Motivational Interviewing in Dietetics to Promote Behavior Change

Where Are We and Where Do We Want to Go From Here?

PRESENTED BY
Ashlea Braun, PhD, RD

Oklahoma Academy of Nutrition and Dietetics

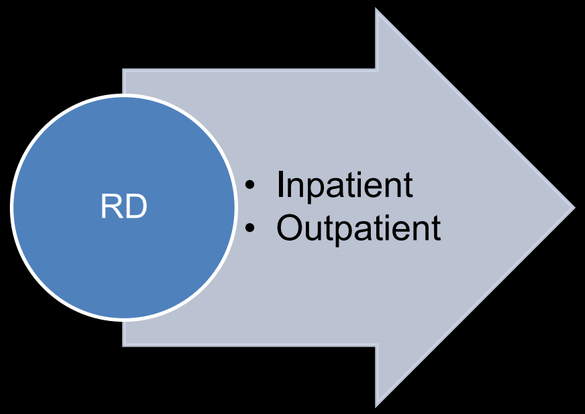
Conflicts of Interest

None to disclose

My Background

- RD – 2011, Medical Dietetics, Ohio State University
- Clinical practice
- Graduate training at Ohio State

My Background



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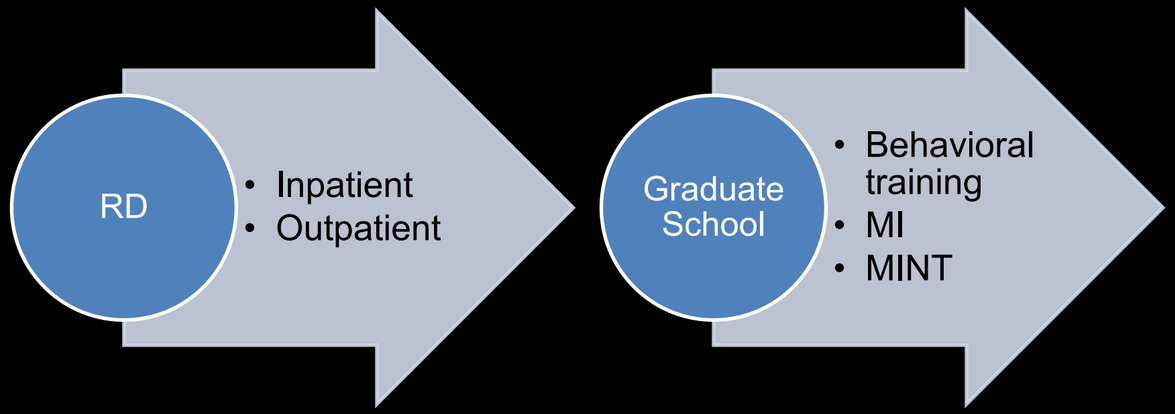

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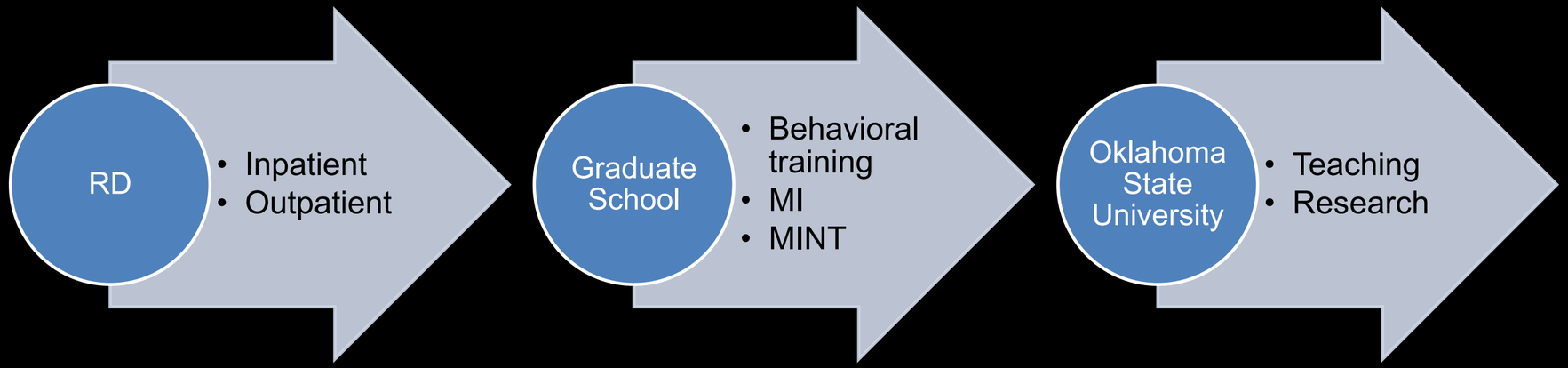

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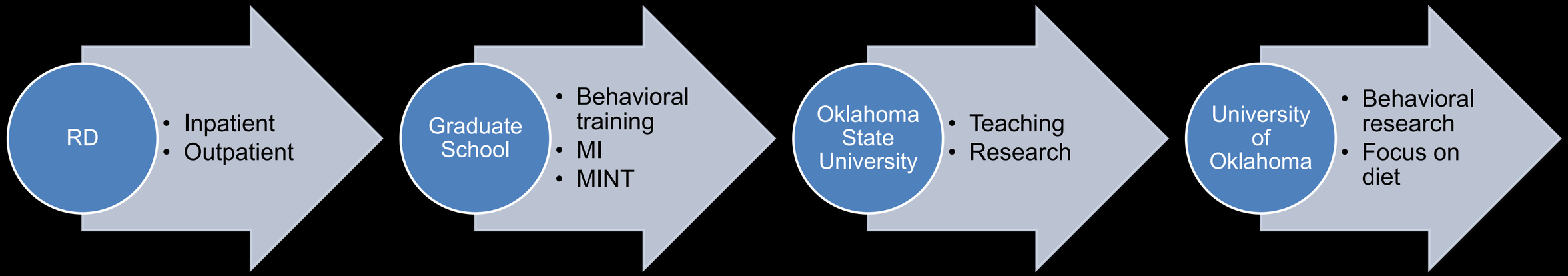


What is MINT?

- Closet thing to a credential in MI
- Documented training completion and training delivery
- Standardized patient

What is MI?

What is MI ***not***?

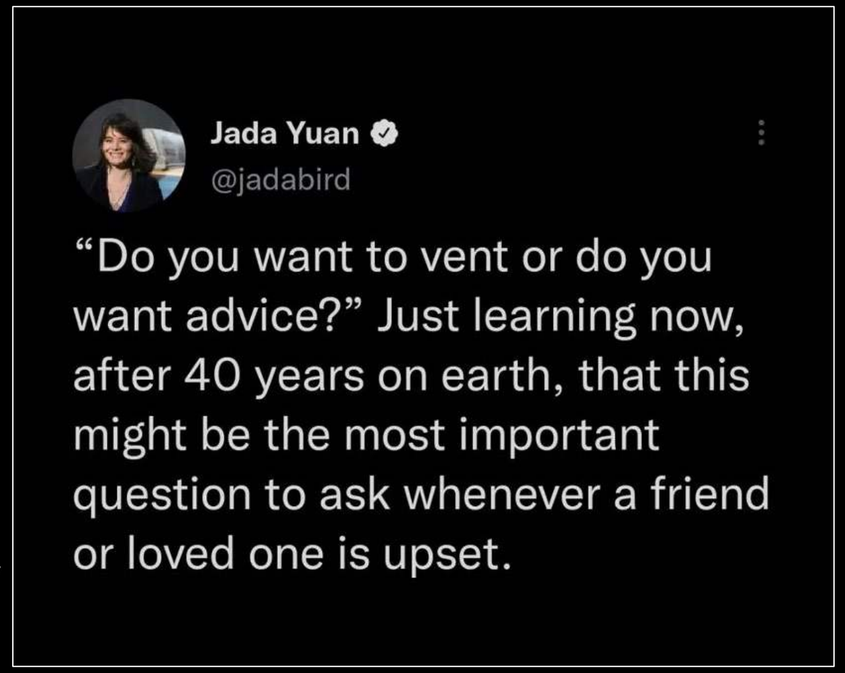
- Not goal setting
- Not asking: “How does that make you feel?”
- Not assessing barriers to change

1. Not based on the transtheoretical model
2. Not a way of tricking people into doing what they don’t want to do
3. Not a technique
4. Not a decisional balance
5. Does not require assessment feedback
6. Not cognitive behavioral therapy
7. Not just client-centered counseling
8. Not easy
9. Not what you were already doing
10. Not a panacea

Miller 2009

What is MI?

