

Engaging Depressed Patients in Psychotherapy: Integrating Techniques From Motivational Interviewing and Ethnographic Interviewing to Improve Treatment Participation

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Treatment dropouts and high “no show” rates are vexing problems for practicing psychologists and the populations they serve. This article describes a one-session intervention based on principles derived from motivational interviewing and ethnographic interviewing designed to improve depressed patients’ participation in subsequent psychiatric treatment. The authors explain the rationale for developing an engagement intervention, describe the intervention itself, and present case vignettes based on a pilot study evaluating the feasibility and acceptability of administering the intervention to depressed mothers whose children suffer from psychiatric illness. The article includes strategies that may be implemented in clinical practice to improve patients’ participation in treatment.

Keywords: engagement, treatment adherence, motivational interviewing, depression, multicultural counseling

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High rates of mental health treatment dropout and low rates of therapy attendance are common problems in the United States (Wang et al., 2005). These issues are especially prominent among socially disadvantaged and ethnic minority cultural groups (Miranda, Azocar, Organista, Dwyer, & Areane, 2003). What strategies can practicing therapists use to increase the likelihood that their depressed patients will adhere to a course of psychotherapy and participate actively in care? The present article describes an engagement session designed to enhance clinicians' ability to recognize, understand, and resolve patients' ambivalence about seeking and entering treatment, thereby increasing the likelihood that depressed patients will follow through with appropriate care. We discuss the rationale for developing an engagement session based on principles of motivational interviewing (MI) and ethnographic interviewing (EI), present data supporting the efficacy of the intervention, describe the session itself, and provide representative case vignettes based on preliminary work with a patient population that is notoriously difficult to engage in treatment: depressed mothers whose children are receiving psychiatric treatment, many of whom are economically disadvantaged.

The Problem: Depression and Treatment Engagement

Investigators have consistently demonstrated that most depressed patients do not receive treatment of either adequate duration or intensity (Young, Klap, Sherbourne, & Wells, 2001). Although depression treatment has been found to be inadequate across demographic groups, the U.S. Surgeon General's report on culture and mental health concluded that racial and ethnic minority groups are especially high risk for underutilization of mental health services (U.S. Department of Health and Human Services, 2001). Depressed patients struggle with a wide range of potential barriers to psychiatric treatment, but most readily identify practical or "time and hassle" factors as among the most significant impediments to care (Maynard, Ehreth, Cox, Peterson, & McGann, 1997). These clearly are important concerns, as some individuals who would otherwise be fully committed to mental health treatment lack mental health insurance benefits or the resources to pay for care, do not have access to transportation to attend scheduled appointments, or cannot find appropriate childcare. In addition to these concrete problems, however, psychological and cultural factors have critical impacts on whether patients seek treatment. Worry or embarrassment about acknowledging their depression and doubts that treatment could be helpful (Scholle, Haskett, Hanusa, & Kupfer, 2003), as well as previous negative experiences of mental health services (McKay & Bannon, 2004), inhibit engagement. Mismatches between type of treatment offered and that desired (McCarthy et al., 2005); incompatible views of the nature of the problem, negative attitudes about legitimacy of help seeking, disclosure of private experiences, or taking care of oneself (Mackenzie, Knox, Gekoski, & Macaulay, 2004), and negative relationship expectancies are also inhibitory. In addition, minority racial and ethnic groups may also underutilize mental health services because of historic failures on the part of mental health professionals to provide culturally sensitive therapy (Sasao & Sue, 1993; Sue, 1998, 2003) as well as a long-standing distrust of services that are informed and influenced by a history of racism (Corbie-Smith, 1999). As described below, the engagement session systematically explores practical, psychological, and cultural

barriers to depression treatment and articulates a set of strategies designed to address each of these issues.

Review of Empirically Supported Engagement Interventions

Many skilled practitioners of psychotherapy across psychotherapeutic "schools" advocate for the use of empathic listening, respect for the patient's beliefs and background, and emphasis on eliciting the patient's central narrative (c.f. McCullough, 2000; Viederman & Perry, 1980), elements of a therapeutic stance consonant with both MI and EI as strategies for engaging patients into treatment. These strategies, however, have not been separated from the broader therapeutic process, and the utility of those specific strategies (or combination of strategies) in exploring and addressing barriers to treatment seeking has not been evaluated.

