“Because I don’t come from their culture”: Examining dietitian’s experiences promoting healthy dietary behaviors among Hispanic Caribbean clients in New York City

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Abstract

This article examined dietitians’ experiences working with Hispanic Caribbean communities in New York City, an understudied community with high incidence of diet-related conditions. We used a qualitative approach to assess perceived best practices and barriers that prevented implementation of these best practices when working with Hispanic Caribbean clients. Data included semi-structured interviews with fifteen dietitians. The analysis was informed by Grounded Theory, revealing three main overarching themes related to perceived best practices: building rapport, incorporating cultural values, and addressing food access. Barriers to applying these approaches included dietitians’ personal factors (language, food preferences), lack of culturally-relevant education and resources available to dietitians, cultural challenges that prevented engaging clients in participatory decision making, and institution-related constraints (time scarcity and funding). The findings underscore the need for improved training for dietitians to be better equipped to work with communities with different cultural and economic backgrounds from their own, for more culturally-relevant resources and funding to address underlying causes of diet-related health disparities in minority populations, and for increased diversity in the profession. Furthermore, our focus on Hispanic Caribbean communities expands existing research promoting cultural competence in the profession, presenting experiences working in with this large segment of the Hispanic community in the United States.

Background

Hispanic communities in the United States (U.S.) have a higher burden of diet-related chronic diseases than non-Hispanic white Americans, underscoring the need for culturally inclusive initiatives that address poor dietary behaviors among U.S. Hispanic populations (Hales et al., 2018; Menke, Casagrande, Geiss, & Cowie, 2015; Rehm, Monsivais, & Drewnowski, 2015). There is great diversity within the Hispanic community. The 2010 Census showed that Mexican Americans account for 63% of Hispanics/Latinos in the U.S., followed by Puerto Ricans (9.2%), Cubans (3.5%), and Dominicans (2.8%) (Ennis, Rios-Vargas, & Albert, 2011). Noteworthy is that Puerto Ricans, Cubans, and Dominicans

(Hispanic Caribbean communities) is a growing yet understudied subgroup within the Hispanic population. Research suggests that differences in diet and chronic disease risk may vary based on country of origin. For example, researchers examining data from the Hispanic Community Health Study/Study of Latinos found that Dominicans and Puerto Ricans have higher rates of obesity and diabetes (G. Heiss et al., 2014; Schneiderman et al., 2014), and lower consumption of vegetables and whole grains (Siega-Riz et al., 2014) compared to other Hispanic groups.

Dietitians play an essential role in providing nutrition education and counseling (e.g., goal setting, motivational interviewing, problem solving) to individuals at risk for

diet-related conditions and it is imperative that these strategies are culturally tailored. For a dietitian to provide culturally inclusive services it is important that they have achieved a level of cultural competence. Achieving cultural competence is a process in which one seeks awareness, knowledge, and skills that enables a system, agency, or professional to work effectively in cross-cultural situations (Campinha-Bacote, 2003). According to the widely cited Campinha-Bacote (2003) Cultural Competence Model, cultural competency is a dynamic process where the healthcare provider is continuously seeking to improve their capacity to work within the specific cultural context of the client (Campinha-Bacote, 2003). The model emphasizes constructs such as having an awareness of one's own cultural background and prejudices, obtaining knowledge about clients' cultures, and possessing skills to perform in a culturally-sensitive manner. The integration of these constructs is essential for improving cultural competence and is dependent on the provider's genuine desire to engage in the cultural competence building process.

While diet-related chronic diseases in the U.S. span across racial and ethnic groups, greater disparities are seen among minoritized groups such as Hispanic Caribbean, who are severely under-represented in the dietetic profession (Olivares, Burns-Whitmore, & Kessler, 2015; Setiloane, 2016). As of March 2020, 93.9% of registered dietitians in the Academy of Nutrition and Dietetics were women and 81.1% were white (AND, 2020). Studies have previously highlighted both the importance of cultural competency (Albritton & Wagner, 2002; Cook, Kosoko-Lasaki, & O'Brien, 2005; Setiloane, 2016; Taylor & Lurie, 2004) and the need for more training on cultural competency for dietetic students (Olivares et al., 2015; Setiloane, 2016). Cultural competency is often assessed using quantitative surveys (e.g., multiple choice questions) that examine cultural nutrition knowledge of specific cultural groups (e.g., Mexican Americans) (McArthur, Greathouse, Smith, & Holbert, 2011). This method of data collection does not allow for an in-depth understanding of how dietitians engage with minoritized groups, especially Hispanic Caribbean, in nutrition education and counseling.

