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Culturally Sensitive Application of the Motivational Interview to Facilitate Care for a Black Male Presenting to the Emergency Department with Suicidal Ideation

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Abstract

Mental health presentations and Black male patients are independent features predictive of a difficult clinical encounter. The Motivational Interview (MI) technique was used to facilitate compliant psychiatric care for a Black male presenting to the Emergency Department (ED) with Suicidal Ideation (SI). The MI technique established a therapeutic alliance for shared decision-making. This case report reviews the four core MI skills by highlighting its culturally sensitive application for motivating participatory mental health evaluation and follow-up of the patient. The MI may have a role in mitigating poor mental health outcomes linked to difficult clinical encounters of Black male patients.

Introduction

Physicians consider 15%–30% of patient encounters as difficult [1]. A difficult patient encounter is one in which there is a compromised alliance between the provider and patient, resulting in worsened patient outcomes [2]. A provider's background and culture are linked to difficult patient encounters. Patients with mental illness and populations most affected by poor social determinants of health are linked to difficult clinical encounters.

Under-managed psychiatric care of Black males has been described and attributed to gender and racial differences of emotional expression [3]. Clinician bias in perception of Black males contributes to under-management [4]. Systemic factors include standardized mental health assessments. Most screening tools and treatment standards for adolescent mental health have been normed by non-blacks. This potentially misidentifies culturally-bound behavior of Blacks as psychopathy [5]. These considerations help predict the difficult patient encounter in psychiatric care for Black males and its associated poor outcomes. The MI is a patient-centered counseling approach that seeks to elicit attitude and behavior change of patients from the base of their perspective. To best manage difficult clinical encounters, providers must recognize all contributing factors to its potential, and the MI has been suggested as a tool to bridge the interactive alliance of provider and patient [1]. The MI has benefits in marginalized populations. This is attributed to the MI serving patient needs which were previously unmet from prior clinical experiences [6]. The MI is a tool capable of provider mastery, enabling adaptive functioning for best outcomes working with various cultural contexts in the clinical setting [7].

Dr. William Miller developed the MI. The concept was drawn from his experience managing mental and behavioral health patients.

In addition to its culturally competent care, the MI demonstrates a particular advantage in psychiatric care [8]. The body of evidence supporting MI has been through psychiatric conditions such as substance use disorders. However, evidence is lacking on its impact on SI care. Nevertheless, clinicians have reported success with the MI in facilitating life-preserving dialogue with SI patients suffering from thoughts of self-inflicting harm [9].

In sequence, the four processes of MI are Engagement, focusing, evoking, and planning [10,11]. Four core motivational skills comprise the engagement process. In sequence, they are open questioning, affirmation, reflection, and summarizing (OARS). This case report demonstrates that each foundation of the MI applied in a culturally sensitive manner to build a patient alliance for therapeutic SI care.

Case Presentation

A 24-year-old Black male with no past medical history presents to the ED with a self-inflicted Gunshot Wound (GSW) to the right shoulder in the setting of SI. The patient was placed under Physician's Emergency Certificate (PEC) for patient safety. On initial presentation, the patient demonstrated flat affect on the physical exam and was non-compliant in providing history. The patient was again prompted to discuss the history and provided limited responses consisting of 'yes' and 'no.' The patient voiced displeasure with PEC and was reluctant to participate in medical evaluation. The patient was informed of pending psychiatric evaluation after medical clearance. The patient became agitated when psychiatric care was mentioned.

A single ballistic wound was limited to the soft tissue structures of the right shoulder. The patient was neurovascularly intact to his right upper extremity. A serial chest x-ray was performed without evidence of complicated injury or acute changes. The right shoulder wound was irrigated and cleaned with the appropriate application of the protective dressing. Laboratory evaluations were unremarkable. The patient was subsequently medically cleared for inpatient psychiatry.

Prior to inpatient psychiatry transfer from ED, the ED treatment team made an additional attempt to obtain patient history using the MI technique. As a result, the four processes of MI were applied in this particular patient discussion.

Methods

Four processes of MI: Engage, Focus, Evoke, Plan.

Engage. The goal of engagement is to establish a provider-patient alliance. The four motivational skills (OARS) were applied in this process.

Motivational skill 1: Open questions.