Formal pretreatment interventions to facilitate entry, engagement, and retention in psychotherapy have included role induction, vicarious therapy pretraining, and experiential pretraining (Walitzer, Dermen, & Connors, 1999). An initial intensive phone session that addressed practical and psychological barriers to care was associated with higher rates of attendance at a first mental health intake appointment among inner-city youth and their caretakers (McKay, McCadam, & Gonzales, 1996). The addition of case management to group cognitive-behavioral therapy (CBT) was associated with improved treatment retention in a group of disadvantaged Spanish-speaking patients treated in a primary care setting (Miranda et al., 2003). Investigators at the Group Health Cooperative in Seattle, Washington, reported that telephone case management and telephone psychotherapy reduced practical barriers to care and were associated with very high rates of treatment retention and improved treatment outcomes, relative to usual care treatment for depression in a primary care setting (Simon, Ludman, Tutty, Operskalski, & Von Korff, 2004). Little systematic work, however, has been done to develop individual interventions for use in mental health settings to improve treatment engagement and retention among depressed adults by addressing barriers to treatment participation.

Rationale for the Engagement Session

The engagement session evolved from the direct clinical experiences of the authors who struggled with recurrent failures of their patients to engage and participate in psychotherapy. Initially, investigators in our group were working in parallel to develop separate engagement sessions based on MI (Holly A. Swartz and Allan Zuckoff) and EI (Nancy K. Grote and Sarah E. Bledsoe), respectively. The theoretical orientations of these two groups were driven both by our academic affiliations and clinical backgrounds (psychiatry/psychology and social work/psychology, respectively) as well as by the intuitively reasonable assumptions that MI and EI approaches would be useful in our respective treatment settings. As discussions between the groups progressed, it became apparent that the two approaches served to address different—but interrelated—components of the observed problems around treatment engagement. First, rather than constituting isolated obstacles, pragmatic, psychological, or cultural barriers were conceptualized as contributors to individuals' overall ambivalence about seeking treatment. From this perspective, exploring and resolving ambiv-

alence about treatment seeking becomes an overarching framework for facilitating treatment entry and adherence. Second, clinician bias, arising from multiple sources, has the potential to interfere not only with the development of an alliance but also with clinicians' ability to recognize the presence and understand the sources of patients' ambivalence about treatment. Thus, the engagement session targets both patient-specific (ambivalence) and clinician-specific (bias) impediments to treatment engagement. As EI and MI strategies provide complementary methods for addressing both of these issues, we decided to join our intellectual resources to develop a "hybrid" engagement session conjointly. From the outset, we worked toward developing an intervention that could be (a) completed within a standard 50-min psychotherapy "hour" (and therefore could be billed as a standard psychotherapy session), (b) delivered by mental health professionals with relatively limited prior experience and training, and (c) taught to a group of clinicians in a relatively brief training session (8–10 hr). Later examinations of the intervention revealed it to be consistent with recommendations made in the multicultural literature with respect to patient engagement. We have subsequently explored the engagement session's relationship to multicultural theory and practice in order to situate our experience-driven intervention within this broader theoretical context.

MI

MI is a "client-centered, directive method for enhancing intrinsic motivation for change by exploring and resolving ambivalence" (Miller & Rollnick, 2002, p. 25). The practitioner of MI expresses empathy to promote an understanding of the patient's concerns, develops discrepancy between the patient's current behavior and her cherished goals or values to build awareness of the importance of change, rolls with resistance in order to reduce it, and supports self-efficacy to strengthen the patient's confidence in her ability to change should she so choose. Miller and Rollnick (2002) characterized the MI "spirit" as one of autonomy, collaboration, and evocation. MI was originally developed as a brief intervention for alcohol and other substance use disorders, and it has accumulated a large number of successful empirical trials that target those problems (Hettema, Steele, & Miller, 2005). More recently, MI has been applied in a variety of other areas and has demonstrated efficacy in promoting physical health outcomes as well (Rubak, Sandbaek, Lauritzen, & Christensen, 2005).