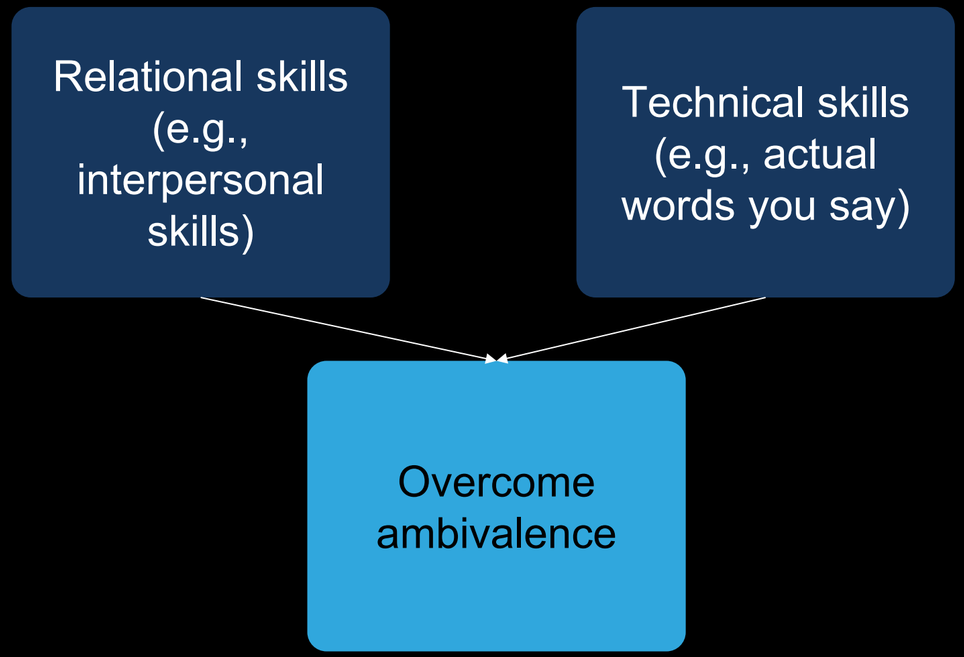
- **What is motivational interviewing?**
  - Conversation about change
  - Not necessarily any “tangibles”
- **Targets ambivalence:**
  - Identify reasons for and against change
  - Leverage intrinsic motivation, show empathy



Miller and Rollnick 2023

What is MI?

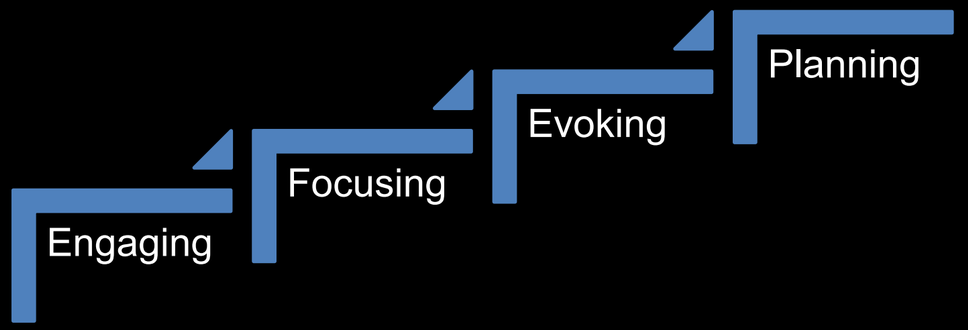
- **Two skill sets:**
  - Relational and technical skills
    - Open-ended questions, affirmations, summaries (*low-hanging fruit*)
    - Reflections
  - Collectively help a person overcome ambivalence
    - Change talk vs. sustain talk



Miller and Rollnick 2023

What is MI?

- **MI occurs in a series of processes:**
  - Occur in order, but can be brief depending on needs of patient
  - Planning need not occur
    - What happens in the first four steps = more important



Miller and Rollnick 2023

What is MI?

- **Do we teach MI in nutrition and dietetics?**

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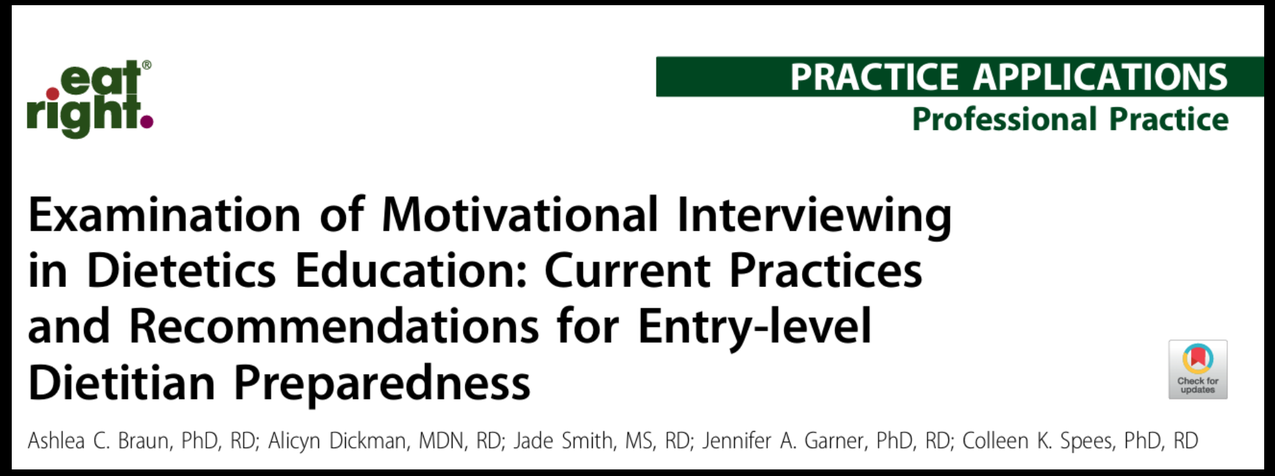
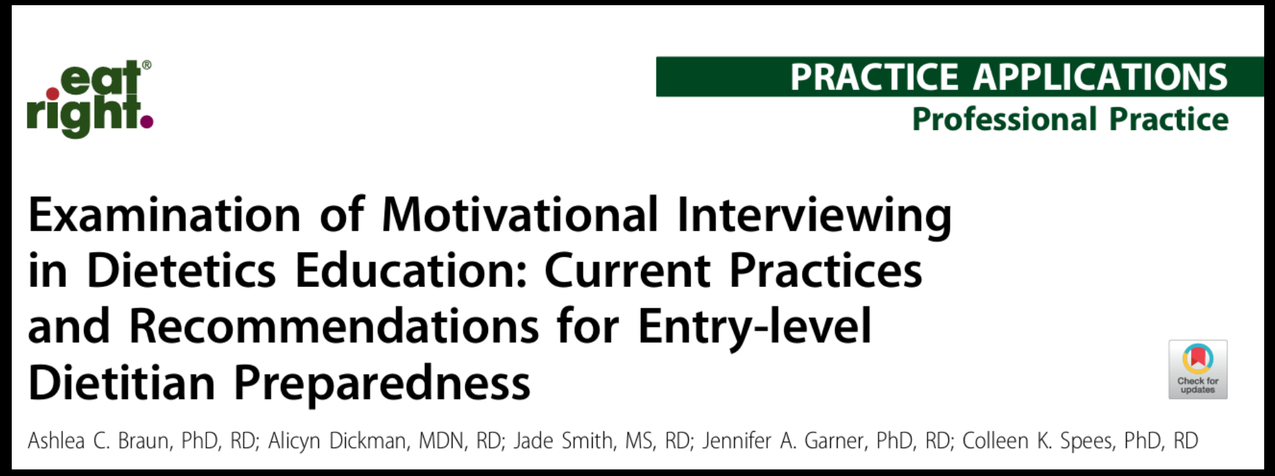


Braun 2024

What is MI?