The present study employed qualitative methodology to examine perceived best practices to promote positive dietary behavior change among Hispanic Caribbean clients, as well as barriers to implementing best practices, according to dietitians based in New York City (NYC). Research suggests that NYC has one of

the largest Hispanic Caribbean populations in the U.S., where Puerto Ricans and Dominicans make up more than half of the Hispanic population (30% and 28%, respectively) (Greer et al., 2017), making this an ideal setting to conduct this study.

Methods

Study Design and Recruitment

In-depth qualitative interviews, informed by phenomenological and grounded theory approaches (Charmaz, 2006), were conducted with NYC dietitians who work with Hispanic Caribbean populations (i.e., clients that identify as Dominican, Cuban, and/or Puerto Rican). Recruitment was done via direct phone calls to community health centers located in areas with a high Hispanic Caribbean concentration (>50% according to census data) (DYCD, 2011), in addition to outreach via professional networks. A snowball approach was also utilized, where participating dietitians referred others to the study. Interested dietitians were screened for eligibility, and dietitians who reported having little or no contact with Hispanic Caribbean populations were excluded. The City University of New York (CUNY) Institutional Review Board reviewed the study protocol and deemed this study as exempt, as a minimal risk study using non-identifiable data.

Data Collection

Data were collected via telephone interviews between August and November of 2016 using a semi-structured interview guide (Table 1). The guide was informed by the principal investigator's prior research with Hispanic Caribbean communities (Fuster, 2017; Fuster and González, 2019) and experiences teaching in a dietetics program. The interviews were conducted by a trained research assistant and dietetic student. After verbal consent was received, the interview began with open ended demographic and professional background questions (i.e., age, gender, ethnicity, years of professional experience, practice setting), followed by open ended questions in the interview guide. The interviews were audio-recorded, lasting on average 26 minutes. The interviewer also took unstructured notes to document emerging findings during and after the interview. These notes were discussed in weekly team meetings with the principal investigator to discuss emerging findings and determine when data saturation was achieved (i.e., when the interviews failed to yield new information) (Saunders et al., 2018).

Table 1. Interview Guide

1. Tell me about your work.
How is a typical day for you?
Prompts: Description of general population served (age, race/ethnicity, income level, general nutrition issues)
2. Tell me about your experiences with the Hispanic Caribbean community (Puerto Ricans, Cubans, and/or Dominicans).
Prompts: common health issues, knowledge/perception of cuisines
3. What do you think are some best practices to address the nutritional and health issues in this population?
4. As a health professional, what are some barriers or difficulties you face in addressing health issues in this population?
5. Is there anything else you want to share regarding your experience with this population?

Data Analysis

Descriptive statistics were used to analyze the demographic and professional background questions. The interviews were transcribed verbatim and data analysis was informed by grounded theory, where codes were first derived from reappearing key words or phrases in the text and were grouped into larger categories based on their relatedness to one another. These categories were further grouped together based on recurring concepts, which were then analyzed to identify major themes (Charmaz, 2006). Two members for the study team coded each transcript independently. This was followed by multiple meetings to discuss, refine, and organize the emergent themes within larger categories related to the study's purpose (perceived best practices when working with Hispanic Caribbean clients and barriers to engage in the perceived best practices).

Results and Discussion

The sample was comprised of fifteen dietitians (100% female), between 24 and 61 years of age (mean=35 years). Two-thirds of dietitians self-identified as "white" or "Caucasian" (n=10), while the remaining participants (n=5) self-identified as Hispanic/Latinas or mixed (specifically, Mexican American, Cuban-Jamaican, Ecuadorian, Colombian, and Dominican). Years of

professional experience ranged from 2 to 32 years (mean=9 years). Regarding practice setting, dietitians worked with community/nonprofit organizations (n=6), community health centers and clinics (n=5), and hospitals (n=4).