Perhaps because MI was developed to address ambivalence about specific behaviors, investigators have only recently begun to explore its potential uses in the more abstract area of engagement in treatment for mood disorders. Simon et al. (2004) used structured MI exercises delivered over the phone to enhance treatment engagement in depressed primary care patients receiving CBT over the telephone. Arkowitz & Westra (2004) described initial work integrating MI with CBT in the treatment of depression and anxiety, and Westra and Dozois (2006) reported that three MI sessions prior to group CBT for patients with panic disorder, generalized anxiety disorder, or social phobia resulted in significantly higher expectancy of anxiety change, homework compliance, and rate of treatment response, compared with a CBT-alone group.

Ethnographic Interviewing

Because many of the mothers we treat come from disadvantaged backgrounds and have lives that are very different from those of our treatment team, we knew that it was important to attend specifically to potential sources of cultural bias in the engagement session. The work of Sue and others (c.f. Sue, 1998) later confirmed for us the relevance of this approach. Many depressed patients from ethnic and racial minority groups avoid mainstream mental health treatment altogether or enter psychotherapy with considerable reluctance because of perceived insensitivity of mental health care providers to their cultural values (Sue, 1998). In addition, therapists from one ethnic group may be unaware of the impact of their tacit biases on therapeutic encounters with patients from different cultural groups (i.e., lack cultural sensitivity; Paniagua, 1996). The EI component of the engagement session encourages therapists to be aware of their own unconscious biases—and ultimately suspend them—in order to attend to cultural issues that may affect patient attitudes toward therapy. EI requires therapists to assume the stance of the student and the patient that of the teacher, a process that helps the therapist acquire a better understanding of the values, beliefs, and norms of the people they treat (i.e., enhanced cultural competence). This approach clearly is in accordance with the recommendations of the multicultural practice guidelines for psychologists, which state that it is the responsibility of practicing clinicians to modify their own behaviors and therapeutic styles to meet the needs of this underserved population (American Psychological Association, 2003).

EI provides a rationale and method for exploring, in a nonjudgmental manner, the experiences and values of our patients, thereby enhancing the salience of mental health treatment to those from historically marginalized cultural groups. More specifically, EI is a method of eliciting information designed to help the interviewer understand the ideas, values, and patterns of behavior of members of another culture without bias (Schensul, Schensul, & LeCompte, 1999). Open-ended ethnographic questions are used both to encourage the interviewee to tell her story and to uncover how the interviewee integrates her beliefs and experiences to create a sense of meaning and coherence. In the context of the engagement session, an increased understanding of the needs, preferences, and worldview of these mothers (elicited by EI) helps therapists to match patients' values to available treatment options and to collaboratively set more realistic and meaningful treatment goals.

Integrating MI and EI

There is a good deal of overlap between MI and EI techniques; asking open-ended questions, encouraging the interviewee to tell her own story, seeking elaboration on important or unclear points, and identifying and affirming strengths are common to both approaches. MI and EI differ in how they conceptualize the most likely sources of clinician bias as well as in the purposes for which they were developed. MI emphasizes the potential for clinicians' own goals, preferences, values, and ideas about what is healthy or adaptive to interfere with their ability or willingness to understand patients' goals, preferences, values, and ideas about what is good for them or in their own interest. MI provides a method for minimizing the possibility that clinicians will either intentionally or unwittingly seek to impose their personal or professional per-

spective on the patient by placing the patient's personal perspective at the center of the discussion. EI emphasizes the potential for clinicians' culturally specific values, ways of understanding others, and judgments about what constitutes rational or desirable behavior to interfere with their ability to grasp an interviewee's culturally specific beliefs, values, and priorities. EI provides a method for minimizing the possibility that clinicians will either intentionally or unwittingly seek to impose their culturally based assumptions on patients who are members of another culture by suspending expectations derived from clinicians' cultural norms and prioritizing the understanding of the patient's culture and way of life from the patient's point of view. In the context of the engagement session, then, these approaches can be seen as complementary. Each draws attention to different sources of clinician bias, but both aim to enable clinicians to understand the patient's world as she experiences it, the patient's way of understanding herself and her world, and the patient's wishes, intentions, concerns, goals, and values.