The patient was asked to explain the context which led to his feelings of self-harm. This broad, inciting question prompted the patient to disclose his functional decline over a three-week period which was marked by a sad mood, anhedonia, guilt, fatigue, and pervasive thoughts about death. This approach aimed to help the patient gain feelings of acceptance and non-judgment by the treatment team. The treatment team hoped patient acceptance would begin to build the trust needed for the therapeutic alliance.

Motivational skill 2: Affirmation.

Open questioning revealed patient thoughts of worthlessness due to unmet personal responsibilities, which impacted family dynamics. The treatment team responded with comments of understanding which included personal testimonials of disappointing events and their impact on mood. The goal of this approach was to validate the patient's concerns and normalize his feelings of disappointment. Additionally, this approach reinforced shared balance in the doctor-patient relationship. The treatment team felt that this perspective would aid the patient in developing behavior change.

Motivational skill 3: Reflective listening.

The treatment team asked a series of clarifying follow-up questions to the patient's voiced history. The patient further defined the context of his presenting illness and, in doing so, revealed details contributing to his episode of SI. This approach aimed to reinforce empathy by focusing on patient concerns and telling his story. Through listening, the team explored motivations for the patient to participate in attitude and behavior change. Reflective listening enabled the treatment team to understand the dynamics of the patient's life, which were core to his mood and motivation and used such to invoke patient motivation for compliant psychiatric care.

Motivational skill 4: Summarizing.

The treatment team summarized both the HPI and the concerns of the patient. The patient agreed with the summary at its conclusion. This approach aimed to communicate to the patient that the treatment team was engaged listeners who understood his concerns and who were advocates of his attitude change. Furthermore, understanding that more deliberate actions towards compliant care were ahead, the treatment team wanted to ensure the patient approved of our understanding of his concerns and perspectives.

Focus: Negotiated agendas are drawn from the provider and patient perspective, which helps the patient determine what is truly important to him or her. This dialogue establishes a shared purpose which gives the provider permission to transition the conversation towards the context of change.

The treatment team asked the patient about his thoughts concerning the discussions that began in the engagement process. The patient expressed understanding of the importance regarding his presenting acuity and its etiology. However, the patient was reluctant to engage in pending psychiatric care. The patient referenced uncertainty with his yield in receiving mental health care. The patient expressed concern that his personal experience of being Black would be misunderstood. The treatment

team, which was a mix of Black and White women and men, briefly mentioned experiences of feeling burdened by biographical biases. This approach aimed to bridge mutual understanding to serve as a foundation to welcome change talk. The treatment team identified equity as a mutually important idea and briefly referenced inspirations such as family as tools used to overcome the negative emotions associated with inequity. The treatment team hoped that this perspective could inspire motivating thoughts of the patient for participation in care. Additionally, the treatment team educated the patient on false stigmas associated with mental health and validated the efficacy of mental health treatments.

Evoking: Discovering the patient's motivation to change. For example, provider recognition of patient communication may suggest their willingness or readiness to change.

The patient communicated to the treatment team that his feelings of hopelessness were largely due to barriers associated with race. The patient expressed that these feelings complicate his role as a father. The treatment team acknowledged the impacts of poor social health determinants on populations and briefly commented on personal experiences with such a burden. A treatment team member mentioned his children as inspirational figures who motivate him. An additional treatment team member spoke on overcoming depression.

The objective of this approach was to negotiate the application of the perseverance of the patient. By referencing personal experiences related to poor social health determinants, the treatment team attempted to validate the patient's concern and potential for mood disturbances. More importantly, the treatment team attempted to awaken the patient's thoughts for reasons to overcome negative mood disturbance and preserve life with ambition. To accomplish this goal, the treatment team agreed to exchange personal vulnerability for the patient's motivation. The patient identified his children as his personal inspiration.

Planning: The plan comes from the patient and is based on their perspective.

The treatment team counseled the patient that his optimal health best ensures his capacity to support his children. The patient progressively developed an understanding that inpatient psychiatric care was a necessary step towards such a goal. The treatment suggested that the patient contact family when possible while receiving care and also suggested the patient utilize pocket-sized photographs of the family as inspiration for outpatient mental health care. The patient stated that both plans worked for him and particularly felt the pocket-sized family photographs for self-care preservation care would be best effective. The goal of this approach was to establish a patient-defined plan to accomplish such a goal. It was important to establish plans which were achievable for the patient. Planning would allow a greater likelihood for behavior change for the patient and mitigate its ambivalence from unimagined capacity to change in the patient.

