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Using Brief Motivational Interviewing to Address the Complex Needs of a Challenging Patient With Heart Failure

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Objective: This case represents a number of themes common in the management of care for a HF patient and explores a 4-session brief motivational interviewing approach to address these themes. The manner in which patient frustration is linked to hospitalization is discussed along with possible ways to address problems in self-care behaviors.

Conclusions: With the use of this brief motivational interviewing approach, the patient reported an increase in her motivation and ability to change and developed a postdischarge plan for incorporating self-care behaviors in her daily routine.

Clinical Implications: Motivational interviewing may be an effective method of increasing the self-care behaviors of patients with HF.

Keywords

heart failure, motivational interviewing, patient acceptance of healthcare, secondary prevention

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Using Brief Motivational Interviewing to Address the Complex Needs of a Challenging Patient With Heart Failure

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Abstract

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Heart Failure

Heart failure (HF) affects approximately 5.1 million adults in the Unites States.[1] The burden to patients, caregivers, healthcare providers, and society is high. The 5-year mortality rate is estimated to be 50%,[2,3] and more than a fifth of patients with HF are readmitted within 30 days of discharge.[4] Hospitals and healthcare providers are looking for methods to reduce these rates and improve patient outcomes. Targeting patients' self-care behaviors is 1 such strategy that has shown promise in improving outcomes.[5]

Motivational Interviewing

Motivational interviewing (MI) is a patient-centered guided approach to behavior change originally developed for alcohol abuse treatment.[6] It has been empirically tested and shown to be effective for managing substance abuse,[7,8] smoking cessation,[9] weight loss,[10] and HF[2,11,12] in both hospital and community settings. The core of MI is a nonjudgmental, guiding communication style acknowledging and exploring the inherent ambivalence present in problematic or unhealthy behaviors.[13] In many cases, patients already know what they should or should not be doing for their health but fail to take action. By clarifying the patient's values, a practitioner can explore the discordance between current behaviors and expressed values. Reflective listening allows the patient to define goals in his/her own words and reinforces the therapeutic bond while selectively emphasizing "change talk" such as expressed desire, ability, reasons for, and need to change. Information is given only with the patient's permission, and confidence in the ability to change is promoted. The importance of change and confidence in achieving that goal are evaluated to move the patient past ambivalence and toward a committed plan for change. True MI requires extensive training and supervision, but Rollnick and Heather developed a brief form of MI for use by healthcare providers in a variety of settings.[15] Brief MI has been used effectively to treat both alcoholism[16] and tobacco use[17] in 10-minute intervention sessions. This case report describes the use of brief MI aimed at improving HF self-care.

Case Illustration

The case described is one that the primary author experienced during work as an interventionist in the Tailored Self-care Intervention study. The purpose of the study was to determine if brief MI was more effective in improving patient HF self-care than active listening or standard care was. Heart failure specialist nurses who had completed training in a brief form of MI provided the interventions in 2012. Treatment fidelity was monitored by a psychologist certified in MI. All of the interventions were audio-recorded, transcribed, and scored to ensure that the brief MI technique was adhered to. Ethical approval was obtained by the international review board from the affiliated university before any interaction with participants. All procedures were in accordance with the Declaration of Helsinki.[18]

Presenting the Problem and Patient Description

The patient, Crystal (the name has been changed), was a single African American woman in her late twenties who had a history of HF. She was admitted to the cardiac intermediate care unit of a large, university-based hospital with complaints of shortness of breath and feeling

"full of fluid." On admission, her temperature was 97.7°F, with a blood pressure of 132/71 mm Hg, heart rate of 111 beats per minute, respiratory rate of 20 breaths per minute, oxygen saturation of 98%, and weight of 157.1 kg (346.3 lb). Based on a recent echocardiogram, her left ventricular ejection fraction was 10% and she was classified as being in New York Heart Association functional class IV.

Six weeks after the birth of her son, at age 22 years, Crystal was diagnosed with peripartum cardiomyopathy. Subsequently, she became pregnant and was advised to terminate because of maternal health risks and had an elective abortion. She has had 9 hospital readmissions to this cardiac unit in the past year for fluid overload related to her HF. Her weight at last discharge was 127 kg (280 lb).