Unlike EI, which was developed as an anthropological tool and as such has no occult therapeutic objectives that are potentially at odds with the views of the interviewee, MI was developed for use in clinical situations (i.e., substance abuse and health behavior change) in which the clinician enters the encounter with the belief that there is a preferred or "healthier" outcome of the interaction (e.g., abstinence or reduction in substance use, changes in diet or activity levels). Because, like the client-centered approach on which it is founded, it treats as axiomatic the idea that people are intrinsically motivated to move toward maximizing their health and well-being (Rogers, 1959), MI provides a framework for the clinician to evoke from the patient decisions that are aligned with the therapeutic aims of the intervention. Thus, MI embraces and reconciles the apparent paradox of both accepting the patient's point of view and maintaining an independent, medically informed, therapeutic stance in the service of an overarching goal of healthy behavior change.

Both MI and EI enhance therapists' capacity to participate in a culturally sensitive dialogue about treatment seeking with individuals from diverse backgrounds, in accordance with the tenets of multicultural counseling (Paniagua, 1996). Both strategies begin with the intention to elicit the patient's story ("narrative," in EI language) in her own words, as the clinician suspends, as much as possible, his or her own culturally bound assumptions. As the clinician forms an alliance with the patient and comes to appreciate her unique perspective, MI also allows the clinician to develop the patient's sense of discrepancy between the way things are and the way she wants them to be and, when used to enhance motivation for treatment as well as motivation for change (Zuckoff & Daley, 2001), to recognize how participation in appropriate treatment can facilitate her achievement of her own valued goals.

Depressed Mothers of Children With Psychiatric Illness

We have previously reported high rates of depression among mothers bringing their children to a pediatric mental health clinic for evaluation and treatment (Swartz et al., 2005). In our study, we found that 61% (135 of 222) of mothers met *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*; American Psychiatric Association, 1994) criteria for a current Axis I disorder, most commonly depression ($n = 77$; 35%). Two thirds of

mothers with a psychiatric diagnosis were not receiving psychiatric treatment at the time of assessment. Other investigators have found that this population is very difficult to engage in treatment (Verdeli et al., 2004), and yet maternal depressive symptoms are associated with poor outcomes in depressed youth receiving care (Brent et al., 1998). Conversely, successful treatment of depressed mothers has been associated with improved mental health outcomes in their offspring (Weissman et al., 2006). Thus, depressed mothers of ill children have been identified as a group in need of treatment, likely to benefit from treatment, but especially difficult to engage in this endeavor.

Empirical Support for the Engagement Session

The development of this intervention was supported by National Institute of Mental Health grants awarded to Holly A. Swartz and Nancy K. Grote. These grants also supported the pilot testing of this intervention, used in combination with brief interpersonal psychotherapy (Swartz et al., 2004) as treatments for depressed mothers of offspring with psychiatric illness (Swartz et al., 2006) and in depressed, low-income, pregnant women (Grote, Bledsoe, Swartz, & Frank, 2004). Preliminary reports from the open phases of these trials are promising, and we are currently conducting randomized studies comparing in these two populations the engagement session plus brief interpersonal psychotherapy to usual care. We have found a significant difference in initial treatment attendance between depressed, pregnant women who did and did not participate in the engagement session: 23 of 24 pregnant, depressed women (96%) who received the engagement strategy subsequently attended an initial treatment session. Of the 33 women assigned to receive standard treatment for depression without the engagement interview, 28 entered the study, but only 7 (25%) attended an initial treatment session. Fisher's exact test indicated that the likelihood of attending a first session was significantly higher in the group receiving the engagement session ($p < .001$; Grote, Zuckoff, Swartz, Bledsoe, & Geibel, in press). We are currently planning additional studies to evaluate the engagement session in other settings and with other populations.

Although these initial reports are encouraging, we caution the reader to consider that this is a relatively new intervention, and we cannot predict how it will perform outside of the controlled research settings described above. Nevertheless, our experiences with the intervention to date have been positive—both in the context of clinical trials and when used more flexibly in nonresearch environments—and we are hopeful that this approach will eventually be demonstrated to have utility under a broad range of clinical conditions.

Engagement Session

We have developed a treatment manual to describe this approach in greater detail, illustrated with relevant case material (Zuckoff, Swartz, Grote, Bledsoe, & Spielvogel, 2004). We summarize the key components of the intervention below.