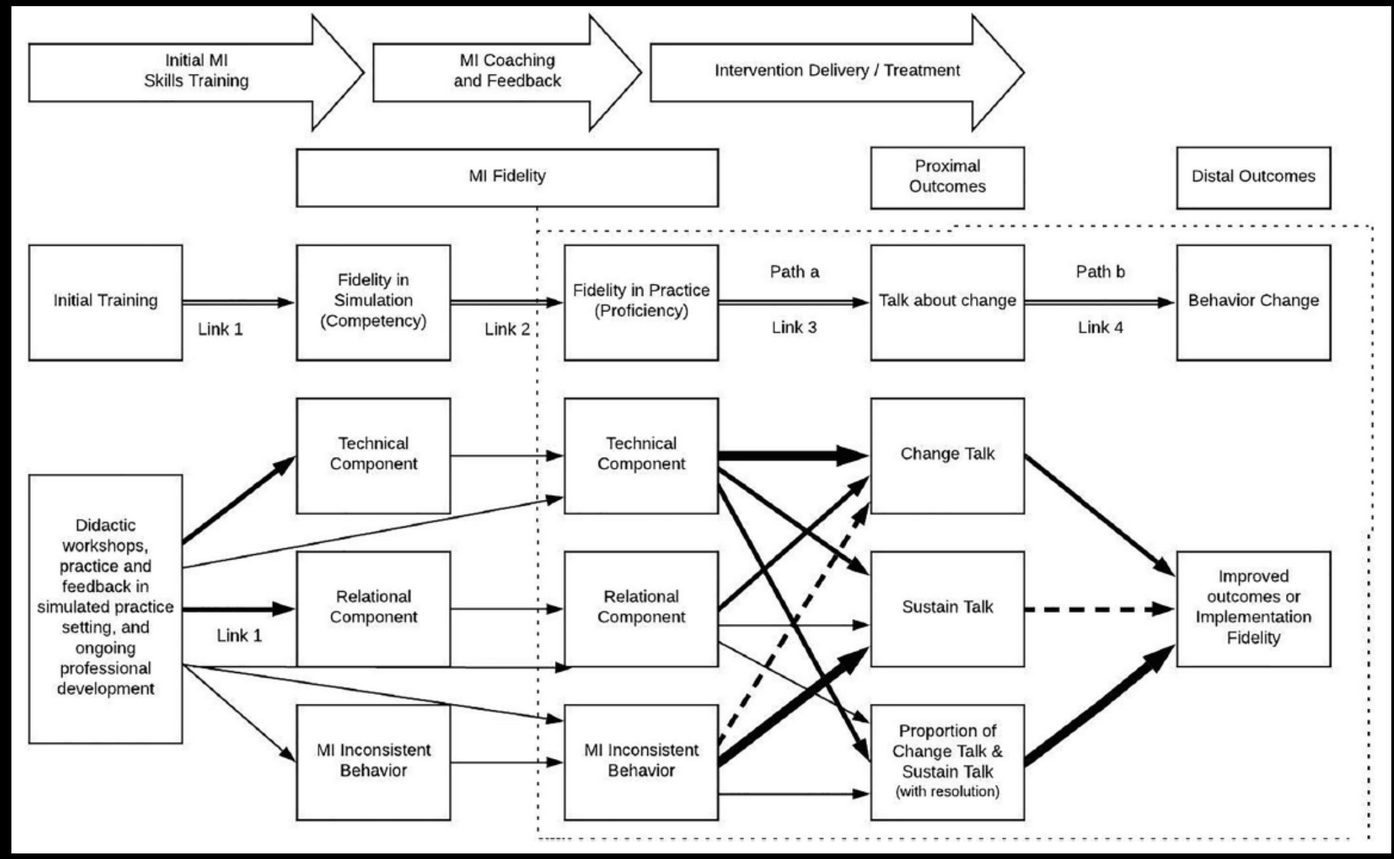
- **Do we teach MI in nutrition and dietetics?**
  - Not really
  - Not in an evidence-based way



Braun 2024

What is MI?

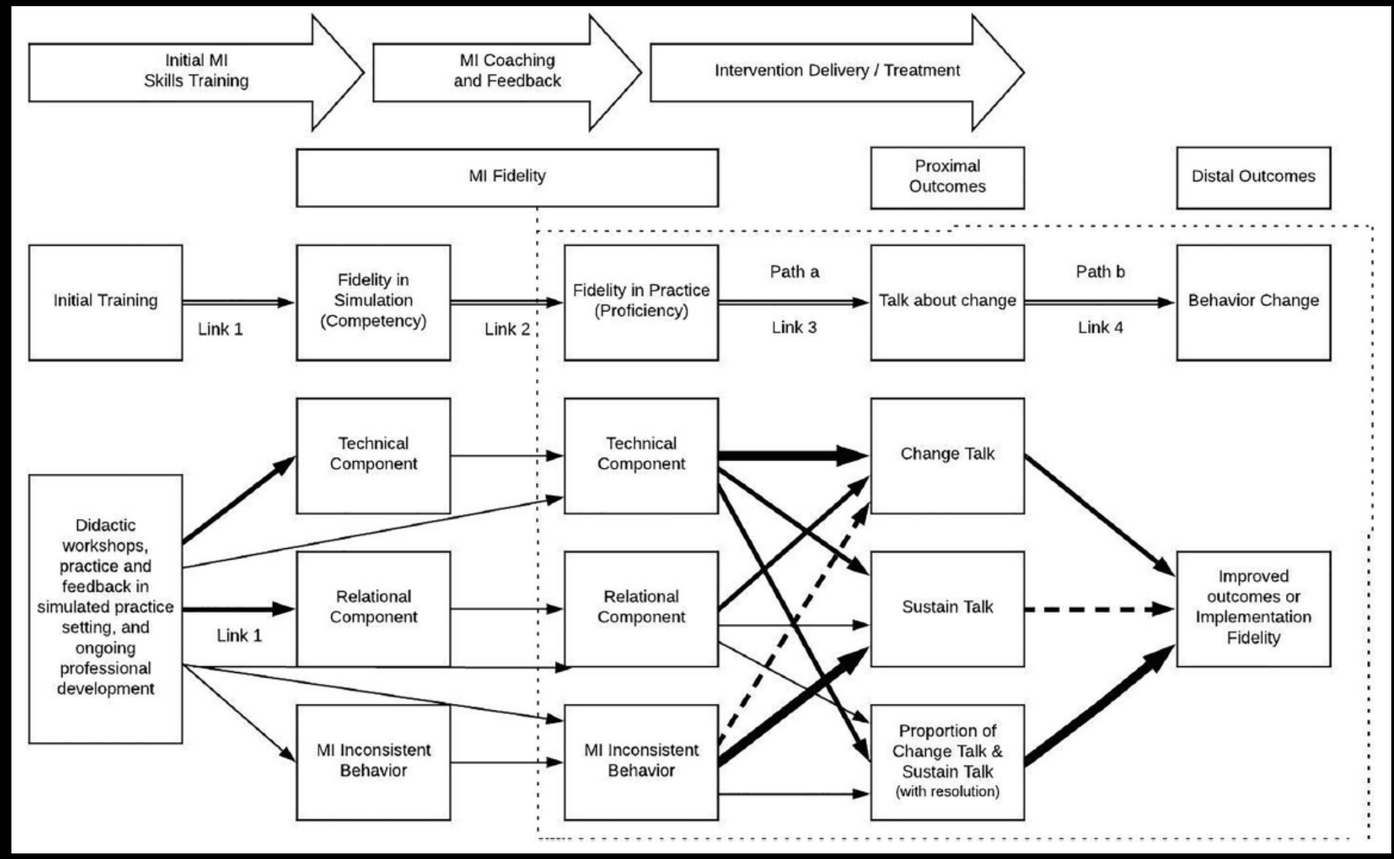
- **Do we teach MI in nutrition and dietetics?**
  - Well-defined and well-studied standards for what is needed to learn *how to use* MI
    - Knowing MI, using MI in simulated settings, using MI in real settings



Frey 2021

What is MI?

