Abstract
Background
Opinion and information in the public domain suggest that an individual's dietary and nutritional intake may be an important factor in both their physical and mental health. However, at this time in the counselling and psychotherapy field, it is not common for therapists to address issues of dietary intake and nutrition with clients.
Aims
This qualitative heuristic study explores the perceptions and beliefs of qualified counsellors and psychotherapists, exploring how they understand dietary and nutritional information to be relevant as part of the therapeutic process with clients.
Method
Six participants were recruited through email, journal advert, poster and leaflet distribution. Data were gathered with semi-structured telephone interviews and analysed using interpretative phenomenological analysis.
Findings
Seventeen themes were identified and organised under four master themes: (A) personal aspects of the therapist; (B) therapeutic approach and philosophy; (C) diet and nutrition within the therapy process; and (D) considering ethical practice.
Implications
Implications for practice include the consideration of multidisciplinary working and developing appropriate training for practitioners in this area.

Introduction

What, when and how we eat can carry a multitude of personal meanings. Provision, preparation, and sharing of food and drink may hold cultural significance: a family meal, a cup of tea or a champagne toast can symbolise love, celebration or comfort as well as family and community (Christensen, **1996**; Christensen & Brooks, **2006**). In addition, dietary habits exist within a social and political context with access to food and nutritional education affected by economic factors, social status and living environment.

At a biological level, it is commonly accepted that our dietary choices affect body, brain and physical development (Holford, **2004**). In terms of mental health, the relevance of diet and nutritional supplementation has also been widely discussed (e.g. BBC, **2014**; NHS, **2010**; Williams, **2015**) and there are resources and information of potential value to clients who present with psychological concerns from a range of sources, including mental health bodies, such as the Mental Health Foundation (**2012**) and Mind (**2012**). The availability of such information would suggest that chances of improved health may lie not only within the resolution of emotional disorder but also from considering the possibility of physiological disturbance due to diet and/or nutritional factors (British Dietetic Association, **2010**; Food and Behaviour Research, **2015**; Food for the Brain, **2015**; Sarris et al., **2015**; Students Against Depression, **2012**). Many studies concerning effects of specific nutrients, food types and eating patterns on brain function have been conducted, and several mental health conditions appear to have received significant attention in

terms of diet and nutrition including depression, bipolar disorder and schizophrenia, as well as attention deficit hyperactive disorder (ADHD) and behavioural problems, such as aggressive and violent behaviour (e.g. Jacka et al., **2009**; Mishra, McNaughton, O'Connell, Prynne, and Kuh **2009**; Montgomery & Richardson, **2008**; Schnoll, Burshteyn, & Cea-Aravena, **2003**; Zaalberg, Nijman, Bulten, Luwe, & van der Staak, **2010**). Biochemical imbalances, such as dysglycaemia (fluctuating blood sugar), are highlighted as producing a range of mental and emotional disturbance, for example anxiety, mood swings, depression and forgetfulness (Food for the Brain, **2015**). Food intolerance and allergies are also linked with mood swings and depression as well as aggression and sleeping difficulties (Holford, **2004**).

The Associate Parliamentary Food and Health Forum (**2008**) conducted a year-long inquiry into the research and evidence concerning omega-3 and omega-6 fatty acids and diet and behaviour of children, young people and criminal offenders, which also encompassed brain function and mental health. The report's recommendations included the following:

More NHS trusts to adopt the approach developed by nutritionist Kevin Williamson of the NHS Early Intervention service, which provided nutritional assessments to individuals presenting with symptoms of depression and psychosis.

For the ‘scanty training of GPs and other medical professionals in nutrition and diet’ (p. 4) leading to diminished care for patients, to be addressed by the Royal Medical Colleges and the General Medical Council.

Constantine et al. (**2011**) conducted a small-scale study exploring therapists’ observations of their clients with bipolar disorder and the effect of dietary and nutritional factors on their symptoms. This study, although limited by being based on a small number of practitioners’ perceptions, concludes that there are benefits of improved dietary knowledge of therapists working with this group due to perceived links between diet and symptoms. A ‘triadic working alliance’ (p. 11) involving client, therapist and qualified nutritional practitioner was also highlighted. Similarly, in a review examining the relevance of diet and nutrition in mental health recovery, Adams, Minogue, and Lucock (**2010**) discussed multidisciplinary team working in order for this issue to be more adequately addressed.