Therapeutic Strategies

According to the tenets of EI, the clinician is expected to suspend his or her cultural biases and assumptions during the

initial phase of the session. Although clinicians' training allows them to claim expertise in many areas, the patient is the expert on herself. It is essential for a clinician to communicate respect for the patient's autonomy and right of self-determination, even if some of the patient's choices conflict with the clinician's core personal beliefs. This stance allows clinicians to develop an accurate understanding of the patient's experience from her own perspective.

During the course of the engagement session, the clinician relies primarily on open-ended questions and expression of empathy to develop an alliance and move the session along. Open-ended questions and empathic reflections encourage the patient to tell her story in an unimpeded flow and reduce the risk that the patient will feel expected to provide specific answers. Empathy is defined as accurate understanding of the patient's communications and experience, as if from inside the patient's world. The clinician expresses empathy through the technique of reflective listening, in which the patient's words, meanings, and/or feelings are communicated back to the patient in the form of a statement. These statements are made with due humility, given that the clinician can never be certain that her understanding is correct. Comments are made in a warm, nonjudgmental manner. In keeping with MI technique, clinicians are encouraged to make at least three reflective statements for each question asked. Summaries that bring together several of the patient's previously expressed thoughts, feelings, or concerns, as well as the clinician's understanding of how these fit together, allow the clinician to help the patient see important connections. They also prepare the way for the clinician to shift to the next part of the session.

In the engagement session, the clinician actively supports and points out patients' strengths, including past attempts at coping with depression and current efforts to resolve the dilemmas with which they are struggling. Self-efficacy refers to patients' beliefs about how likely they are to succeed at something they try to do (Bandura, 1999). This plays a key role in engaging patients in treatment: No matter how much they come to believe they need it, patients who do not believe they can succeed at treatment are unlikely to try very hard to stick with it. Depressed patients often believe that they will be unable to succeed at anything they try because their symptoms include, by definition, feelings of helplessness and hopelessness. Therefore, although the clinician is asked to suspend his or her cultural beliefs, the therapeutic stance itself is not neutral. The clinician acts as patient advocate and offers sincere affirmations of the patient's strengths at appropriate points during the interview.

Because of the history of racial and ethnic prejudice in our society, it often is very difficult for individuals of different backgrounds—most especially White people and people of color—to frankly discuss issues of mistrust and misunderstanding. Therefore, it is imperative that the clinician invite and even encourage patients to voice concerns related to aspects of psychotherapeutic treatment of depression that may be considered culturally unacceptable. These may include confiding in a clinician of a different race, gender, or religion; revealing sensitive information in a professional treatment context (rather than within the context of their own community); or other concerns. As patients may be reluctant to broach these topics, the clinician should actively solicit patient concerns about race, culture, and gender. This frequently requires the clinician to ask the question several times before the patient feels that it is truly acceptable to voice her concerns about

these issues. This method of addressing racial issues is based largely on the experience of McKay and colleagues at Mount Sinai Medical Center in New York City (M. M. McKay, personal communication, November 2003), who found that it was important to actively elicit patients' negative experiences with a racially biased culture.

Related to the concept of soliciting patient concerns about race, culture, and gender, it is important that the therapist approach the patient in a culturally sensitive manner, especially when the patient is from a minority ethnic group. In the engagement session, therapists work actively both to avoid making assumptions about patients based on their personal cultural affiliation and to uphold the values and beliefs of individual patients, as recommended in the American Psychological Association's guidelines for multicultural practice (American Psychological Association, 2003). In addition, it is important to recognize and support culturally specific avenues of self-help, such as spirituality (Cervantes & Parham, 2005) and indigenous healing practices. These strategies are consonant with approaches tested and recommended by experts in multicultural counseling (Sue, 2003) and may help to mitigate concerns of patients who are paired with a therapist from a different cultural background.

Working with resistance is one of the key features of MI. In the engagement session, we directly appropriate several of these techniques to explore and address resistance to treatment seeking. Patients are expected to be ambivalent about whether they are really depressed, whether they need treatment, or both. That is, they will often feel both ways about these issues. Whereas the goal of the engagement session is to help them make a commitment to treatment strong enough to ensure that they receive the help they need, the method used to accomplish this involves accepting the normalcy of ambivalence and working with patients to resolve it. From this perspective, resistance simply reflects the negative side of ambivalence, and rather than challenging or confronting it, the clinician seeks to understand and work with it. Techniques for working with resistance include double-sided reflection, amplified reflection, reframing, emphasizing personal choice and control, and shifting focus. These techniques are described in greater detail in the MI manual (Miller & Rollnick, 2002).

