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# Motivational Interviewing: An Effective Intervention for Faith Community Nurses

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Abstract

Motivational interviewing (MI) is an effective technique for helping clients make lifestyle changes and adhere to recommended treatment plans. Faith community nurses trained to use motivational interviewing can empower individuals to make changes which reduce their risk for complications from chronic health conditions. Findings suggest a faith community nurse who uses motivational interviewing techniques during health coaching has a greater likelihood of helping clients with hypertension make lifestyle changes that reduce the risk for complications from cardiovascular disease.

*Keywords:* motivational interviewing, empower, self-management, faith community nurse, chronic disease management, hypertension

Motivational Interviewing: An Effective Intervention for Faith Community Nurses

Throughout scripture, God calls people of faith to healing. 3 John 1:2 (New International Version) says, "*Dear friend, I pray that you may enjoy good health and that all may go well with you, even as your soul is getting along well.*" The Reverend Dr. Granger Westberg developed *parish nursing* in the 1960s to reinstate outreach work done in churches by religious orders in the 1800's (Westberg, 1990). Today nurses who promote health within the faith community are called *faith community nurses* (American Nurses Associations & Health Ministries Association [ANA & HMA], 2012). This nursing specialty is now the largest contingent of community based nurses with more than 15,000 nurses in this ministry in the United States (International Parish Nurse Resource Center [IPNRC], 2011). King and Pappas-Rogich (2011) established faith community nurses as viable partners for promoting health improvement in communities.

## Rising Health Care Costs Associated with Chronic Conditions

With an increase in the aging population and higher costs of health care, one of the biggest challenges of this century is improving health outcomes for individuals living with chronic conditions. Complications from chronic conditions can be deferred or avoided with healthy lifestyle habits (American Diabetes Association, 2010). More than 90 percent of Americans aged 40-74 years have one or more chronic health conditions; unfortunately, adherence to a healthy lifestyle amongst these individuals is poor (King, Mainous, Carnemolla, & Everett, 2009).

In 2010, 1 of every 6 dollars spent on health care in America was for treatment of heart disease (Centers for Disease Control & Prevention [CDC], 2011a). Since nearly one-third of Americans have high blood pressure which is a major risk factor for heart disease, managing

hypertension is important (CDC, 2011c). Egan (2013) reports only one in three clients have their blood pressure under control which doubles the risk for heart disease but effective treatment can reduce cardiovascular risk by 25 percent. Randomized cohort studies show lowering diastolic blood pressure by as little as 5 mmHg reduces the risk heart disease by 21 percent (Law, Wald, & Morris, 2003).

In 2003, a "prehypertension" classification was established for a systolic blood pressure of 120-139 mm Hg or a diastolic blood pressure of 80-89 mm Hg to identify those at risk for developing hypertension. By recognizing prehypertension individuals can adopt healthier lifestyles to reduce their risk for developing cardiovascular disease (Miller & Jehn, 2004).

The American Medical Group Foundation (AMGF), which represents some of the largest integrated health systems in the country, identified lifestyle change as an effective method of lowering blood pressure (2013). Faith community nurses (FCNs) who treat individuals wholistically are in an excellent position to influence behavioral change and empower congregants to take charge of their personal health. Training FCNs to use motivational interviewing may be one possible solution for improving self-care practices of individuals living with chronic conditions such as hypertension. Motivational interviewing (MI) is a demonstrated technique for helping individuals successfully achieve lifestyle change (Tahan & Sminkey, 2012).

The purpose of this article is to discuss the benefit of increasing the faith community nurse's proficiency with MI as an effective technique for helping clients reduce the risk of complications from hypertension. Faith community nurses who are competent with using MI will recognize change talk and guide individuals to take action that leads to improved health. The article will be submitted to the *Journal of Christian Nursing (JCN)* which is a peer-reviewed,

quarterly, professional journal published for the purpose of helping nurses integrate issues of faith with nursing practice. The mission of this journal is to help nurses practice from a biblically-based, Christian perspective. *JCN* has been offering relevant topics for faith community nursing practice since 1984. *JCN* is read by many faith community nurses as those who are members of Health Ministries Association, the professional organization for faith community nurses; receive a substantial discount on this journal. Faith community nurses are also attracted to *JCN* because the journal offers continuing education credits with selected journal articles.