More recently, the focus of dietary studies has moved from the impact of individual nutrients to the eating patterns of individuals and this may aid consideration of how an individual in psychological therapy might achieve beneficial change from dietary improvement. For example, in terms of adolescent mental health, a cross-sectional study by Jacka et al. (**2011**) found relationships between the diets of young people (aged 11–18) and their mental health; dietary intake low in processed and high-sugar foods and increased fresh and wholefoods mirrored improvements in mental health. Mental health problems have been found to frequently manifest in adolescence (Hogg, **2011**); therefore, such findings may be of relevance to practitioners working therapeutically with young people.

Many practitioners will comfortably engage in discussion with clients about their alcohol intake and use of recreational drugs (Burks & Keeley, **1989**), and exploratory discussions with practitioners prior to

conducting this research would suggest that even caffeine and its potential impact on sleep, stress and anxiety symptoms might be discussed during therapy, although this observation would warrant further investigation. However, it does not seem to be common practice to engage with a client's dietary intake as part of the therapy process (Burks & Keeley, **1989**; Edwards, **2002**; Pointon, **2006**). Yet, if therapists are aware of dietary factors that may exacerbate or alleviate distress for clients, does this then become a pertinent issue for therapy? And if so, how might appropriate exploration of dietary issues be achieved within a therapist's espoused theoretical orientation?

Recommendations for the education of mental health practitioners in the connection between diet/nutrition and mental health are evident in the literature, highlighting the potential for a client's problems to be more adequately assessed and addressed, and ultimately providing clients with the best opportunity for wellness (Adams et al., **2010**; Edwards, **2002**; Pointon, **2006**; Walsh, **2011**). However, whilst inclusion of diet and nutrition in the consideration of mental health symptoms was often suggested, this has often been followed by concerns for mental health practitioners' competence and recommendations for the acquisition of appropriate training and education (Burks & Keeley, **1989**; Dwyer, **2000**; White, **2009**).

Only two American quantitative studies were found exploring psychological therapists' approach to dietary issues with clients. Royak-Schaler and Feldman's study (**1984**) showed that therapists are more likely to advocate healthy habits with which they were personally familiar. Burks and Keeley's study (**1989**) showed that therapists tended to refer clients for nutritional advice and were generally more confident to recommend physical exercise. Also apparent was the conflict of dietary exploration with theoretical orientation. Both studies conclude that further research into therapists' approach to lifestyle intervention and appropriate education in this area are needed.

Method

This qualitative study aimed to explore the views of therapists; when and why practitioners may be applying dietary and nutritional information when engaging with client's psychological or physical distress; and their experience of such client work.

Heuristic method

An exploration of the experience of therapists' perception, values and ideas required a qualitative stance, with its focus on the subjective experience of individuals operating from a different world view to that of established quantitative traditions (Maykut & Morehouse, **1994**). A qualitative heuristic approach was chosen, the research positioned at a point along a phenomenological–heuristic spectrum. Whilst the inquiry requires a presentation of 'what is seen', it also aims to draw upon the researcher's experience transparently within the project (Moustakas, **1990**; Willig, **2008**).

Moustakas (**1990**) provides guidelines for heuristic inquiry with six phases to structure what can be an organic and potentially amorphous process.

