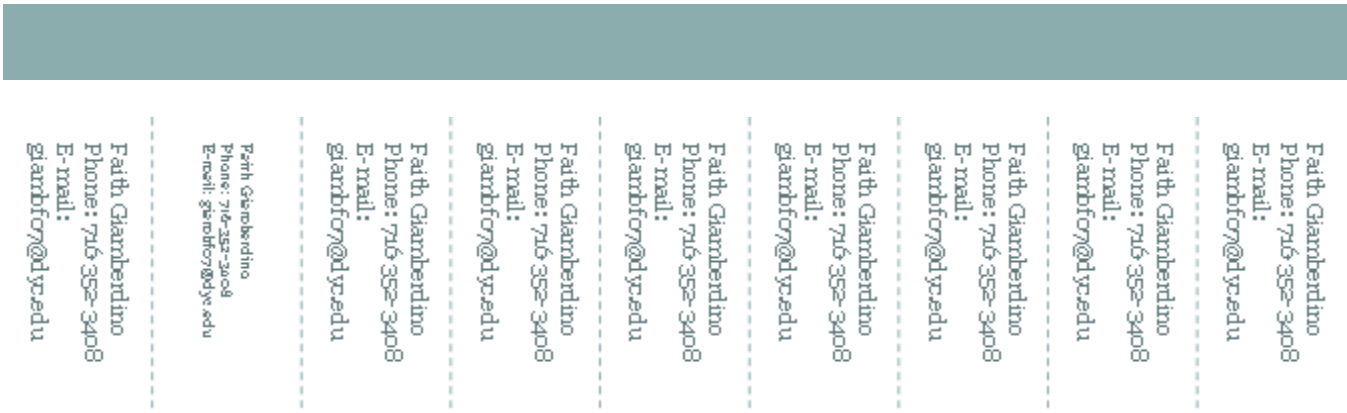
You are invited to participate in an interview regarding your experience with your Dietitian.

Your participation and time is very important and greatly appreciated.

Please contact Faith Giamberdino with the following contact information if you have any questions.

This study has been reviewed and approved by the D'Youville College Institutional Review Board. Your participation is voluntary and confidential.

Phone: 716-352-3408
E-mail: giambf07@dyc.edu



Appendix C

Informed Consent

Informed Consent Form

Perceptions of rapport among clients of a medically underserved clinic in western New York

Purpose of Research

The purpose of this project is to learn more about how dietitians work with their clients in a community health clinic.

Specific Procedures

You will participate in one 45-60 minute interview. You will be asked to talk about your relationship with your dietitian. We will discuss your thoughts and feelings about the dietitian and your experience with the dietitian. You may also request a follow up interview to discuss the findings of this study once the data has been analyzed.

Duration of Participation

Limited to 45-60 minute interview and optional follow-up interview.

Risks

Risks of participation are no more than you would have in everyday life. In rare instances, you may be uncomfortable with answering the questions. However, because I want to learn from you, there is no such thing as a "right" or "wrong" answers. Please be as truthful and open as you are comfortable with. You are free to skip questions. Another risk common to most research is breach of confidentiality – which means that someone could find out that you were part of this study and what you said. Please see the confidentiality section below to learn how I make the risk of that very low.

Benefits

You may not directly benefit from this study, but the information that you share may help other dietitians improve their relationship and interactions with their clients.

Compensation

You will receive no monetary payment for your participation in this study.

Confidentiality

I will be recording your interview with a digital audio recorder. Only I will have access to these recordings and hardcopy transcripts. Real names will be replaced with fake names in transcripts and any research reports and only first names will be used in digital recordings. A list matching real names with fake names and all other research data will be kept with the results. These items will be stored in locked file cabinets and password-protected computers contained in a locked room at D'Youville College. Finally, please note that the project's research records may be reviewed by departments at D'Youville College responsible for overseeing research. The results of this research will be published in the D'Youville College library. A report of analyzed data may also be shared with the other study participants through follow-up interviews. You will not be identified in these reports. I welcome any feedback you have on these reports

Initials: _____ Date: _____

Voluntary Nature of Participation

You do not have to participate in this research project. If you agree to participate you can withdraw participation at any time up to the data analysis process without penalty.

Contact Information

If you have any questions about this research project, you can contact Faith Giamberdino at 716-352-3408 or at giambf07@dyc.edu or Dr. Megan Whelan at (716) 829-7755 or at whelanm@dyc.edu. If during the course of the study you have questions about the research, tasks, or activities you are asked to perform or complete, or your rights as a research subject, you may contact Dr. Julia Hall, Director of the D'Youville College Institutional Review Board at (716) 829-7840 and all your questions will be answered.

Documentation of Informed Consent

I have had the chance to read this consent form and have the research study explained. I have had the chance to ask questions about the research project and my questions have been answered. I am ready to participate in the research project described above. I will receive a copy of this consent form after I sign it.

_____ _____

Participant's Signature Date

_____

Participants Name

_____ _____

Researcher's Signature Date

Appendix D

Interview Script

Interview Script

Initial Remarks: Hello, thank you for meeting with me today. I am a student dietitian and I want to learn more about how dietitians work with their clients. Is it okay if I ask you some questions?

1. Have you met with a dietitian here at this clinic?
    a. Did you ask to see the dietitian, or did someone tell you to/suggest that you see the dietitian?
2. Did you follow the advice the dietitian gave you?
    a. Why or why not?
3. Can you tell me about the session? (Prompts include: How was it? What did you talk about? What did you think about the conversation?)
4. What are your thoughts and feelings about your relationship with your dietitian? (Prompts include: Is it a positive relationship? Is it a negative relationship? Is it good or bad?)
    a. What do you feel made it [positive, negative, good, bad, etc.]? (Adjective based on participants answer.)
    b. What do you think your dietitian feels about you?
5. Do you feel that your dietitian cares about you and is sensitive to your concerns?
    a. What about your interactions with the dietitian make you feel that way?
6. What do you think is involved in developing a good relationship, or rapport, with someone?
    a. Can you describe what empathy, trust, and respect look like to you?

7. Is there anything you would change about your experience with your dietitian? If so, what would it be?

Appendix E

Pilot Test Feedback Form

Pilot Test Feedback Form

Please answer the following questions regarding the interview. Comments, critiques, and suggestions are welcome.

1. How did you feel about the length of the interview script?
    a. Too short
    b. Just right
    c. Too long

    Comments/Suggestions:

    _____
    _____
    _____

2. Were the questions clear?
    a. Yes
    b. No

    Comments/Suggestions:

    _____
    _____
    _____

3. Do you feel the interview script was designed to gain the perspective on rapport?
    a. Yes
    b. No

    Comments/Suggestions:

    _____
    _____
    _____

4. Do you have any additional comments/suggestions?

    _____
    _____
    _____
    _____
    _____
    _____

Survey adapted from Darden, 2017