## Hypertension: A Growing Problem

Morbidity & Mortality Weekly Report (MMWR) identifies approximately 68 million Americans aged ≥18 years have hypertension which is a contributing factor in 1 out of every 7 deaths in the United States (CDC, 2011c). The age-adjusted prevalence of hypertension by state ranges from 20.9% to 35.9% of the adult population (CDC, 2013). Unfortunately, less than half of those with hypertension have their condition controlled (MMWR, 2011). The American Medical Group Foundation [AMGF] estimates the national economic impact of hypertension to be $156 billion annually for healthcare services, medications and missed days of work (2013). Increasing awareness that high blood pressure is a modifiable risk factor is important in preventing heart disease (MMWR, 2011).

## Health Promotion Programs

*Healthy People 2020* guides planning of programs for addressing hypertension; the overarching goal is to increase the proportion of adults whose blood pressures is under control from 43.7% to 61.2% by 2020 (U.S. Department of Health and Human Services, 2007). The predominant interventions recommended include education about healthy lifestyle choices,

regular monitoring of blood pressures, and use of appropriate medications. The American Medical Group Foundation's (AMGF) *Measure Up, Pressure Down* program recommends instruction on lifestyle, physical activity, diet, and taking anti-hypertensive medication as prescribed (AMGF, 2013). The Centers for Disease Control and Prevention and Centers for Medicare and Medicaid Services (CMS) *Million Hearts* national initiative encourages people to lead a heart-healthy lifestyle and improve use of appropriate medications (CDC, 2011b). The American Heart Association's *Life's Simple 7* program identifies seven key health behaviors that lower the risk for cardiovascular complications; they include avoiding tobacco, selecting food low in saturated fats, being physically active, maintaining a healthy weight, and having regular medical exams (Paddock, 2010). Lloyd-Jones et al. (2010) reports improvements in these measures improves quality of life, extends life, and reduces the financial burden of the Medicare-eligible population.

**Role of the Faith Community Nurse in Hypertension Management**

The faith community nurse promotes health and prevents illness within the context of the values, beliefs, and practices of the faith community (ANA & HMA 2012). The traditional roles of this nurse include being a health educator, health counselor, health advocate, and referral agent (IPNRC, 2011). Solari-Twadell & Hackbarth (2010) assert a revised paradigm is in order as the faith community nurse now facilitates physical functioning, lifestyle change, and appropriate use of the health system. Health screening, specifically blood pressure monitoring, is a common intervention employed in this nursing specialty. For congregants who seek assistance from the faith community nurse, 82 percent are looking for help with managing hypertension (King, 2007; Shores, 2011). Faith community nurses follow standard protocols for managing individuals with poorly controlled hypertension which includes encouraging lifestyle changes

and counseling about the importance of taking medications as prescribed (Monay, Mangione, Sorrell-Thompson, & Baig, 2010).

## Health Coaching as a Means of Improving Health Outcomes

Luck (2010) describes nurse coaching as facilitating meaningful conversations to empower individuals to control their own health. It involves assessing readiness to change, identifying barriers, supporting decisions, and building confidence (Vincent & Birkhead, 2013). Studies demonstrate statistically significant improvements in health outcomes from nurse coaching. Vale, Jelinek, and Best (2005) identified improvements in fasting serum total cholesterol, body mass index (BMI), fiber intake, and levels of physical activity as well as adherence with dietary recommendations and prescribed medications with coaching. Patients with cardiovascular risk factors achieved target goals for blood pressure, BMI, cholesterol and blood glucose levels, smoking cessation, and adherence with medications when provided a combination of face-to-face and internet based coaching (Goessens et al., 2008). Physicians expressed satisfaction with improvements in patients with hypertension achieved through nurse-led coaching (Springrose, Friedman, Gumnit, & Schmidt, 2010).

Health coaching complements the supportive guidance offered by FCNs assisting congregation members who are making life-style choices. Effective FCNs and successful coaches both instill hope in those they guide. The Old and New Testament offer insight about coaching. Jethro is an Old Testament example of an effective coach. Jethro meets with Moses to learn how he is doing, listens to his successes and challenges, asks probing questions, addresses unproductive behaviors, and offers astute counsel (Exodus 18: 1-24, New International Version). In the New Testament, Barnabas the encourager walked alongside Paul when everyone else

turned away. Barnabas watched others, discerned their potential, fortified them, and guided them in a manner that allowed them to stay on course (Acts 11:22-26, New International Version).

## Motivational Interviewing Improves Coaching Effectiveness

The approach used by successful coaches including active listening, identifying beliefs and values, and recognizing readiness for change (Huffman, 2009) are familiar to FCNs. Health coaches and FCNs provide support and education while making referrals to professional colleagues when necessary. Faith community nurses meet people where they are, without judgment, which creates a trusting alliance that fosters dialogue. Within the context of the personal relationship, the client becomes motivated to make lifestyle changes that produce positive health outcomes. A professional who is proficient with motivational interviewing (MI) exercises empathy, demonstrates respect for the client's autonomy, advocates for the client, and facilitates life transitions (Tahan & Sminkey, 2012). The congregational setting promotes success by offering a comfortable, familiar surrounding that allows open face-to-face conversation between the client and the nurse.