The following descriptions can be seen as reflective of the researcher's experience of this study:
Initial engagement sees the researcher recognise a question ‘that holds important social meanings and personal, compelling implications’ (p. 27). During the *immersion* phase, the researcher ‘lives’ the question, savouring every opportunity to discuss and learn from their environment and others.
Incubation allows gathered information to exist within the researcher without pressure until the next phase of *illumination* occurs, bringing fresh insights or ‘corrections of distorted understandings’ (p. 29).
Explication sees the analysis of the data involving close reflection and indwelling leading to a creation of a new whole in *creative synthesis*. Utilising a high degree of reflexive working in heuristic inquiry, the researcher is both subject and object of inquiry, using themselves as a tool for exploration, acknowledging the existence of a filter through which participants’ accounts are rendered (Etherington, **2004**).
Recruitment
Participants were recruited using the online research noticeboard in BACP's *Therapy Today*, as well as the circulation of an email amongst colleagues, peers and other practitioners in the field of nutrition and psychological therapy and relevant organisations. A poster was displayed in a counselling organisation and a set of leaflets distributed. Participants made initial contact via email or telephone. All interviewees received information sheets and a pre-interview questionnaire, which enabled the researcher to ascertain participants’ suitability for the study. Consent to conduct and record the interview was acquired with a signed consent form via email or post which was assigned with a code to protect participants’ confidentiality.
Participants
All six participants were qualified counsellors or psychotherapists, in supervised practice and identified as integrative or eclectic in theoretical orientation. The average length of experience was 27 years in the profession, with shortest career at 12 years and longest in excess of 40 years. All were female and currently worked in private practice with experience of at least one other organisational setting, including colleges and universities, GP surgeries and mental health centres. All participants shared a belief in the relevance of diet/nutrition for their client work and in addition to counselling/psychotherapy qualifications, Participant 2 had completed nutrition training for mental health; Participant 5, a naturopathy qualification; and Participant 6, education in medical nutrition. Criteria for exclusion were those working exclusively with eating disorders as this was deemed inappropriate for the purpose of the study, and NHS employees, as permission had not been sought from the NHS ethics committee.
Participants’ accounts were obtained using an hour-long semi-structured interview and were digitally recorded. The interview explored the extent of professional experience and route into the field; past and current work settings, client groups and practice influences; theoretical orientation;

origins and evolution of interest in dietary issues; the application of dietary information to therapy; and the therapists' experience in doing so.

Data analysis

Before choosing the interpretative phenomenological analysis (IPA) method, ontological and epistemological positions were considered. IPA was deemed to be in keeping with the aims and philosophy of this study, and consistent with this method, each transcript was treated 'on its own terms' (Smith, Flowers, & Larkin, **2009**, p. 100), thus allowing the idiosyncratic themes of each case to exist as far as possible. Highlighting descriptive, linguistic and conceptual comments within the transcript, each comment was grouped under a theme and resulting themes were assigned to a master theme until participants' idiosyncratic accounts were represented as fully as possible (Smith et al., **2009**).

Ethical considerations

Ethical approval was obtained from the Research Ethics Committee at the University. As a BACP accredited counsellor/psychotherapist, the researcher worked in terms of the Ethical Framework during all contact with participants (BACP, **2010**). BACP ethical guidelines for research were also followed (Bond, **2004**). Issues of power imbalance are pertinent in relationships with participants, and participant safety was seriously considered: food for some people is an extremely personal subject and each interviewee's history may include food-related problems. The researcher held this fact respectfully: after the transcription of each interview, a copy was emailed to all participants for approval with any identifying details changed or omitted. All participants understood that they could withdraw at any time before the analysis of the data began. Care was taken to obtain full agreement regarding the final transcript before analysis took place. Information regarding therapeutic resources for support postinterview was also provided. In terms of the researcher's well-being, consideration was given to the potentially vulnerable position of visibility through heuristic inquiry. Self-disclosure and how much to show is an issue that Etherington (**2004**) highlights, citing self-care as one of the guiding principles in the BACP framework for good practice (BACP, **2010**).

Reflexive statement

My personal experience of physical and mental ill health, encountering various health literature, discussions with others and subsequent recovery through dietary change has led me to believe that dietary intake is relevant to the psychological therapeutic process. In keeping with the heuristic approach, relativism acknowledges that the researcher is central to the research process and constructing the study findings (Willig, **2008**), and due to my passion and personal connection with the study, it seemed important to explore my influence on the findings as far as possible. Therefore, with participant interviews complete, the same interview was conducted exploring my own experience to reveal what ideas and beliefs might be influencing my line of questioning. I appreciate that a researcher without my personal experience of health and diet may have pursued different lines of questioning and identified alternative sets of themes.