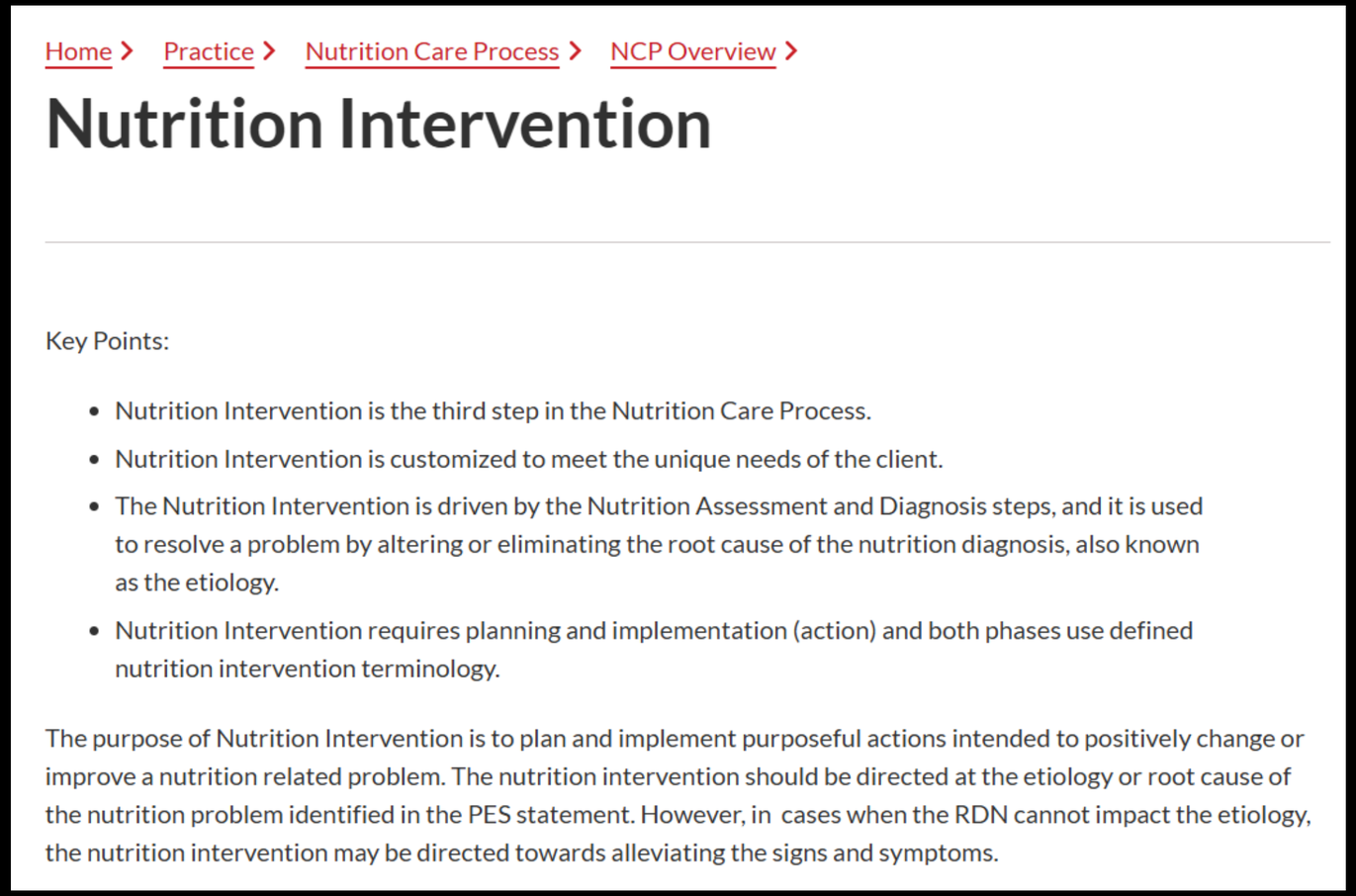
- **Do we teach MI in nutrition and dietetics?**
  - Evidence says:
    - 5-8 FULL days of MI training
    - 3-4 individualized feedback/coaching sessions



Frey 2021

What is MI?

- How does MI differ from what we *do* learn?
- NCP
- ADIME



Home › Practice › Nutrition Care Process › NCP Overview ›

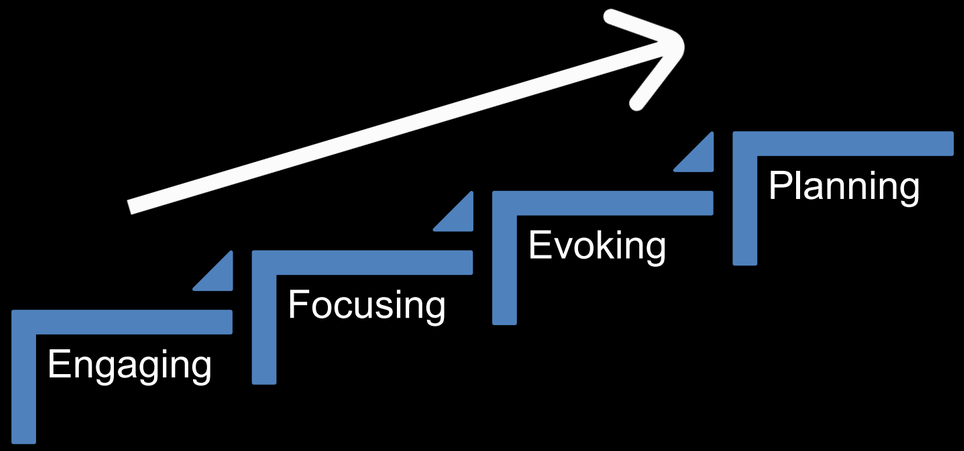
Nutrition Intervention

Key Points:

- Nutrition Intervention is the third step in the Nutrition Care Process.
- Nutrition Intervention is customized to meet the unique needs of the client.
- The Nutrition Intervention is driven by the Nutrition Assessment and Diagnosis steps, and it is used to resolve a problem by altering or eliminating the root cause of the nutrition diagnosis, also known as the etiology.
- Nutrition Intervention requires planning and implementation (action) and both phases use defined nutrition intervention terminology.

The purpose of Nutrition Intervention is to plan and implement purposeful actions intended to positively change or improve a nutrition related problem. The nutrition intervention should be directed at the etiology or root cause of the nutrition problem identified in the PES statement. However, in cases when the RDN cannot impact the etiology, the nutrition intervention may be directed towards alleviating the signs and symptoms.

What is MI?



A.D.I.M.E.

Motivational interviewing?

What is MI?

Home > Practice > Nutrition Care Process > NCP Overview >

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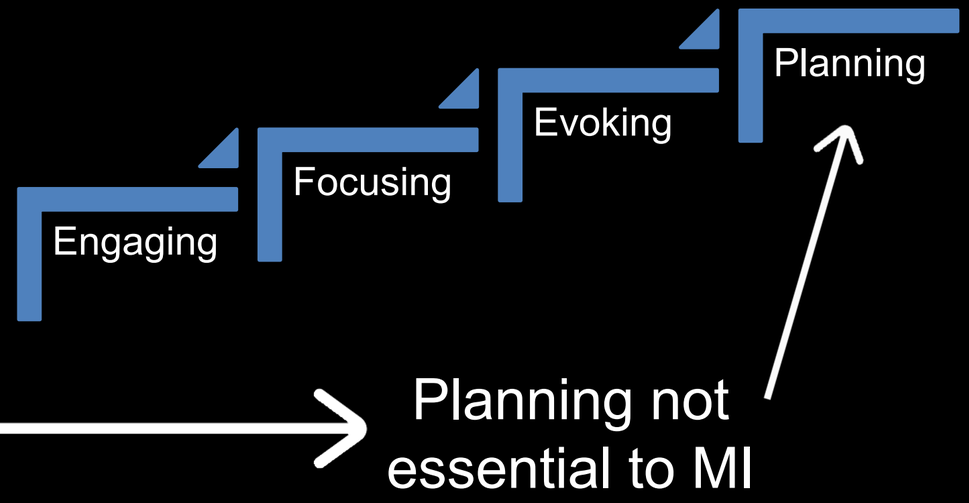

What is MI?