Result

The motivational interview technique was effective in facilitating compliant and patient-engaged psychiatric care. The engagement process established balanced decision-making and promoted patient autonomy. This helped shape the patient's confidence to explore his thoughts and provide meaningful context about his presentation, including family challenges and thoughts of inequity. The treatment team used this information to consider its impact on expressing his love to his family. The treatment summarized the patient's story and had accomplished patient engagement through open discussions, which took place without feelings of judgement. However, at the conclusion of the engagement, the patient was still ambivalent towards participatory psychiatric care and follow-up.

As a result of focusing, the patient became less ambivalent towards non-compliant psychiatric management. During the focus process of MI, the patient became aware that his attachment to family was the foundation of his critical illness. Interactive dialogue with the patient revealed the patient thoughts of inequity and racial exclusion as contributing factors to his critical illness. The treatment team added testimonials of personal experiences dealing with biases and healthy coping strategies used to endure such. The patient acknowledged the team's understanding of his concerns. The treatment team also informed the patient about the efficacy of psychiatric medications and the inaccuracies of stigmas associated with mental health. During this particular discussion, the patient's mood evolved from sad to neutral and demonstrated one proactive thought in the decision-making process.

The treatment team engaged the patient's ideas about family to invoke this thought as motivation for active behavior change. Initially, the approach was unsuccessful as the patient expressed doubt about the relatedness of active behavior change with the future family outcome. The patient described previous experiences of unrewarded personal efforts related to overcoming socioeconomic adversities. After a period of ambivalence, the patient recognized that lack of participatory acute psychiatric care and complaint long-term follow-up could further hinder his family dynamics. Although the patient acknowledged this, he appeared uncertain on how to carry out this idea. A Black male treatment team member referenced wallet-sized photographs he keeps of his children for daily motivation. The treatment team's use of anecdotal personal experiences of challenges relatable to the patient's current experience was effective in evoking patient impetus for behavior change.

Prior to his departure from the ED to inpatient psychiatry, the patient was encouraged to reflect upon the family when thoughts of discouraged or non-compliant care arose. The patient agreed and expressed a desire to be well. The patient stated that he

wished he would have used this approach over the previous weeks when he faced the onset of mood difficulties. The patient started a plan for daily thoughts and calls to family while receiving inpatient psychiatric care. The treatment team subsequently suggested the use of handy photographs of the family for ongoing self-care when discharged. The treatment team commended the patient for action-planning. The patient thanked each treatment team member and was transferred to inpatient psychiatry in a cheerful mood.

Discussion

This case report demonstrates the capacity of the motivational interview to facilitate patient-complaint psychiatric care and follow-up in high-risk, difficult clinical encounters. A systemic review demonstrated that the motivational interview outperformed traditional advice by nearly 80% [12]. Considering it has been suggested as an adaptable tool capable of educating providers, MI skills are crucial to promoting embracing clinical environments inclusive of the variances of patient care.

Black males, and other minority subgroups, may experience under the management of psychiatric care from lack of culturally-adaptive provider care. As data in subgroup-specific effects from the MI is limited, field explorations may leverage pivotal insight and contribute to innovative strategies to improve population health in psychiatric care. Ethnic and racial minorities bear a more debilitating burden from mental illness and are less likely to receive mental health care [13,14]. Patient factors contributing to this breakdown include dilemmas tied to providers with a lack of cultural compentency [13]. The cultural framework of providers is a leading contributor to a difficult patient encounter. Thus, Black men, among the least likely to participate in mental healthcare, potentially face undue implications in the difficult patient experience [15].

Compared to the general population, African Americans are less likely to receive psychological approaches such as psychotherapy to address mental health [16]. Heightened patient and provider emotions may likely contribute to bilateral biases, which equally compromise the therapeutic alliance of a difficult clinical encounter. The motivational interview optimizes patient morale for complaint follow-up and potentially precedes compliance by engaging cultural competence into the therapeutic dynamic. The OARS of the engagement process is highly active in creating an alliance with patients. Scholars have demonstrated the great resilience capacity of Black males [17]. Enduring difficult psychiatric care encounters with this population is necessary, and adjustments such as the MI application may help to do so and improve outcomes.

This case report presents the role of MI in mitigating difficult psychiatric patient encounters associated with cultural differences in the clinical encounter. The treatment team applied each skill of the MI in a culturally sensitive manner to ease patient reluctance to psychiatric care and promote ongoing care in a Black male who presented noncompliant to do so.

Conflict of Interest

The authors declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article. Informed consent was obtained for this publication.

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