## Transtheoretical Model of Change

The paternalistic medical model assumes that clients provided with information will make behavioral change. However, experienced professionals know numerous clients who do not change even when they clearly realize their behaviors are unhealthy. An understanding of the stages of change emerged in the 1980s. James O. Prochaska, Carlo C. DiClemente, and John C. Norcross developed a theoretical model based on different theories of psychotherapy that is now known as the Transtheoretical Model of Change (Prochaska, DiClemente, & Norcross, 1992). This model describes four different stages any individual goes through in undertaking intentional change. In the *precontemplation* stage the individual is not ready for change, during the

*contemplation* stage the individual is considering change, in the *action* stage the individual is modifying behavior, and throughout the *maintenance* stage the individual is attempting to sustain changed behaviors (Konkle-Parker, 2001).

Motivational interviewing (MI) was introduced by Professors William Miller and Stephen Rollnick as a technique to promote recovery from substance addictions (Smith, 2012). MI is used to strengthen the motivation for change that exists during the *contemplation* stage. A basic precept is that change is associated with the value placed on the anticipated outcomes. The Transtheoretical Model identifies motivation as the key ingredient in the change process. But experienced professionals work with clients daily who are motivated but still have not been able to effectively change their behavior. So what is missing? Rollnick, Miller, and Butler (2008) report individuals who successfully modify behavior must overcome their ambivalence and lower their resistance to change. They further indicate that an effective health coach helps client's identify what they are getting out of the unhealthy behavior and what they seek to gain by changing. A coach who becomes proficient with MI assists clients by identifying *change talk,* which is language the client is using to convince himself about the importance of the change and the level of self confidence in the ability to make this change. Lundahl and Burke (2009) use mathematical equations to describe the historical phases of understanding about the factors associated with change:

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| Initial understanding | Knowledge = Change |
| Emerging understanding | Knowledge x Motivation = Change |
| Current understanding | $\frac{\text{Knowledge x Motivation}}{\text{Resistance}} = \text{Change}$ |

**Using the Technique of Motivational Interviewing while Coaching**

Motivational interviewing (MI) is an evidence-based tool that is effective in helping individuals change poor health habits associated with chronic health conditions (Rollnick, Butler, Kinnersley, Gregory, & Mash, 2010). Proponents of MI contend the way health professionals talk with individual's influences motivation. MI is designed to move individuals from a point of ambivalence towards taking action (Rollnick et al., 2010). The four guiding principles of MI are to 1) resist the temptation to correct the individual's course, 2) explore the individual's motivations, 3) listen with empathy, and 4) empower the individual (Rollnick, Miller, & Butler, 2008). The first phase is to listen reflectively to build trust and acknowledge the strengths the individual possesses (Rollnick et al., 2010). During the second phase, the individual identifies specific behaviors they want to change and classifies their level of confidence in making the changes (Rollnick et al., 2010). Neithercott (2012) reports to achieve behavior changes, established goals need to be meaningful to the individual and be specific, measureable, achievable, realistic, and timed (SMART).

The principles of motivational interviewing are consistent with the faith community nurses' approach to integrating faith and health. Cornell et al. (2009) identified individuals trust health advisors associated with the church and seek help from them with the belief that religion is central to their ability to cope with health issues. The FCN can build on this foundation of trust and rely on the numerous Biblical references that offer hope with a promise for change while encouraging individuals to modify behaviors to improve their overall health and well-being (2 Corinthians 5:17, New International Version).

## Results Obtained Using Motivational Interviewing

MI has been used successfully in patients with both psychological and physiological conditions. The effectiveness of MI in the treatment of clients with addictions is well established and there is growing empirical evidence that MI has merit in addressing many health related problems. A meta-analysis completed by Lundahl and Burke (2009) evaluated the effectiveness of MI on alcohol, marijuana, tobacco, and other drug use disorders. Clients in the 68 studies reviewed who received MI had a cessation success rate that was 15-28% better when compared with alternative treatment modalities. A meta-analysis demonstrated the effectiveness of combining MI with cognitive-behavioral therapy to treat clients with a dual diagnosis of major depression and alcohol use disorder (Riper et al. 2014). The 12 studies consisting of 1721 patients proved the combined therapy was effective for both decreasing the symptoms of depression and decreasing alcohol consumption when compared with treatment as usual. Follow up assessment at 12 months showed the effect size was maintained at a significance level of $P = 0.063$.