2.4 (cont.)	2.4.10 Translates basic to advanced food and nutrition science knowledge into understandable language tailored to the audience. (D) 2.4.11 Communicates complex nutrition information to broad and diverse audiences. (D) 2.4.12 Evaluates effectiveness of nutrition education and makes modifications as required. (D) <u>Psychological Counseling and Therapies</u> 2.4.13 Assesses client/patient's nutritional needs and appropriateness for the recommended counseling or therapy. (D) 2.4.14 Applies counseling principles and evidence-informed practice when providing individual or group sessions. (D) 2.4.15 Identifies the indications, contraindications, benefits, risks and limitations of the counseling or therapy. (K) 2.4.16 Demonstrates understanding of transference and counter transference in the therapeutic relationship. (K) 2.4.17 Demonstrates awareness of various appropriate counseling techniques. (K) 2.4.18 Evaluates effectiveness of the counseling or therapy and makes modifications as required. (D) 2.4.19 Refers/transfers client/patient to appropriate health professionals when counseling therapy or client/patient's mental health issues are beyond personal competence or professional scope of practice. (D)	• Create and present a workshop or education session to a community group. • Develop education materials to support a public health and global health issue. <u>Psychological Counseling and Therapies</u> • Implement counseling strategies to promote behavioral change • Counsel clients/patients on healthy lifestyles and weight management using various counseling techniques. • Use motivational interviewing skills to obtain food and nutrition practices of a patient and promote behavior change. • Identify psychotherapy approaches (psychoanalysis, psychodynamic therapies, behavior, cognitive, humanistic therapy, integrative therapy). • Provide nutritional counseling and psychological therapy modalities (e.g., behavioral and cognitive therapy) to increase awareness of patterns of thinking and the impact of healthy eating habits and eating behaviors on nutritional and mental wellness. • Define transference and countertransference in the therapeutic relationship; and recognize possible situations when this may occur in the nutrition and dietetic therapeutic relationship. • Refer client/patient to psychiatrist when acute mental health needs are identified (e.g., psychosis).	presentation based on age. • Counsel clients/patients on healthy lifestyle and weight management using various counseling techniques. • Create a nutrition care plan which includes behavior modification to address eating disorder (e.g., anorexia nervosa, bulimia nervosa, binge eating disorder). • Review evidence-based literature related to eating disorders and identify evidence-based psychotherapy modalities: the different indications, risks, contraindications, benefits and limitations.

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What is the purpose of MI?

Do RDs do MI?

- We can but…

Tele-Motivational Interviewing for Cancer Survivors: Feasibility, Preliminary Efficacy, and Lessons Learned

Ashlea Braun, RDN, LD[1]; James Portner, LISW-S, LICDC-CS, BCD[2]; Elizabeth M. Grainger, PhD, RDN[3]; Emily B. Hill, BS[1]; Gregory S. Young, MS[4]; Steven K. Clinton, MD, PhD[3,5]; Colleen K. Spees, PhD, RDN, FAND[1,3]

ABSTRACT

Objective: Determine the feasibility, acceptability, and efficacy of tele-Motivational Interviewing (MI) for overweight cancer survivors.

Design: Six-month nonrandomized phase 2 clinical trial.

Setting: Urban garden and remote platforms.

Participants: Overweight and obese cancer survivors post active treatment.

Intervention: Remote tele-MI from a trained registered dietitian nutritionist (RDN).

Main Outcome Measures: Feasibility, acceptability, and preliminary efficacy.

Analysis: Groups were stratified as users and nonusers based on tele-MI use. Qualitative survey data and remote MI interaction logs were analyzed for trends. Two-sample *t* tests were performed to assess pre-post intervention changes in physical activity and dietary behaviors, quality of life, self-efficacy, and clinical biomarkers.

Results: A total of 29 participants completed the intervention. There were 17 tele-MI users (59%) and 12 nonusers (41%). Users were primarily female (88%), breast cancer survivors (59%), college educated (82%), with a mean age of 58 years. Users set 50% more goals, lost more weight (4.8 vs 2.6 kg), significantly improved quality of life ($P = .03$), and trended more positively in clinical biomarkers (eg, cholesterol, blood pressure) than did nonusers.

Conclusions and Implications: Findings from this study indicate that tele-MI is a feasible and acceptable intervention for overweight cancer survivors after active therapy. Larger randomized trials are needed to establish efficacy and generalizability to a variety of demographic populations.

Key Words: motivational interviewing, telehealth, cancer survivor, lifestyle, technology (*J Nutr Educ Behav*. 2018;50:19-32.)

Impact of Dietitian-Delivered Motivational Interviewing Within a Food is Medicine Intervention Targeting Adults Living With and Beyond Cancer

Ashlea C. Braun[1,2] · James Portner[3] · Elizabeth M. Grainger[4,5] · Steven K. Clinton[4,5] · Menglin Xu[6] · Amy Darragh[11] · Keeley J Pratt[8,9,10] · Lindy L. Weaver[7] · Colleen K. Spees[1,4]

Accepted: 28 November 2024

Abstract

Food is medicine (FIM) interventions are a strategy for preventing and managing chronic disease via diet. These interventions often combine the provision of food with access to behavior change support (e.g., from registered dietitians (RDs)), though the ideal approach for the latter is not fully elucidated. The objective of this study is to evaluate integrated motivational interviewing (MI) from an RD (RDMI) on outcomes among adults living with and beyond cancer (LWBC) with overweight and obesity enrolled in a FIM intervention (Clinicaltrials.gov: NCT03489213 (02/09/2018)). Specifically, RDMI with autonomy in the mode of delivery (i.e., phone, email, text, video) and dose (frequency) was offered within a 6-month intensive FIM intervention followed by a 6-month step-down maintenance phase. Dose and engagement with RDMI were measured. There were 52 and 33 participants who requested RDMI during the intensive and maintenance phases, respectively. Completion of ≥ 1 RDMI telephonic encounter significantly predicted weight loss post-intervention ($R^2 = 0.07$, $p = 0.03$); there were no differences in dose, engagement, or weight loss based on the mode of delivery. The dose during the intensive intervention was moderately and significantly correlated with weight loss post-intervention and maintenance ($r = 0.43$, $p < 0.01$; $r = 0.33$, $p = 0.02$, respectively); there was a weak correlation for engagement at the same follow-up points ($r = 0.28$ and $r = 0.15$). In conclusion, higher doses of RDMI improved weight loss for adults LWBC with overweight or obesity. Careful consideration of the implementation of MI from providers, including RDs, in the context of cancer-focused FIM interventions should be further examined.

Braun A 2018, **Braun A** 2024

Do RDs do MI?

- We can but…

This is NOT standard care!

Clinical Investigation

Eating As Treatment (EAT): A Stepped-Wedge, Randomized Controlled Trial of a Health Behavior Change Intervention Provided by Dietitians to Improve Nutrition in Patients With Head and Neck Cancer Undergoing Radiation Therapy (TROG 12.03)

Ben Britton, PhD,*,† Amanda L. Baker, PhD,* Luke Wolfenden, PhD,* Chris Wratten, MBBS,‡ Judith Bauer, PhD,|| Alison K. Beck, D.Psych,* Kristen McCarter, PhD,|| Jane Harrowfield, BSC, MPH,¶ Elizabeth Isenring, PhD,#,** Colin Tang, MBBS,†† Chris Oldmeadow, PhD,*,†† and Gregory Carter, PhD*,†

*School of Medicine and Public Health, University of Newcastle, Newcastle, Australia; †Psycho-Oncology Department, Calvary Mater Newcastle, Newcastle, Australia; ‡Radiation Oncology Department, Calvary Mater Newcastle, Newcastle, Australia; §Center for Dietetics Research, The University of Queensland, Brisbane, Australia; ||School of Psychology, Faculty of Science & IT, University of Newcastle, Newcastle, Australia; ¶Nutrition and Speech Pathology Department, Peter MacCallum Cancer Center, Melbourne, Australia; #Faculty of Health Sciences and Medicine, Bond University, Robina, Australia; **Honorary Research Fellow, Princess Alexandra Hospital, Woolloongabba, Australia; ††Radiation Oncology, Sir Charles Gairdner Hospital, Nedlands, Australia; and ‡‡CREDITSS—Clinical Research Design, Information Technology and Statistical Support Unit, Hunter Medical Research Institute, Newcastle, Australia

Received Nov 14, 2017. Accepted for publication Sep 21, 2018.