Fundamentally, my interest in conducting this study lies in achieving the best possible outcomes for my clients in their search for health and well-being, with my approach to therapy underpinned by a belief in the empowerment of clients through knowledge and improved self-awareness; attaining not only recovery but sustained well-being. Therefore, if a client's dietary intake may be inadequate for healthy physical and mental function, I understand it could be in the interests of successful therapy to address this through appropriate exploration and provision of information. My hope is that this study will further the development of my own therapeutic approach and also encourage other therapists to consider the role of such knowledge in therapeutic practice.

Findings

Seventeen themes were identified and organised under four master themes (A–D) (Table 1):

Table 1. Master and subordinate themes

Master theme	Theme
A. Personal aspects of the therapist	Personal life history
	Personal lifestyle
	Therapist perceptions and beliefs regar diet and nutrition
	Perceptions of the medical approach
B. Therapeutic approach and philosophy	Learning and development
	Attitudes to therapy
	Therapists’ aims in therapy
	Maintaining the therapeutic alliance
	Client responsibility and collaboration
C. Diet and nutrition within the therapy process	Assessing clients’ presenting issues
	Exploring diet as part of lifestyle and se care

Master theme	Theme
	Use of dietary intervention
	Client responses to interventions
D. Considering ethical practice	Working with competence
	Socio-economic issues in diet and nutri
	Awareness of own process as therapist
	Experience of supervision

Personal aspects of the therapist

This set of themes demonstrated how participants had experienced diet and nutrition in their lives; from memories of childhood to their choices now as adults; recovery from ill health; and maintaining general well-being.

I can still link a lot of the memories of my mum and dad to food… many of my very positive memories of being cared for have a food element in them (P6).

I'm diabetic… I don't take medication. I've had serious cancer and come through it and I think it's if you're in the right frame of mind… with the food and nutrition (P5).

I've got an autistic son… and found that there were certain [food] allergies that he had that affected him… his behaviour (P3).

I had breakfast before I talked to you and I knew that if I didn't eat my breakfast, it would affect our ability, my ability to enjoy this interview (P4).

In clarifying ideas regarding the relevance of diet and/or nutrition for mental health, participants' beliefs and perceptions were revealed, including the idea of commitment to care for one's self.

I see it as a part of life that if you eat right, then you feel right. You've got lots of energy, you can concentrate better… keeps you on an even keel (P5).

It's about looking after yourself, it's not just about the intake of food, it's making time for yourself, so food has… all sorts of implications (P6).

Perceived inadequacies and lack of awareness of GPs and the NHS regarding diet and mental health were discussed by a majority of participants. Participant 4, who also disclosed inadequate diet/nutritional care after her own bowel operation with the NHS, expressed doubts as to the competence of GPs and the NHS to adequately address nutritional issues:

There's a gap in the NHS where there's not enough nutritional advice … If food is that basic, why [hasn't] the average GP got much nutritional expertise? …Or why isn't there a nutritional expert at each GP surgery?
And Participant 5 commented on clients seeking alternatives to antidepressants:
The majority of people who come and are on medication don't really want to take it…it's not what they really want to do (P5).

Therapeutic approach and philosophy

This category contained themes pertaining to the maturity of the therapist. The concept of 'maturity' can be understood not simply in terms of adult years, but to include the degree experience acquired through time spent in the profession, encountering a range of clients and issues – described here by Participant 3:
I think as you get older and the more you practice… I have become more and more direct and immediate and I think that goes with confidence because you're meeting the same thing…
A particular work setting or client encounter proved influential and changed participants' perspectives and subsequent methods of working. Participant 1 spoke of how a client's brain tumour was understood to be a significant factor in his presenting mental health symptoms and realising that a client's mental health symptoms could be connected to their physical health led her to a change in her approach:
It was discovered that he had a brain tumour… in my mind for the future is, 'don't therapise a tumour'… So partly for my assessments with people is, let's clear the decks of any possibility of there being a physical cause for what's going on for you here.
For Participant 3, an encounter of therapeutic significance occurred with a bulimic client:
So that brought me into thinking 'goodness, how the nutritional side can affect people' because I noticed that when we got a sensible diet going… there was notice of mood change, confidence and her self-esteem grew.
Pragmatism – that is a tendency towards what was perceived to be the most useful avenue in therapy and a matter-of-fact attitude – included not limiting oneself to a single theory which was deemed unhelpful, but instead aiming to tailor therapy to accommodate clients:
It isn't just self-exploration… that has a place but I tend to be more pragmatic than kind of just keeping it in say, a person-centred area session after session… for the most part I tend to be more directive (P2).
I'm always looking at things from a different perspective and angle… because it's not, sort of, set in stone, is it? I like the freedom to be able to move around and look at different theories and therapies (P5).
Solving a puzzle and getting to the root cause of a client's problems were considered key. Participant 6 employed a metaphor*, we're all like jigsaws,* referring to *bits of information from clients* and storing them *until I've got enough to make a pattern*. Half the participants were keen to empower clients, and for Participant 2, the exploration of diet and self-care was a *necessary* process of education, providing alternatives and getting clients *to a place where they can self-sustain*.