A number of studies suggest MI is a promising method of increasing healthy behaviors. Three meta-analyses demonstrated MI was effective in encouraging increases in physical activity and adoption of better eating habits (Lundahl & Burke, 2009). Individuals who receive health coaching using MI were more likely to increase exercise levels and reduce sodium intake (Rollnick, Miller, & Butler, 2008). They also improved eating habits and increased physical activity endured over time (Martins & McNeil, 2009).

Motivational interviewing improves adherence with taking medications as prescribed, which reduces the risk for complications from chronic health conditions. Williams, Manias, Walker, & Gorelik (2012) enrolled 39 participants with coexisting diabetes, chronic kidney

disease, and hypertension in a pilot project using MI during telephone interviews offered every two weeks over a three month period. Participants attained an improved understanding of the medications, side effects, and administration instructions as well as an improved ability to self-manage taking the medications as prescribed.

Experts are encouraging professionals to use MI with clients who are at risk for developing cardiovascular disease (Folta & Nelson, 2010). A meta-analysis concludes that MI has demonstrated positive effects in a variety of settings for increasing physical activity, reducing caloric intake and basal metabolic index, and increasing vegetable and fruit consumption (Martins & McNeil, 2009). These healthful changes were required to reduce risks associated with cardiovascular disease. Individuals (n:815) at risk for cardiovascular disease were enrolled in a randomized controlled study using MI. They acquired a better understanding of their risk and improved their lifestyle, which reduced their mortality rate (Koelewijin-van Loon et al., 2010). Their lifestyle changes related to smoking, alcohol, diet, and physical activity. Söderlund, Madson, Rubak, and Nilsen (2011) completed a systematic review of nine MI studies in the area of diabetes which demonstrated long-term improvements in glycemic control. Clifford Mulimba and Bryon-Daniel's review of 24 studies determined women with diabetes who received MI had statistically significant lower blood glucose levels (HbA1C), significant improvements in intake of saturated fat, fruits, and vegetables, and significantly more weight loss at six months than a control group (2014).

The utility of using MI to achieve reductions in blood pressure is just beginning to emerge. Ireland et al. (2010) conducted a pilot study with 20 clients with uncontrolled hypertension to determine whether MI could improve medication adherence. At six months, there was a significant improvement in adherence and reductions in blood pressures. Thirty

percent of the participants achieved the nationally recommended blood pressure target of < 140/90 mmHg. Analysis using *t*-tests showed a mean reduction in systolic blood pressure of 16.75 mmHg ($p = 0.00$) and a mean reduction in diastolic blood pressure of 5.025 mmHg ($p = 0.004$). Only three participants reported having missed taking one or more pills per week on average ($p = 0.003$). Results from 591 participants enrolled in a hypertension intervention study demonstrated participants administered MI had lower blood pressures; there was a trend for the intervention group (58.6%) to achieve national blood pressure guidelines more often than participants who received the usual care (37.0%). Participants reported many positive improvements in lifestyle including smoking cessation, checking blood pressure regularly, reading food labels, reducing sodium intake, and increasing physical activity (MacKenzie et al., 2013).

Seventy five participants with co-existing diabetes, kidney disease, and hypertension in a randomized controlled trial watched a 20-minute video describing the effects of blood pressure on the body, the benefit of prescribed medications, and tips to help individuals remember to take medications as prescribed. The intervention group was taught to take and record their blood pressure daily and received a MI telephone call every two weeks for three months to discuss their overall well-being, their blood pressure measurements, and their adherence to taking medications as prescribed. Adherence was confirmed through pill counts and checking dispenses from the pharmacy. The average reduction in systolic blood pressure was 6.9 mmHg for the intervention group compared to 3.0 mmHg for the control group ($p = 0.37$). The mean adherence rate for the intervention group was 66.0% compared to 58.4% in the control group (Williams et al., 2012). Rocha-Goldberg (2010) enrolled 17 clients in a pilot study using a culturally tailored approach to improve hypertension related behaviors in Hispanic/Latino adults. The intervention consisted of

six weekly group sessions incorporating MI to encourage clients to lose weight, adopt the *DASH* diet, increase physical activity, and modify consumption of fruits, vegetables, dairy, and fats. With the exception of fat consumption, at the end of six weeks all physiological, dietary, and activity outcomes were more favorable in the intervention group. The systolic blood pressure decreased on average by 10.4-10.6 mmHg, weight decreased 1.5-3.2 pounds, the basal metabolic index decreased 0.3-0.5, and physical activity increased by 40 minutes per week.