Table 2 Comparisons of primary and secondary outcomes

Outcome	Means, %, or counts: Control	Intervention	Statistic	95% CI	*P*
Primary outcome					
PG-SGA*					
Last week	16.24	14.71	β = −1.53	−2.93 to −0.13	.03
Secondary outcomes					
SGA category A†					
1st week	87%	84%	OR = 2.88	1.38-5.99	<.01
Last week	21%	34%			
1 mo	43%	49%			
3 mo	69%	71%			
>10% weight loss					
Last week	37%	24%	OR = .23	0.06-0.86	.03
1 mo	55%	39%			
3 mo	63%	49%			
Percentage weight loss	9.88	8.64	β = −1.24	−2.35 to −0.13	.03
PHQ-9 depression score	6.68	5.79	β = −.88	−1.74 to −0.02	.04
RT interruptions	14%	8%	OR = .23	0.06-0.92	.04
Unplanned admissions	130	100	IRR = .73	0.52-1.03	.07
Mean length of stay	6.1	4.1	β = −1.80	−4.09 to 0.50	.13
Total days	922	653			

Abbreviations: CI = confidence interval; IRR = Incidence Rate Ratio; OR = odds ratio; PG-SGA = Patient-Generated Subjective Global Assessment; PHQ-9 = Patient Health Questionnaire 9; RT = radiation therapy; SGA = Subjective Global Assessment.

* Higher score indicates worse nutritional status or risk.

† SGA, A = well-nourished; B = moderately malnourished; C = severely malnourished.

Britton 2018

Can RDs Learn MI?

- Can we integrate MI into standard education?

Can RDs Learn MI?

- Can we integrate MI into standard education?
- NSCI 5613, OSU

NSCI 5613: Advanced Nutrition Education and Counseling
Oklahoma State University, College of Human Sciences
Department of Nutritional Sciences
Spring 2022

Basic Course Information

Instructor:	Ashlea Braun, PhD, RD
Class Day/Time:	Tuesday & Thursday, 9:00-10:15 AM
Office:	312 Nancy Randolph Davis
Office Hours:	Zooms, Monday 1:00-2:00 pm (https://educationokstate.zoom.us/j/98256216564) & by appointment
Telephone:	567-240-1582
Email:	ashlea.braun@okstate.edu

Course description: Analysis of various learning and behavior change theories and their application in nutrition education.

Objectives: At the end of the class the student will be able to

1. Deliver motivational interviewing
2. Evaluate the motivational interviewing others provide
3. Explain the differences between counseling, education, and their integration with models and theories of behavior change.
4. Identify behaviors and endpoints intended as targets of behavior change interventions.

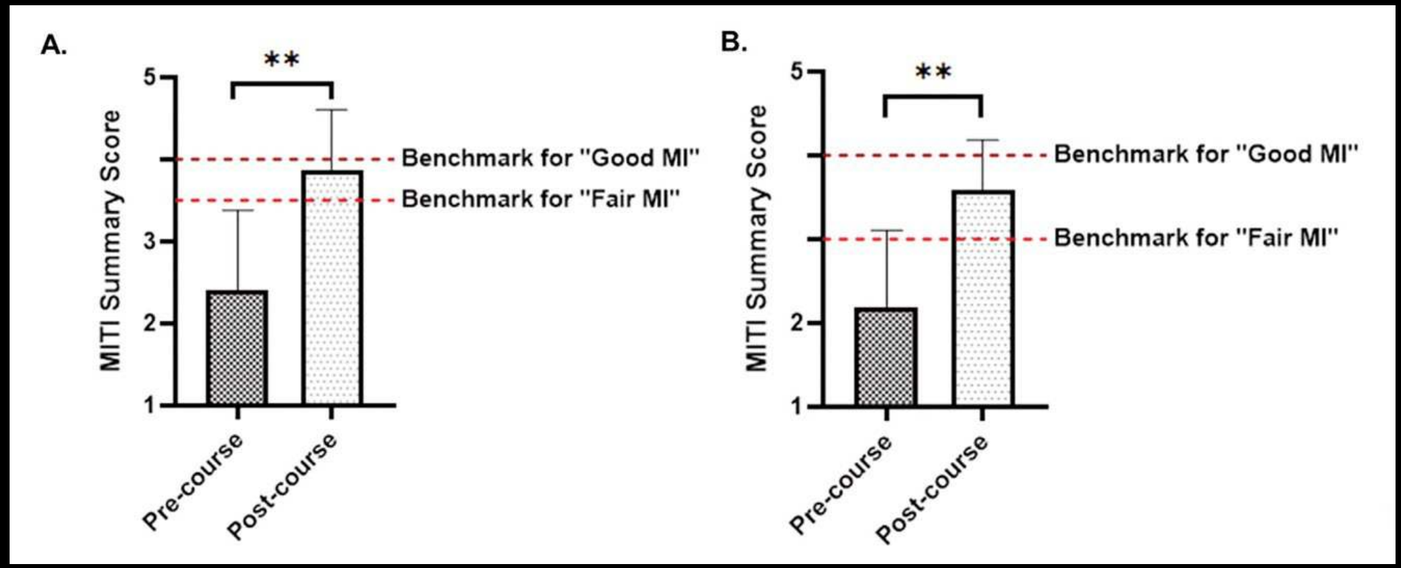
Optional Text: Contento, IR. Nutrition Education: Linking Research, Theory, and Practice. 3rd Ed. 2016. ISBN 9781284078008 or the online textbook ISBN 1284083187.

Online modules: Motivational Interviewing, Third Edition: Helping People Change (available online through OSU library, or on loan from Dr. Braun)

Braun A 2025

Can RDs Learn MI?

- Integrated into course:
  - 10+ full days on MI
  - Two individualized feedback sessions:
    - Coded using the Motivational Interviewing Treatment Integrity Tool



Braun A 2025

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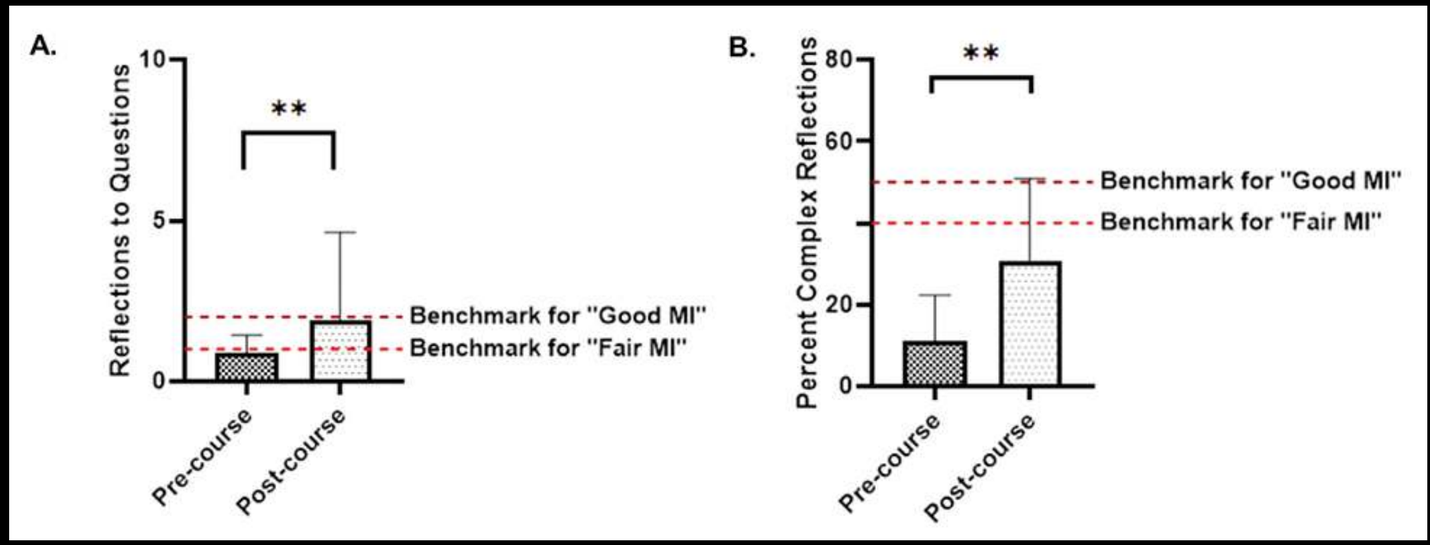

Braun A 2025

Can RDs Learn MI?