All therapists expressed considerable understanding of the necessity of the therapeutic alliance: engaging sensitively with dietary issues, keen not to create defences in clients. Patience and empathy were captured by Participant 4 in her notion of being *alongside and if they're ready to work with it then they'll be ready to work with it*. Participant 2 was also keen to not create defences in clients:

If they seem irritated or whatever, I'm not going to persist, I will drop it instantly. … I just don't wanna alienate them at the first session.

Examples of unconditional positive regard were also given. Participant 5 explained, *if the client doesn't want to do it, then that's all well and good, you have to respect that*, an attitude mirrored here by Participant 1:

I mentioned this [dietary] theory and he said, 'that's absolute rubbish' and I said, 'that's fine' and then changed the subject… he lacked confidence and I was trying to show him that whatever he thought was good, was good.

When engaging with clients regarding their dietary lifestyle, participants reported a preference for clients to take responsibility for this process, entering into a collaborative partnership. Clients' avoidance of responsibility or engagement with their dietary self-care was also deemed to be significant, a way to gauge their readiness to take steps towards real change:

It's a very useful indicator, you know, if I'm talking to somebody about their coffee intake and their water intake and their junk food and then the next week they come and it's identical, it's like, ok, that tells us… that tells us a lot, doesn't it? (P1).

Diet and nutrition within the therapy process

Themes here captured how clients' diet/nutritional intake might be taken into account alongside their symptoms during the therapy process. Specific foods beneficial to health, such as healthy fats; serotonin- and tryptophan-rich foods for depression; and water, fruit and vegetables were discussed as was maintenance of blood sugar and energy levels. Reduction in processed, high-fat and high-sugar foods was also considered important. The impact of caffeine was of interest, especially when considering symptoms of anxiety, depression and sleeplessness.

If we decide that [panicky clients] are thinking these thoughts at night and they're also having lots of caffeine…, 'are you, you know, drinking Coca-Cola or having coffee and tea late at night?' (P4).

Participants also sought to gain a broader understanding of clients' lifestyle and self-care, including dietary habits, taking time for oneself and physical exercise.

What's their day like? Have they got time to sit? Have they got time to eat? I wonder what they're eating?… I look at how they're affected in their lives [in] a physical and emotional and behavioural way… (P3).

Participants used a variety of tools in interventions with clients, including food diaries and drawing diagrams. All participants told of positive outcomes for clients: for example, a client identifying allergies and subsequent improved health, whilst others changed eating habits. Working with bulimia, one therapist collaborated with her client to achieve a more balanced diet with positive results.

…She then wasn't craving… if she kept to a diet like that then she wouldn't binge and wouldn't want to make herself sick, and you see [bingeing] made her feel bad about herself, so there was a link with the self-confidence and self-esteem (P3).

However, defensive and resistant responses were also illustrated.

They think it's all about, you know, the mind and you can sense the tension and the anger and the frustration with a few of them who come in and think it's all about the emotional side and nothing else (P5).

Considering ethical practice

Themes grouped here illustrated participants' acknowledgement of necessary competence when addressing issues of diet/nutrition, and half of participants had undertaken formal training. Caution in approaching diet with clients and engaging in ongoing personal research were recommended by participants. Reference was also made to ethical guidelines in practice, as was the ability to recognise one's professional limitations and for clients to seek further qualified opinion.

…'This is now counselling, please go and research that yourself, please go and consult with your doctor, consult with a nutritionist', you know, I'm not saying I'm an expert (P1).