Crystal denied medication or dietary nonadherence leading up to the admission, although she had a history of missed follow-up appointments and, when hospitalized, ate foods brought in by family members that were inconsistent with a low-sodium diet. In addition, the healthcare team was unable to optimize treatment during her previous admission because she had left against medical advice (AMA) to take care of her 5-year-old child.

Crystal lived in a 2-bedroom apartment with her mother, son, and 4 other family members. She had inconsistent access to a cell phone shared with her mother and relied on financial aid to support herself and her child. During hospitalizations, her mother took primary care of her son.

Case Formulation

This particular case represents a number of typical themes common in the management of care for a challenging patient with HF. Crystal had multiple readmissions for fluid overload, each time growing more and more frustrated with herself and with the hospital staff. The healthcare team believed that she was "noncompliant" and, despite their best efforts, would ignore their advice and treatment plan. They saw Crystal spiraling downhill and felt powerless to help because she frequently missed follow-up appointments and would check out AMA before completion of her medical treatment.

Course of Intervention

Session 1—A nurse trained in brief MI met Crystal for the first session in the hospital. After a brief assessment, the nurse focused on engaging the patient, building interest in change, and eliciting willingness to engage in self-care behavior. Within the first few minutes, a number of important themes emerged in Crystal's history. Beginning with the shock of her diagnosis, she felt overwhelmed and fatalistic. When she was told that her heart worked only 10%, she concluded that even if she took her medicines and ate a low-sodium diet, she would still become fluid overloaded and get rehospitalized. Interestingly, throughout the course of the multiple sessions, Crystal had an awareness of recommended self-care behaviors yet rarely followed through on these behaviors.

Crystal also expressed grief over feeling alone in her diagnosis and a lack of understanding of how she could have a healthy child and still get HF in the process. The nurse used reflective statements to explore these feelings and found that her son was her main

motivation for living. An underlying theme of a lack of trust with the medical team was present throughout the initial conversation, which escalated when she related that she felt pressured to have an abortion. Crystal believed that she should have been offered an alternative and was not. This lack of trust was amplified by her frustration and perception of the nursing staff treating her with a negative attitude with each readmission.

C: When I come here it is, “you are back again?’... It is the negativity, like I already understand I'm going through much. Why do you have to make me feel so bad?... I thought me coming to the hospital was helping me.... But when somebody says something negative like that, it makes me not want to come here...and then I wait at home until it is too late.

It was clear, however, that although she was highly skeptical of the nursing staff and was not a collaborative partner, she was thankful for the opportunity to tell her story. Interestingly, the nurses caring for Crystal expressed their own frustrations at seeing her return, but from a different perspective. This is not altogether uncommon as nurses may place blame for frequent readmissions either on themselves or on their patients.[19] The general assumption was that despite their best efforts, she was not listening and not following her care plan. In hospital parlance, she was labeled a “frequent flyer” and “noncompliant.” Crystal was very sensitive to this attitude, which may have affected her behavioral response to treatment.

Rather than focusing on the negative experiences of her hospitalization or defending the actions of well-meaning staff, the intervention nurse redirected the conversation to her son in an attempt to help Crystal begin to link her motivation for living with HF self-care behaviors. Crystal valued being a mom to her son and could verbalize proper self-care behaviors and yet continued to be readmitted for fluid overload. When viewed through the lens of MI, this incongruity can be explained as ambivalence inherent in behavior change. In an effort to treat the patient, sometimes, healthcare providers overlook the ambivalence to change seen in the patient's behavior.[15] Whereas the negative aspects of poor HF self-care are emphasized repeatedly with the patient, the benefits that the patient derives from not changing problematic behaviors are rarely discussed. Recognizing that there are costs and benefits to the patient and having the patient verbalize these may increase the patient's motivation and readiness to change.[20]

Once the nurse understood Crystal's motivation for potential change, he asked Crystal why she thought that she was coming back to the hospital so frequently and where she felt she needed assistance with her HF. By offering her the opportunity to set the agenda, the nurse hoped to strengthen her confidence. For example, “You want to be alive to take care of your son, and managing your HF is 1 way to do this. I want to help you get to your goal. What do you feel you need the most help with? Reducing salt, staying within your fluid restrictions, recognizing symptoms, or something else that I haven't mentioned?” Letting the patient set the agenda is a key element of MI. Crystal was ambivalent about what to discuss, and with her permission, the nurse evaluated her understanding of the link between salt, fluid retention, and how to maintain a low-salt diet. Offering a small range of options helped to guide the intervention while giving the patient some autonomy over the content.[13] Crystal asserted her current adherence to and demonstrated understanding of these self-care behaviors by teaching the skills back to the nurse.