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TABLE 3. Counseling Skills Incorrectly Labeled as Principles of MI by Students Before and After Taking an Education and Counseling Course Integrating Intensive, Competency-Based MI Training

Counseling Skills	Pre-Course % (n) n=18	Post-Course % (n) n=18
Educate about risks	72.2 (13)	22.2 (4)
Confront resistance	61.1 (11)	16.7 (3)
Maximize external pressure	5.6 (1)	0.0 (0)
Acceptance of label	5.6 (1)	0.0 (0)
Breakdown denial	33.3 (6)	16.7 (3)
Use subtle coercion	33.3 (6)	5.6 (1)
Make them set goals	27.8 (5)	16.7 (3)
Encourage submission to disease	22.2 (4)	0.0 (0)
Give clear consequences	22.2 (4)	5.6 (1)
Give direct advice	16.7 (3)	0.0 (0)
Require abstinence as only acceptable goal	0.0 (0)	0.0 (0)

Braun A 2025

Are We Doing MI?

- The answer is…no. It does not seem that we are, but we can *if trained*.

Are We Doing MI?

- The answer is…no. It does not seem that we are, but we can *if trained*.
- **Do we want RDs to be able to do MI?**

Are We Doing MI?

- MI has immense empirical data in support of its use
  - MI is operationalized, can be quantified
- However, all of these data are in substance use
- What about diet/nutrition?

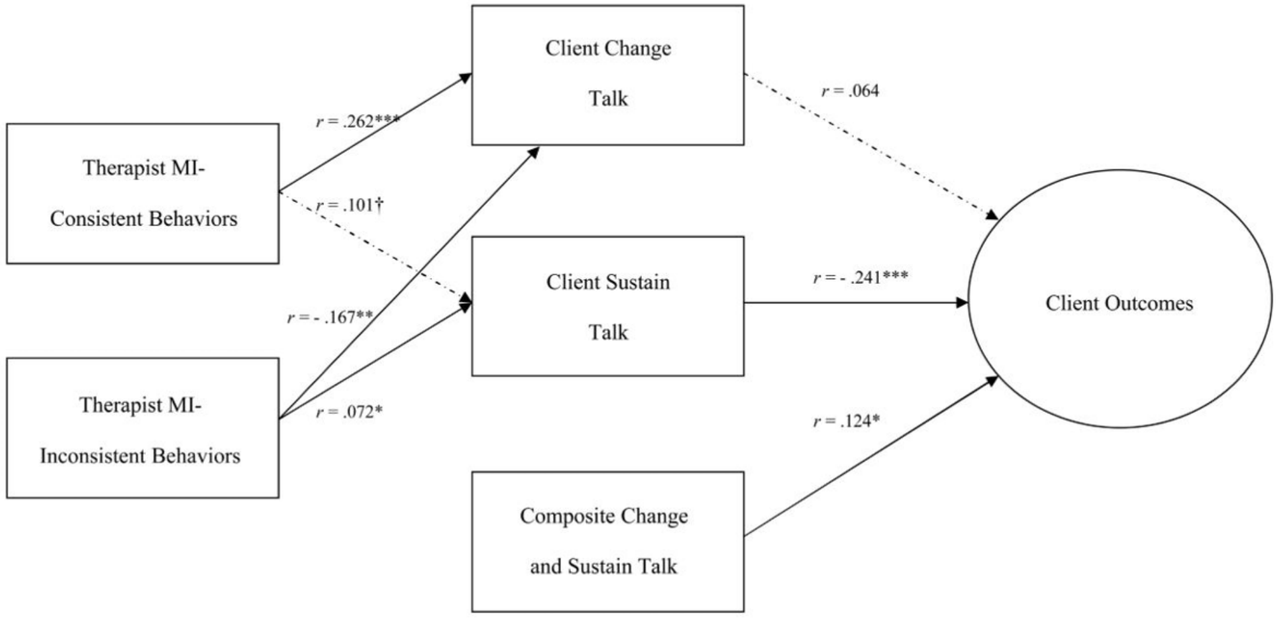


Figure 2.
Meta-analytic results on the Technical Hypothesis of MI efficacy
Notes. *** $p < .001$; ** $p < .005$; * $p < .05$ †$p < .10$.

Magill 2014

Are We Doing MI?

- In clinical trials, outcomes improve pre to post with MI
- Mechanistic data not clear

Comparisons of Healthy Eating Index 2010 (HEI-2010) Scores Between Tele-Motivational Interviewing Users and Nonusers (Based on Perception of Use)

HEI-2010 Component (n = 29)	Maximum Score	Baseline (mean ± SD)		Postintervention (mean ± SD)		Difference (95% Confidence Interval)		*P*		
		Users (n = 17)	Nonusers (n = 12)	Users (n = 17)	Nonusers (n = 12)	Users (n = 17)	Nonusers (n = 12)	Users (n = 17)	Nonusers (n = 12)	Between Group
Total diet	100	72.3 ± 13.46	69.6 ± 8.81	76.9 ± 9.20	74.5 ± 9.21	+46(0.68 to 8.67)	+4.9 (−2.04 to 11.79)	.02*	.15	.95
Adequacy (higher score indicates higher consumption)										
Total fruit	5	3.7 ± 1.63	3.5 ± 1.26	4.5 ± 1.10	4.3 ± 1.01	+0.8 (0.23 to 1.40)	+0.8 (−0.24 to 1.89)	.01*	.12	.98
Whole fruit	5	4.3 ± 1.32	4.1 ± 1.29	4.8 ± 0.63	4.7 ± 0.77	+0.5 (−0.07 to 1.12)	+0.6 (−0.04 to 1.29)	.08	.06	.82
Total vegetables	5	4.4 ± 0.94	4.6 ± 0.73	5.0 ± 0.17	4.7 ± 0.60	+0.6 (0.09 to 1.05)	+0.1 (−0.58 to 0.73)	.02*	.80	.19
Greens and beans	5	4.3 ± 1.29	4.4 ± 0.98	4.8 ± 0.65	4.3 ± 1.41	+0.5 (−0.03 to 0.96)	−0.1 (−1.09 to 0.91)	.06	.84	.25
Whole grains	10	6.0 ± 3.81	5.9 ± 3.43	5.7 ± 3.68	5.7 ± 3.38	−0.3 (−1.24 to 0.65)	−0.2 (−2.20 to 1.87)	.52	.86	.90
Dairy	10	7.0 ± 2.56	8.4 ± 1.77	6.0 ± 3.11	7.9 ± 2.09	−1.0 (−2.17 to 0.30)	−0.5 (−1.76 to 0.83)	.13	.45	.59
Total protein Foods	5	4.6 ± 0.66	4.8 ± 0.25	4.4 ± 1.05	4.5 ± 0.85	−0.2 (−0.69 to 0.34)	−0.3 (−0.80 to 0.19)	.48	.20	.71
Seafood and plant proteins	5	4.3 ± 0.99	4.4 ± 1.06	4.6 ± 0.99	4.5 ± 0.79	+0.3 (−0.18 to 0.79)	+0.1 (−0.18 to 0.33)	.20	.54	.44
Moderation (higher score indicates lower consumption)										
Fatty acids	10	5.1 ± 3.24	4.1 ± 2.42	6.9 ± 2.99	4.9 ± 2.93	+1.8 (0.66 to 2.99)	+0.8 (−1.26 to 2.81)	.004*	.42	.31
Refined grains	10	9.3 ± 1.22	7.8 ± 3.01	9.9 ± 0.20	9.5 ± 1.04	+0.6 (0.09 to 1.28)	+1.7 (−0.29 to 3.75)	.03*	.09	.22
Sodium	10	3.3 ± 2.95	1.9 ± 2.49	1.9 ± 3.01	2.7 ± 2.84	−1.4 (−2.77 to −0.04)	+0.8 (−1.58 to 3.15)	.04*	.48	.07
Empty calories	20	16.2 ± 3.89	15.8 ± 3.63	18.5 ± 2.58	16.8 ± 3.73	+2.3 (0.54 to 4.06)	+1.0 (−1.39 to 3.42)	.01*	.37	.35

Braun A (unpublished data), **Braun A** 2018

Are We Doing MI?

- MI has empirical support. MNT and education and advice STILL have a place.