Next, we organized this section based on the three overarching areas related to perceived best practices to promote positive dietary behavior change among Hispanic Caribbean clients: 1) building rapport, 2) incorporating cultural values and norms, and 3) addressing food access challenges. Each section included barriers to implementing these perceived best practices, as experienced by participating dietitians.

Best Practice: Building Rapport

Dietitians talked about the importance of building rapport with their Hispanic Caribbean clients. This meant creating a welcoming environment and getting to "know your participants first before rambling about all your experience and all your credentials" (N05/community-based Caucasian dietitian). One way in which dietitians built rapport was through education, as a vehicle for empowering clients for healthy dietary changes, as discussed below.

You would like to empower them to know about the benefits or downsides of some of the foods they may be eating and to make healthier choices. (N11/Hospital-based Caucasian dietitian)

Participatory approaches were also utilized to establish rapport, such as encouraging clients to contribute their recipes as part of community programs and using discussion-oriented nutrition education classes with interactive activities (e.g., cooking together). One dietitian discussed the benefit of partnering with community partners when developing programs, to "strategize ways to uplift our community members who are making an active change in their lifestyle and to try to create community around that." (N02/Community-based Hispanic dietitian)

Rapport building was constrained by several barriers. The most commonly mentioned personal barrier dietitians noted was the inability to speak Spanish and having to rely on an interpreter, which speaks to cultural differences between dietitians and their clients:

I'm white [and] they might respond better if I was Hispanic because that's not the kind of diet that I've ever followed. I think most Hispanic people know that that's not the way white people eat. So I don't know if they would be as likely to take my advice because

I don't look like them, I don't speak their language, I don't understand the lifestyle. (N03/Health care center Caucasian dietitian)

Another personal barrier identified was having limited or no experience with Hispanic Caribbean cuisine, as reported by a few of the dietitians we spoke with. They attributed this to their own dietary limitations and food preferences, as the following excerpt shows:

I have tried [the] fried plantains and that is pretty much that I have tried to be honest. Because I am a very picky eater. I don't need a lot of meat. I am picky with the texture and things like that. (N09/Clinic-based Caucasian dietitian)

Granted, the dietitian quoted above may be an extreme case. However, the issue brought up in this excerpt points to the influence of personal factors (in this case, food preferences and behaviors) and their potential influence in dietary counseling in general, but potentially more pressing when working with clients from a different culture. At the same time, this issue may have repercussions when incorporating cultural values and norms, another identified best practice, given the important role food can have in social interactions and dietary counseling.

The dietitians included in the study also discussed clients' perception of healthcare providers as a barrier when interacting with their Hispanic Caribbean clients. This included the perceived prevailing view of dietitians as someone who "takes away" preferred foods. They noted that Hispanic Caribbean clients were "deferent to their expertise," and this was perceived as a barrier to establishing the collaborative relationship dietitians sought to establish when using rapport building and participatory counseling approaches. For example, one dietitian recounted common attitudes when attempting to identify diet-related goals, where clients typically responded with "tell me what to do and I will just do it." (N10/Community-based Caucasian dietitian). This perceived deference is related to the Latin American cultural value of *respeto* (respect) and social hierarchies, where health care providers are viewed as highly educated and authoritative figures (Juckett, 2013). In practice, this perceived deference interfered with building client rapport as well as the application of collaborative approaches dietitians are trained to engage in when promoting dietary change (Taylor & Lurie, 2004). This issue is further exacerbated by the lack of time in health care settings, further preventing

the encouragement of healthy eating in clinical settings. One dietitian considered this a limitation on a more systemic level:

[There is] not enough time within the health center to explain what their health issues are. The whole medical industry is not conducive to encouraging healthy eating. They're not getting to the core of what these issues are. (N04/Health care center Caucasian dietitian)

This perception resonates with other research with other healthcare providers (Coeugnet, Forrierre, Naveteur, Dubreucq, & Anceaux, 2016).