Lundahl and Burke (2009) conclude the degree of effectiveness of MI is impacted by client and provider factors. The effects of MI last for at least one year beyond treatment with the meta-analysis showing effects lasting up to two years in some studies. More interactions between the client and the professional produce better outcomes; treatment "dose" accounts for a quarter of the variance in outcomes. Although some methods used with MI (i.e. a values sort) fit in a group format, in general the results obtained by using MI are relationship based with the best results achieved when MI is delivered individually. Professionals perceive MI is time consuming, but clients receiving treatment with MI required on average 100 less minutes of face-to-face time those in usual treatment programs (Lundahl & Burke, 2009). The meta-analysis confirmed MI works well for clients with severe problems, non-cognitively impaired adults of both genders, and individuals in a variety of diverse minority groups. Neither the academic degree (e.g. bachelors, masters, or doctorate) nor the profession of the practitioner influenced the outcomes attributed to MI.

Motivational interviewing is effective for helping individuals manage chronic health conditions such as hypertension. It is a patient centered method that encourages individuals to modify behaviors and promotes adherence to prescribed medications.

## Inhibitors to Using Motivational Interviewing

Motivational interviewing courses are not readily available and class size is limited to insure the instructor is able to provide frequent, individualized feedback to improve proficiency. The instructor must have expertise in MI and an ability to monitor class participants and demonstrated compliance with application of the techniques. Participants must make a commitment to practice the techniques of motivational interviewing and become more proficient if provided with constructive feedback from colleagues and instructors. Since the training often extends over a four-week period, FCNs from remote rural areas are less able to participate without considerable hardship. Rural nurses also have less access to class colleagues who can observe and provide feedback between sessions. In addition, using MI while interacting with individuals takes time; FCNs that serve on a part-time basis may not be able to dedicate sufficient time to coach individuals on a one-to-one basis to achieve similar results.

## Implications for Nursing Practice, Education, and Research

Research confirms MI works for various health conditions and in a variety of settings. Further research is needed to identify the factors that make MI work; by identifying how positive outcomes are achieved and results can be extended into lasting benefits for individuals with most chronic health conditions. Faith community nurses who use MI need to learn how to identify individuals most likely to respond to this technique and to modify the techniques to fit the diverse individuals who seek their assistance; this is important because of the growing number of individuals diagnosed with a wide array of chronic conditions. Since FCNs frequently assist clients with management of hypertension, further investigation is needed to determine whether using MI with these clients will improve outcomes. Various outcomes to be explored should include client knowledge about lifestyle choices, health conditions, and the risk for long-term

complications associated with poorly controlled hypertension. Researchers will also want to determine whether there is a difference in biometric measurements such as blood pressure, weight, body mass index, and cholesterol levels for individuals who are offered motivational interviewing as a part of their strategy for improving their self-management of this chronic condition. Additionally, investigators should explore whether the number of MI sessions between the health professional and the patient impacts the outcomes achieved for clients with hypertension.

Individuals have different levels of commitment to change and busy clients may only be able to interact with the FCN by telephone. Since FCNs make many contacts by telephone, comparative studies should be done to determine whether using MI in telephone contacts is as effective as face-to-face coaching and to establish the number of contacts that produce the best outcomes.

To make MI courses more accessible to FCNs, educators should explore the feasibility of using simulation, distance learning and other modalities. Nurse educators should design methods of offering courses remotely and of providing feedback to those taking the course from a distance.

Research is needed to evaluate whether training extends beyond improved knowledge and confidence with MI to true competency in using MI when working with clients. The Motivational Interviewing Treatment Inventory (MITI) is a well-validated tool for evaluating MI competency (Moyers, Martin, Manuel, Hendrickson, & Miller, 2005). The MITI should be used to evaluate the performance of FCNs who have been trained through different educational options. Of particular interest is whether participants who attend a series of sessions with an opportunity to practice techniques between sessions and who have the opportunity to be critiqued

by peers as well as the instructor achieve higher proficiency with using the MI techniques when compared to other modes of delivering this educational content.

## Conclusion

Faith community nurses are an important representative in disseminating information about the association between lifestyle choices, hypertension, and cardiovascular risk to a great number of community members. The knowledge and support offered through coaching empowers individuals to take control over the determinants of health. Health coaching provided by FCNs trained to use motivational interviewing might be an effective method of improving management of hypertension. MI should be viewed as an additional tool in the kit FCNs use to assist individuals they serve. Health systems and providers should collaborate with FCNs to improve management of chronic health conditions including hypertension. FCNs are encouraged to seek training related to MI and to offer their services as a health coach to clients who are struggling to make lifestyle changes.

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