Recommending nutritional consultation posed dilemmas, depending on clients' financial resources and socio-economic background. Limitations posed by social class were highlighted when exploring dietary habits.

[The lack of healthy eating habits] did seem to be the level of… deprivation that they grew up in… education and some of the social class side does feed into that… some of those students, who've come from more privileged backgrounds… it's almost such a no-brainer, the [healthy] habits were entrenched at such an early age (P2).

When working with clients' diet, participants acknowledged the matter of their own process with a recommendation to explore difficult encounters.

You have to take that back and think, 'did I push? Was I banging on too much about nutrition or something?'… analyse it and reflect on it and wonder (P3).

Although all participants attended regular supervision, experiences of their individual supervisor's level of interest in this issue or support varied. This seemed to be influenced by the theoretical stance of the supervisor or the supervisor's own perceptions and beliefs regarding the relevance of such an approach to mental health and well-being.

Discussion

Research and discussion in the literature suggest that dietary habits and nutritional status are significant for mental health. Yet, consideration of such information for its relevance for counsellors and psychotherapists in a therapeutic capacity with clients remains scarce. This study shows that, at times, therapists will consider dietary and nutritional issues as part of their therapeutic practice, with diet and nutrition also holding personal significance. Viewing clients holistically was a key factor, and all participants held a passionate belief in a healthy diet being essential for good mental health; that inadequate dietary intake or eating patterns lead to a range of mental and emotional disturbance, reminiscent of the points made by Holford (**2004**).

It is generally understood that life events shape an individual's perceptions and their expectations of the world; when relevance or importance is assigned to an event, this is often influenced by the individual's previous experience. This principle may also apply to the use of particular approaches to client work and supports previous findings by Royak-Schaler and Feldman (**1984**) that concluded that therapists were happier to recommend activities for well-being to their clients that were personally familiar and part of their own lifestyle.

All six participants talked about pragmatism, with approaches to therapy often conveying a sense of the practitioners' maturity, that is both the extent of their professional lives and their personal lived experience. Rønnestad and Skovholt (**2003**) identified these same issues in their qualitative study, which explored the developmental process of counsellors and psychotherapists and identified six phases of growth and integration. The flexibility in approach described at *Phase 5: The Experienced Professional Phase* (p. 20) is echoed in this study's findings – as a result of encounters with many clients, a range of work settings and life itself, participants identified the limitations of single theories, opting instead for the freedom of an integrative or eclectic approach.

Participant comments regarding the NHS and GPs echoed that of The Associate Parliamentary Food and Health Forum's report (**2008**), which listed amongst its findings a less than satisfactory standard of training and nutritional support for patients by GPs. It cannot be assumed, therefore, that GPs will address issues of diet when considering their patient's mental health symptoms. Subsequently, a discussion in therapy may be the first time that a client will be invited to consider their mental health in this way (Pointon, **2006**).

This situation raises the issue of therapist isolation when considering psychological and emotional problems with this type of approach. Despite clear recommendations for nutrition to be considered in mental health (Associate Parliamentary Food and Health Forum, **2008**; Sarris et al., **2015**), therapists may find that other professionals involved in a client's mental health support do not share the therapist's approach to improving well-being (Caldwell & Jorm, **2000**) and may result in the therapist working in conflict with the rest of client's support system.

In addition, several participants spoke of a lack of engagement with issues of diet by their supervisors, with one participant perceiving lack of engagement with dietary issues to be a result of her supervisor's psychoanalytic model, an issue raised previously by the findings of Burks and Keeley (**1989**). This is important to consider with regard to practitioners' continued opportunities for exploration and growth. Supportive supervision is important: a client's relationship with food may trigger reactions within the therapist, especially if linked to the therapist's own relationship with food, or if perceived as a client's method of self-harming.

In advocating a healthier lifestyle, issues of a socio-economic nature were raised with a social class divide observed in terms of nutritional knowledge and those from less privileged backgrounds potentially having less access and exposure to beneficial foods and habits. Therefore,

differences in social class are important to consider when making suggestions for change, with issues concerning the affordability of certain lifestyle choices and clients more likely to choose cheaper, accessible options (Jorm et al., **2000**).