Best Practice: Incorporating cultural values and norms

The dietitians stressed the importance of "understanding" and "validating" cultural foods, seeking to balance the promotion of healthy diets, while also being respectful of tradition. This was done by asking clients questions demonstrating an interest in food preferences and traditions, as this dietitian explained:

Definitely cultural sensitivity as far as suggesting dietary change through researching what the cultural food practices are even in making recommendations [and researching] what types of food that they are coming up with, [which] recipes they are still in keeping with more traditional recipes rather than just saying like a one size fits all. You have got to eat seeds, vegetables you got to eat these type of things. I think asking people, you know, what they eat, how they eat, why they eat it. [...] I think asking a lot of questions about why things are happening and how we can work together to change them. So keeping what's important about the food for the patients. (N10, Community-based Caucasian dietitian)

They also shared strategies used to encourage healthful dietary changes. Some emphasized the consumption of smaller portions and/or the addition of healthier foods, such as "more non-starchy vegetables, because they already do eat them but they need to eat more" (N3/Health care center Caucasian dietitian). Similarly, dietitians avoided recommendations that focused on the elimination of cultural foods, as many did not consider it feasible for Hispanic Caribbean clients to switch from white rice to brown rice, such as white rice given the cultural preference for the former.

When providing dietary recommendations, the dietitians also stressed a need to understand the influence of familial values among Hispanic clients:

We have to think of the family structure first and foremost [which] has been essential for my understanding of what family-style meals look like and what families can do to support a child and an entire household in eating healthy and engaging and healthy eating habits. (N02/Community-based Hispanic dietitian)

While dietitians stressed the importance of incorporating cultural factors, they were limited by their level of knowledge about Hispanic foods, as well as the culturally-relevant resources available. When describing the cuisine, some cited a lack of knowledge of basic foods found in Hispanic cuisines (e.g., rice, beans, meat, and plantains). For instance, one dietitian had “no idea what they’re talking about” when clients discussed traditional leafy vegetables (N01/Community-based Caucasian dietitian). The lack of knowledge concerning Hispanic Caribbean foods prevented dietitians from promoting potentially healthier aspects of the cuisine, such as the “greens that they ate back home”, which may present a missed opportunity to encourage more culturally appropriate foods. One dietitian expressed, “needing more education because I don’t come from the culture” (N13/Hospital-based Caucasian dietitian). Notably, this issue was not unique to white dietitians. As exemplified by this Mexican-American dietitian,

I use the language [Spanish] but I would sometime – they tell me their diet recall and I am, like, I don’t know these foods. Like so -- especially from the Dominican culture they call different foods different names, there different vegetables were called different and I was like okay I need to start a like a running list foods that have different names. (N05/Community-based Mexican American Dietitian)

This shows that the barrier to incorporating cultural foods is more than just the language, as being a Spanish-speaker or even having Hispanic heritage does not guarantee the deeper cultural knowledge dietitians felt they needed to be truly effective in their interactions with their Hispanic Caribbean clients. Hence, dietitians need to make an effort to get to know the specific cultural foods and food practices in the community. In accordance with this, most of the dietitians did make efforts to learn about traditional Hispanic Caribbean cuisine, often through eating the food.

These discussions also pointed to barriers related to culturally-specific resource availability at the institutional level to address and understand cultural food practices

among Hispanic Caribbean clients. While resources may be translated to Spanish, further adaptations are needed. As noted by one dietitian, existing adaptations typically do not account for the diverse foodways existing among Hispanic communities overall and particularly for Hispanic Caribbean clients:

One of my frustrations was that there was scarcity in education materials to address the cultural aspects. I found educational tools that were translated from English, but they did not have the foods that were encountered in the Caribbean. It really was in Spanish but wasn’t helpful because culturally it wasn’t inclusive and it was [targeted] to the Mexican communities. I remembered coming across an article that said that Dominicans do not eat apples. The article was by a Dominican woman that started going to weight watchers. She wanted information in Spanish and she had chilaquiles, tortillas, enchiladas. The person through, “well you are Latina, so this is appropriate for you”. And she said, “I eat Mexican food but this is not appropriate for my culture.” (N15/Columbian Hospital-based dietitian)

The lack of truly tailored resources for Hispanic Caribbean populations places a greater burden on dietitians in their development as culturally competent practitioners, making the desire to improve a key aspect that may not always be readily monitored (or fully rewarded) as part of professional development benchmarks.