Before the end of the first session, the nurse assessed Crystal's confidence in being able to take care of her HF and how important she felt it was to manage her HF by asking her to rate importance and confidence on a scale. She rated importance 10 of 10. The question was followed up by asking her why she didn't rate the importance a 9. By having the patient think about why she rated it higher on the scale, she came up with her own reasons for why it was important, “Because my heart is like a very vital organ.... And you can't live without your heart.” Confidence was rated a 5. Crystal had insight into her adherence problems and intimated that, up until this moment, she always followed the physician's advice, “The reason that I only say a 5 is because I am only human...and being only human, I understand. We do have slip ups and we have mistakes...I can walk out this hospital and know all the right things to do and don't do it.” She expressed a desire to be more confident in her abilities and, when asked why, argued for her own change by stating her desire to get out of the hospital and be with her child.

In summary, session 1 focused on building rapport and trust to establish the therapeutic relationship. Principles specific to MI, such as exploring ambivalence to change and assessing confidence and importance, were investigated. Finding a patient's unique motivation to change, in this case Crystal's son, was a vital step in assisting the patient in focusing on why she wants to change. Unfortunately, her understanding of being there for her child meant leaving AMA.

Session 2—Once Crystal returned home, the nurse visited her for the second session, bringing a scale and information handouts. In conducting brief MI, information and advice were offered to the patient with the patient's permission.[15] For example, 1 of the handouts was a chart for tracking daily weights. The nurse asked if Crystal would like to know how other patients manage to keep track of their weight. With Crystal's consent, the nurse explained the concept of writing down daily weights and times. When Crystal commented that this was a good idea, she was offered the handout. Rather than explaining how he would use the handout, the nurse asked Crystal how she would use it.

One of the more challenging aspects of using brief MI for practitioners new to the approach is the urge to “right” the patient and attempting to convince them of the need to change with unsolicited information. Health-care providers may find that allowing the patient to discover his/her own reasons for change and her own unique methods for accomplishing change not only alleviates the significant burden of “fixing the patient” but also is more satisfying.

Another area for improvement, physical activity, was linked to Crystal's goal of being present for her child. The nurse evaluated Crystal's current understanding of how much activity she needed and then brainstormed with her about what types of activities she felt she could manage. In keeping the motivation of her child omnipresent, Crystal realized that she could walk with her son, thereby spending more time with him. When asked about the probability of starting tomorrow, she responded by rating that a 10. This response is evidence of change talk, which is integral to knowing when the patient is responding to brief MI and ready to change. In Crystal's case, she used a conditional statement, “if I put my mind to it, I'm going” and then assured the nurse that she would begin the next day. Two

MI-specific principles were highlighted in this session: listening for and amplifying the patient's change talk and offering advice only with the patient's permission.

A few weeks after this session, Crystal was rehospitalized with chest pain and was placed on dialysis after becoming oliguric. Her weight was 338 lb, 30 lb higher than her previous admission weight. She was unable to ambulate without assistance, as her swollen legs were too heavy to lift. Crystal admitted that she began planning for her funeral because she thought this would be the end.

Session 3—The intervention nurse suspected that Crystal was not following the self-care behaviors, which Crystal herself had accurately taught-back. The healthcare team had witnessed Crystal's nonadherence with diet restrictions and was frustrated. In this third session, the nurse's challenge was to explore with Crystal the longer-term consequences of leaving AMA in terms of her value of motherhood and its incongruity with her goal of being present for her child. Around this hospitalization, Crystal's son was graduating from kindergarten and she was determined to attend. There was resistance when the study nurse suggested that Crystal might need to stay in the hospital longer.