All participants spoke of clients' improvements due to simple dietary modifications as a result of receiving information from their therapist and exploring dietary issues. No doubt, further research is required. Whilst studies linking diet, nutrition and mental health are numerous, the methods of dietary exploration in therapy and its impact; clients' experience of interventions; and the degree of improvement to mental health and well-being after therapist intervention all seem to be areas worthy of further study.

Limitations

All participants were self-selecting and, to meet the study's aims, had an existing interest in this area. This meant that there was no opportunity to consider the views of those who deemed diet and nutrition as irrelevant to the therapy process. Furthermore, others with an interest in this area may not have responded to the advert and were possibly reluctant to discuss what may be considered an uncommon approach to therapy. All participants were female and experienced practitioners, leaving no opportunity to consider the views of male practitioners or those with less experience. Also, all practitioners practised an integrated or eclectic form of therapy meaning that the views of therapists from other theoretical orientations were not explored.

Implications for practice

Integration of diet and nutrition into therapeutic practice means that as excessive alcohol or recreational drug use might be explored in session, client's mistreatment of their body with more socially acceptable substances – caffeine, sugar, fat or junk food – might also be explored, and established mental and physical health organisations provide substantial information to interested practitioners. However, the abundance of studies concerned with nutrients and mental health is potentially overwhelming for both practitioners and clients and it would seem unhelpful to overload clients with information during therapy. Publicly available literature may provide a start point for the issue to be discussed or signposted in session, promoting autonomy and responsibility of clients for their recovery.

The pharmacological approach to mental health and its effectiveness has been questioned (Davies, **2013**; Sarris et al., **2015**). Some clients, preferring a natural approach to health, avoid medication (Caldwell & Jorm, **2000**; Jorm et al., **2000**), so a holistic or multidisciplinary approach to mental health may provide clients with additional options. However, dietary habits are a sensitive issue and the appropriateness of interventions is best assessed on a client-by-client basis, with vigilant attention paid to clients' responses. The need for ethical practice and competence also dictates that, unless suitably qualified, the practitioner should observe their limitations, consulting a dietary expert where necessary, especially regarding nutritional supplementation.

Food choice is a complex area influenced by many factors (Adams et al., **2010**), and therapists need to hold realistic expectations of a client's willingness and ability to tackle dietary change. Therapist self-awareness is crucial: a therapist's physical appearance, values and beliefs all influence therapy, and reflection on one's own personal self-care and dietary habits is required in order for sensitive work with clients. Bias, due to the therapist's own lifestyle choices, is an area that would ideally be explored in supervision; however, it seems crucial that an appropriately informed supervisor is necessary to enable adequate discussion and support. Financial issues are also an important consideration: the affordability of nutritional consultations, particular health foods or supplements, must never be assumed. However, reducing unhelpful substances, drinking water and eating more whole, natural foods mean simple and beneficial change does not necessarily have to be expensive. In response to a recent review of NICE by the Department of Health, BACP highlights 'growing calls for practitioners to be trained to treat people as whole people, with a core understanding of the interactions between mental and physical health' (BACP, **2015**, p. 52). To this end, counselling and psychotherapy training courses might consider introducing diet and nutrition modules, providing opportunity for exploration of theoretical stance and practical dilemmas, especially regarding issues of directivity and appropriate intervention in therapy. To support standards, guidance from professional bodies is needed. Practice guidelines, fact sheets, ongoing research and discussion in journals, potentially developing links with other professional bodies within diet and nutrition, would contribute to dietary issues becoming more integrated into the field.

Clearly, there are challenges that need to be better understood, but a mechanism that helps therapists embrace this underexplored area has the potential to facilitate important therapeutic change for clients.

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Biographies

Nicola Terry is a BACP-registered accredited counsellor/psychotherapist in private practice, and this study was completed as part of her Master's degree at the University of Chester. Her professional interests include the development of training for therapists regarding issues of diet/nutrition in client work, and she has written and delivered CPD workshops on this subject.

Andrew Reeves is a BACP senior accredited counsellor/psychotherapist at the University of Liverpool. His research focuses on therapeutic interventions with people who are suicidal or who are self-injuring, and he has published widely in this area.

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