Best Practice: Addressing Food Access Challenges

When discussing their interactions with Hispanic Caribbean clients, the dietitians spoke about the importance of considering the neighborhood food environment when providing dietary advice. Some recognized that poverty and lack of food access often prevented their Hispanic Caribbean clients from eating healthier. One dietitian described the economic and social context in which some of her clients lived, where high-stress situations are commonly experienced among low-income populations, where “so many things come into play that makes it even more challenging to start talking about nutrition” (N05/Community-based Hispanic dietitian). This was attributed to various issues that often competed with each other, such as housing or unexpected family illnesses, and is similar to previous findings from research documenting these barriers (Beck et al., 2019; Laraia, Leak, Tester, & Leung, 2017). Dietitians tried to facilitate food access in their practice by increasing awareness about safety net program

eligibility, such as the Supplemental Nutrition Assistance Program (SNAP) and providing vouchers for fruits and vegetables at farmer's markets.

We're actively looking at the food environment. We also offer food boxes at schools and community centers, [and] we link our participants with those resources. (N03/Health care center Caucasian dietitian)

As the excerpt shows, dietitians sought to facilitate healthier diets within existing environmental constraints, empowering clients to select the healthier options of the food available. These activities included conducting supermarket tours and conducting cooking demonstrations at farmer's markets. Two of the dietitians interviewed recounted working with local restaurants to highlight healthier options, as well as facilitating group visits that focused on choosing healthier menu items to support the management of diet-related conditions such as diabetes. However, these were discussed in a more general way, as they did not include engaging Latin American restaurants, or working specifically with Hispanic Caribbean clients.

Some dietitians went beyond these approaches by seeking to work with food businesses to increase access to healthier foods in predominantly Hispanic communities. This included collaborating with bodegas (corner stores) to provide healthier options (e.g., fruit smoothies) and to increase their capacity for healthy, fresh foods offered by providing refrigeration and assisting in shelving displays. One dietitian discussed the potential to use food to motivate entrepreneurship, as a tool for economic opportunity:

We're hoping to start up a cafe of our own that will train women in the program and hopefully provide like a food entrepreneurship for people who are members of the community. (N01/Community-based Caucasian dietitian)

While business partnerships were seen as a good way to improve community health, the dietitians noted several barriers that prevented these collaborations. Aside from time, the most notable was the business need to make a profit. While one dietitian described how bodega owners profited from children coming to the stores to buy junk food, others recognized that these community businesses were fragile and in need for profit, which may dissuade them from partnering in community nutrition interventions:

These aren't like [corporate businesses]. If they make changes and they get less customers, they go out of business. (N12/Hospital-based Caucasian dietitian)

Additionally, some of these businesses were also being displaced through increased rents, being affected by the same economic forces as many in the community.

Institutional constraints within the dietitians' workplace were also identified as a perceived barrier to addressing food access and insecurity, at the scale needed. Both time and a lack of resources were cited as preventing participants from establishing an active community presence. One dietitian, for example, noted that her position in a hospital did not allow her to participate in policy advocacy to improve food access in the community, as a matter of institutional policy. Insufficient funds were an important barrier, particularly for dietitians working in community settings, depending often on short-term grants to carry out the work. Beyond the constant reliance on fundraising to create and sustain programs, one community dietitian also mentioned the "distractedness of various community programs", where multiple organizations often engaged in short-term programs, as opposed to a "unified effort to lift people out of poverty" (N01/Community-based Caucasian dietitian).

Implications For Research and Practice

This qualitative study provided needed insight on the experience of dietitians engaging in healthy diet promotion among Hispanic Caribbean communities, an understudied segment of the growing U.S. Hispanic population that disproportionately experiences diet-related health disparities (G. Heiss et al., 2014; Schneiderman et al., 2014). The dietitians shared their perceived best practices, which were grouped across three larger themes: building rapport, incorporating cultural values and traditions, and considering the neighborhood food environment when providing nutrition education and counseling to their Hispanic Caribbean clients. While presented individually, these best practices are inter-related. For instance, building rapport may be influenced by whether dietitians seek to incorporate cultural values and food environment constraints in their interactions. Considering the client's neighborhood food availability may also influence how well dietitians can incorporate cultural food traditions. Similarly, the barriers identified may have repercussions across these perceived best practices, ultimately

influencing the effectiveness of dietary counseling efforts. These barriers can be understood across three main areas: institutional based barriers that influence resource availability, personal factors that can influence client-dietitian interactions, and client-based factors, including perception of health care providers.