When resistance is encountered during MI, the practice is to acknowledge and “roll with it” rather than attempt to persuade a resistant point of view. The goal is for the patient to make an argument for change and then own that decision.[13] When a clinician makes the argument, the patient may become defensive and retreat further away from meaningful behavior change.

Crystal acknowledged that if it were “life and death,” she would consider listening to the medical team and staying. Slowly, she regained use of her kidneys but did not lose fluid as rapidly as she would have liked. Considering that she also refused dialysis, the healthcare team expected a poor prognosis if she left AMA.

Session 4—A seismic shift occurred in the fourth and final session when Crystal decided to stay in the hospital to finish off her treatment as recommended by her healthcare team. She missed her child's school graduation, which she had described as “nonnegotiable” 2 weeks before.

> RN: What convinced you to stay here?
>
> C: My health. I want to be here in the long run for him.
>
> RN: Hmm. So by staying here a little longer, you could be here for him much longer. Is that what you were thinking?
>
> C: Yeah. Actually taking initiative to grow up. Not be a baby and leave.
>
> RN: So what changed between last time I saw you and now?
>
> C: Praying, motivation. Keeping myself up. Things that we talked about really helped me.

Crystal repeatedly used the word *motivated* when addressing HF self-care behaviors such as increasing her activity and monitoring her symptoms. During this latest hospital admission,

Crystal had already lost 75 lb, with an overall goal of losing another 53 lb. This would be the lowest she had weighed since her early teens and Crystal was ecstatic because she could now wash independently. Before losing weight, she always required assistance bathing.

During this session, the nurse asked Crystal what she would do differently now that she had a long-term outlook. In response, she admitted to sneaking high-salt foods throughout the course of her treatment and vowed to change her shopping and eating habits. She already knew how to cook healthier meals but had not been motivated enough to do so consistently. Once Crystal admitted eating high-salt foods and expressed a desire to change those habits, the nurse elicited possible barriers.

> C: I always cook healthy meals whenever I cook. It was always a healthy meal...
>
> And now I have got to do it on a regular basis so I can survive.... For me to wake up and say, I am not going to die. I am going to get up and cook a small pot of rice. Some steamed chicken. I realized that that is the growing up in me that I needed. And with me seeing my deathbed, I had to grow up.... So now it is a matter of just testing myself.
>
> RN: So what are some of the things that are going to help you? What could you do?
>
> C: Keeping my doctors' appointments, keeping a strong head. Not letting things get to me.

Another large change in Crystal's outlook was her sense of control of her disease and, by extension, her life. At the beginning, despite having her son as motivation, she saw HF readmissions as inevitable. The nurse emphasized that responsibility for change was hers, and with a growing sense of mastery, her outlook became longer-term.

> RN: So you lost a lot of weight...your mood is much better. Your goal was to get out of the hospital, and be there for your son.... And be there for your son a long time, okay. So when you were talking, when we were talking 2 months ago to be there for your son were you thinking long-term or were you thinking more short-term? Or maybe you were not thinking in those terms?
>
> C: I never realized how sick I was.
>
> RN: When I talked to you the first time, did you feel like HF controlled you or you controlled the HF?
>
> C: The HF controlled me.
>
> RN: The HF controlled you, okay. How do you feel now?
>
> C: That I have a better knowledge.... Better understanding of myself. And that it is not that hard.
>
> RN: It is not that hard to do what kind of things? What is not that hard?
>
> C: To better myself, and take care of myself. I don't like being in the hospital. I was here and it is no walk in the park.

In this fourth and final session, the MI principles explored during the previous encounters were reinforced. In addition, Crystal and the nurse elucidated potential barriers to maintaining behavior change.

Discussion

Behavior change is based on mutual respect and collaboration between the healthcare team and the patient. However, without the patient actively engaged and motivated, no change will occur. In this case, both the patient and the medical team distrusted one another. The patient assumed that the team may not have had her best interests in mind and the medical team did not believe that the patient was adhering to the treatment plan. This may not be uncommon, as noted in a recent study by Leone et al[19] using nurses caring for patients with HF. Those investigators uncovered negative nursing attitudes toward “repeat offenders” as well as feelings of failure for patient nonadherence. Crystal eventually admitted to nonadherence, but only when she felt that she could be heard. The nonconfrontational and reflective style of brief MI helped to foster trust and repair the breaches in communication.