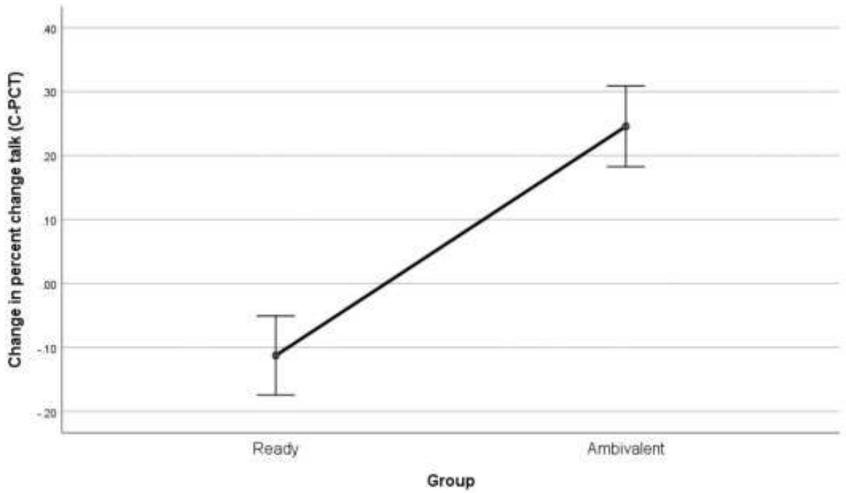


Fig. 1. Between-group difference on change in percent change talk (C-PCT).

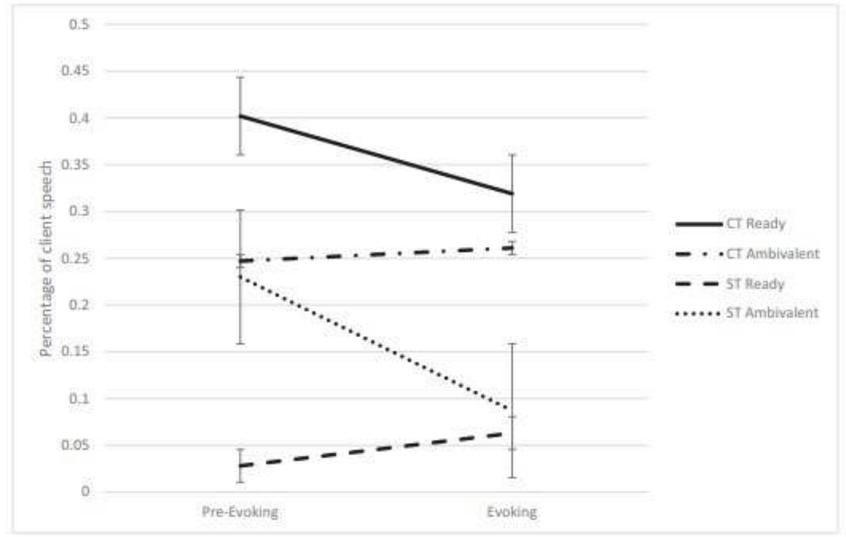


Fig. 2. Change in clients' speech from pre-evoking to evoking.

Forman, 2022

Are We Doing MI?

- **When** you give advice, and to **whom**…
- When MI is needed, it's important, but when it's not, it's important not to use it

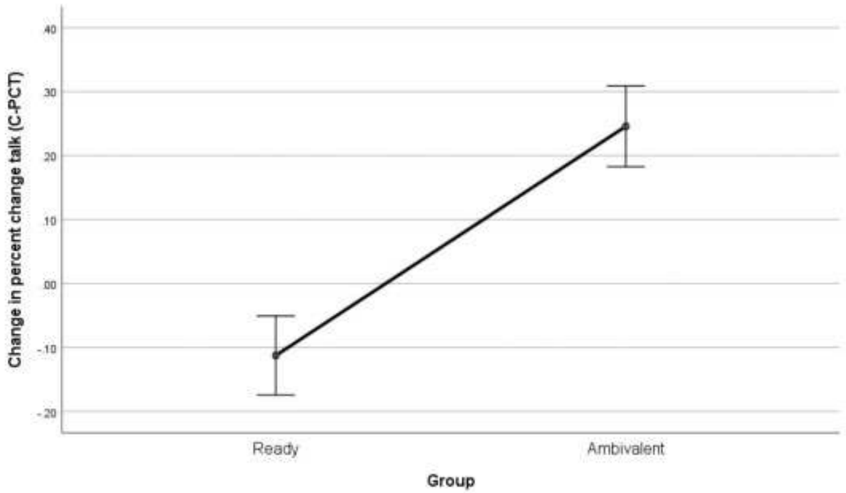


Fig. 1. Between-group difference on change in percent change talk (C-PCT).

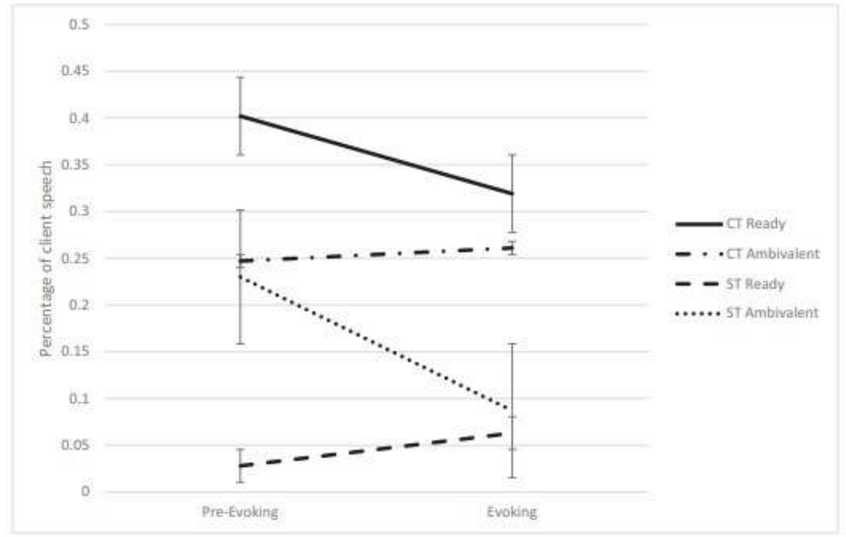
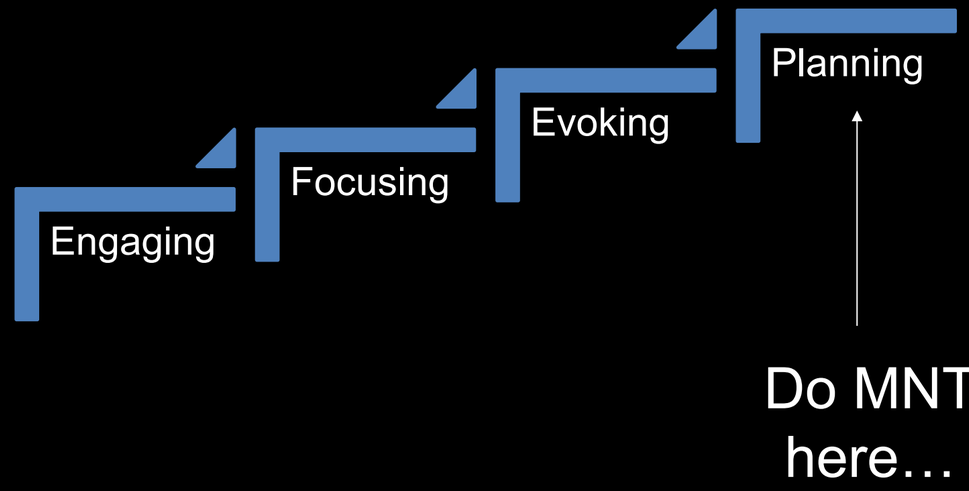


Fig. 2. Change in clients' speech from pre-evoking to evoking.

Forman, 2022

Are We Doing MI?

- What I propose is to rethink how we combine MI + MNT/NCP
- Start with MI, then move into MNT/NCP



Summary

- RDs and dietetic students are doing **exactly what they are trained to do**, and it is *not* motivational interviewing
- At present, training in ACEND-accredited programs is **insufficient** for RDs to learn how to do MI
- There is a role for MI, in combination with other skills
- If we want RDs to do MI, **training has to be longer and higher quality**

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Thank you!

Questions?

Ashlea-braun@ouhsc.edu