Cultural differences were perceived to prevent dietitians and their clients from building rapport and incorporating cultural aspects in nutrition education and counseling sessions with Hispanic Caribbean clients. Cultural differences between providers and patients/clients have been documented in previous research (Cynthia J. Heiss et al., 2011; Taylor & Lurie, 2004; Weller, Baer, Garcia de Alba Garcia, & Salcedo Rocha, 2012). Self-identified White/Caucasian dietitians noted how these racial differences may create a wedge between them and their Hispanic Caribbean clients, as well as language barriers. While this underscores the need for interpreters, our findings show that this barrier goes beyond language, requiring an in-depth understanding of the client's cultural background and food practices. The lack of knowledge is further compounded by the lack of culturally appropriate resources when providing services to specific ethnic groups, as the case of Hispanic Caribbean populations.

These findings suggest that more education and training opportunities for cultural competence are needed for dietitians to effectively engage with Hispanic Caribbean populations as well as more efforts to diversify the profession. Current training is limited to eating or preparing some ethnic foods and watching movies about other cultures, with only small percentage of dietetic students interacting with other cultures in internships, fieldwork experiences, or through study abroad programs (McArthur et al., 2011). Additional training opportunities should be extended to practicing dietitians, through programs that continue their cultural competency development through cross-cultural encounters (Stein, 2010). Aside from an emphasis on cultural competence training, dietitians also need to be competent when working with economically distressed communities, and how factors relating to economic and physical food access can influence the application of nutrition knowledge. This can include organization-level activities that promote community-engagement and participation, for providers to become more in tune with issues faced in the lower income settings they serve.

Greater cultural competency among dietitians may also

be addressed with more diversity within the field, a need which has been documented previously (Rogers, 2013), as well as greater sensitivity training to bring greater awareness about the influence of structural racism and inequities ultimately creating the persistent chronic, dietary conditions found among Hispanic Caribbean communities and other minority groups. While there are ongoing efforts to increase diversity in the dietetics profession (C. J. Heiss et al., 2012), more work is needed to recruit and retain students of diverse background, including addressing perceived bias (Hawkins, Balsam, & Graves, 2015; Rogers, 2013), lack of support, and the lack of role models (Olivares et al., 2015). As documented by Mahajan and colleagues, further action can be taken across multiple levels to improve diversity in the profession through actions including dietetic associations, practice settings, education and recruitment activities, as well as further research efforts incorporating Critical Race Theory to better understand dietetics practice (Mahajan et al., 2021).

Beyond cultural differences, other research points to the importance of socioeconomic differences between providers and clients. When Weller et al. (2012) examined differences between physicians and lay groups concerning diabetes conceptualizations in the U.S. and Mexico, the research showed that the largest differences were in Mexico, where providers and clients had shared culture and language. This gap was explained by differences in formal education and social class, highlighting their important role in understanding the client-provider relationship (Weller et al., 2012). While this was not a salient finding from our study, similar differences may be at play, given that the dietitians included in the sample worked in mostly low-income (and potentially low-educational level) communities.

Conclusion

To our knowledge, this is the first qualitative study to examine perceived best practices to promoting positive dietary behavior change, and barriers to implementing best practices, with Hispanic Caribbean populations. These findings offer a greater understanding of barriers health care workers face when working in culturally-diverse communities. Some challenges can be addressed by the development of more culturally-relevant resources and training opportunities, but other challenges are more personal in nature (e.g., food preferences). More research is needed to further understand how dietitians engage with clients from

culturally diverse backgrounds, promoting self-awareness and reflection within the dietetics profession. At the same time, further insight would be gained for studies examining the experience of Hispanic dietitians working within their own communities, to assess differences in barriers and perceived best practices, beyond cultural differences. Lastly, we focused on Hispanic Caribbean communities, which are an understudied, yet important segment of the Hispanic population in the U.S. (Ennis et al., 2011). Future research may expand, comparing experiences within different geographic areas and examining experiences with other immigrant/ethnic groups. Additionally, these efforts will provide needed insights to improve health promotion efforts (at the provider level) to prevent and address health disparities in culturally diverse communities.

Bios

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