Outcome

Over the course of approximately four 1-hour sessions, the patient regained a sense of control over her disease and began to think about long-term goals. Brief MI was helpful in eliciting and linking the goals of the patient and treatment team. Because the motivation and actions needed to achieve those goals originated from the patient, the chance for successful behavior change was increased.

Even with the desire to modify behavior, change may be difficult because of the patient's ambivalence toward altering long-standing negative behaviors or reluctance implementing positive behaviors. Although Crystal demonstrated knowledge of self-care behaviors, this did not necessarily correlate with action. In the preceding case, ambivalence to change was acknowledged and explored in a nonjudgmental manner. The patient recognized her nonadherence and felt empowered to voice it without fear of negative attitudes. She began to internalize the arguments for change rather than simply hearing the extrinsic advice of the treatment team. The nurse helped to encourage the positive arguments for change by recognizing the patient's readiness to change and eliciting a plan. By the final session, the benefits of change for the patient clearly outweighed the benefits of the status quo.

The intervention nurse encountered several challenges not uncommon for many hospitalized patients. There were frequent interruptions both in the hospital and in the home that were overcome through the use of rephrasing and summarization. This technique helps foster empathy and is also useful when the practitioner desires clarification from the patient. The lack of patient resources such as a cell phone made it difficult for follow-up until the hospital social worker was able to secure a telephone for the patient. The social worker also connected the patient with transportation for office visits and temporary food assistance. Unfortunately, the implementation of these programs was delayed because of the patient's frequent AMA hospital departures. When Crystal was willing to take more control of her HF, she was also able to receive the help that the social worker and hospital had to offer.

Clinical Implications

Brief MI was developed as a relevant method of implementing MI in a busy practice. The potential advantages to both patients and staff of using brief MI in the in-hospital setting are great despite conceivable challenges. In this case, the same nurse was available to consistently deliver the brief MI intervention. The reality of staffing may preclude this level of consistency. However, many hospitals train select nurses to teach patients about HF self-care behaviors, with the emphasis being the prevention of hospital readmissions. These nurses may be optimal candidates to train in the brief MI approach, which will help them effectively communicate about self-care skills and behavior change.

Short and interrupted interactions with multiple team members may make implementing a therapeutic intervention such as brief MI a challenge as well. Moreover, not every team member will feel comfortable interacting with patients using MI principles. However, Irby et al[21] conducted a study where interactions with multiple team members at different time periods were successful owing to the use of brief MI. With coordination, team members may contribute to a patient's positive behavior change. Using the entire hospitalization as an opportunity for learning HF self-care behaviors has been advocated for critical care environments.[12] Brief interactions throughout the hospital stay can be beneficial for reinforcing critical behaviors such as symptom recognition or daily weights.

A concern in having a patient determine goals may be the potential for goal incongruity between the patient and the treatment team. A postdischarge goal to prevent readmission, such as intervening early if a patient's weight increases, requires that patient to weigh himself/herself daily. The patient may not share the same goal of tracking his/her weight but will likely share the goal of staying out of the hospital. One of the advantages of using brief MI is being able to link the patient's goals with the self-care behaviors necessary to achieve those goals.

Summary

The brief MI intervention may be helpful for a patient with chronic HF at risk for readmission or for a newly diagnosed and overwhelmed patient. The patient's goals are the endpoint, with brief MI providing the map to discover and explore ambivalence to change and desirable self-care behaviors. When performed correctly, brief MI encourages communication and trust and makes patients an active participant in their care. This intervention is only 1 of several factors that may contribute to the patient's success. Proper medical management, coupled with the use of available resources, is crucial to patient progress. However, without a willingness to change behavior, no amount of resources will be successful.

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Clinical Pearls

■ Motivational interviewing explores ambivalence to change in service of the patient's goals.

■ Motivational interviewing is possible in shorter interactions in the clinical setting.

■ Motivational interviewing encourages communication and trust and makes the patient an active participant in his/her care.