Change talk and adherence talk are the positive side of ambivalence—indications that the patient desires to work at overcoming her depression and/or to receive help from treatment, sees a need for treatment and/or change, has reasons for committing to treatment and/or change, or believes she has the ability to succeed at changing or sustaining a commitment to treatment (Zweben & Zuckoff, 2002). Change talk and adherence talk are what the engagement session clinician is listening for and looking for opportunities to evoke. According to the theory of MI, when patients hear themselves saying these things, they are in effect convincing themselves to commit to treatment and change. Thus, when the patient engages in change talk and/or adherence talk, the clinician highlights it (through reflection and/or summarizing) and asks for more (through requests for elaboration or specific examples).

Structure of the Engagement Session

The engagement session is organized into five sections that can be administered in a sequence that makes sense for each patient-clinician dyad. The clinician attempts to cover each section during

the course of the session, but the amount of time spent on each section will vary widely, depending on the patient's history and presenting complaint. It is useful to begin each session with a brief explanation of the function of the engagement session (e.g., "The purpose of our meeting today is to help me understand your reasons for being here, your feelings about coming in for treatment, and what you would want from treatment") followed by an open-ended question or statement (e.g., "How have you been feeling lately?" or "Tell me about your current concerns or difficulties"). Because the word *engagement* usually makes little sense to patients when used in this context, we typically refer to the meeting as a "feedback and discussion session." It also is helpful for the clinician to remind himself or herself that the purpose of the session is not to gather history but rather to explore and resolve ambivalence about treatment seeking.

The engagement session is designed for the first clinical encounter with a patient. In practice, however, many clinics require "intake interviews" before clinicians officially begin treatment. If this is the case, clinicians are encouraged to summarize what they know of the patient at the beginning of the session, ask for patient confirmation and elaboration (if needed), and then move on with the engagement session. If clinicians are aware of any potential barriers to treatment engagement raised by the patient during the initial encounter, these should be paid especially close attention. In all cases, clinicians are urged to make the session feel natural, rather than asking the patient to repeat verbatim material that was covered previously.

The Story

The first part of the session is devoted to eliciting the patient's "story." Typically, depressed patients come to treatment with a seemingly unsolvable problem or dilemma. The clinician attempts to draw out and understand the central dilemma, as conceptualized by the patient, with special attention paid to the patient's mood symptoms (and how they impact on her life) and the social context in which the story is unfolding (i.e., the impact of poverty, racism, etc. on her experiences). The clinician uses empathic statements to elicit additional information about the story and, when he or she feels that he or she "gets it," the clinician summarizes the key features of the story for the patient and looks for verbal and nonverbal indications that the patient feels heard and understood. To develop an accurate understanding of the patient's experiences and problems, it is important that the therapist accept at face value the patient's statements without attempting to impose culturally bound qualifiers on the material. For instance, a patient may say, "My children are making me crazy. If those child doctors were better at fixing my kids' problems, I'd be fine." Although the therapist may suspect that there are additional determinants of the patient's current difficulties, he or she would reflect back to the patient an acceptance of the statement's validity without imposing alternative hypotheses. In the context of the engagement session, a typical response would be "Your children's problems really affect how you are feeling. If they were to receive better treatment, your situation would seem infinitely better." In the end, it is less important to strive for the "correct" formulation of the dilemma than to communicate that the therapist is listening and understands the patient's experience of being in a dilemma.

Feedback and Psychoeducation

To provide a rationale for treatment, the clinician presents the patient with data about her mood symptoms and provides some education about the clinical concept of depression. In this phase of the intervention, the therapist shifts from a pure EI stance and invites the interviewee to consider new information provided by the clinician. Using the MI strategy of elicit-provide-elicite (i.e., asking patients' permission before offering information and eliciting their reaction to the material once the information is given), the clinician summarizes information derived from either the story (described above) or from a standardized clinical instrument, such as the Beck Depression Inventory (Beck & Steer, 1993), completed prior to the first visit. In addition, the clinician explores the patient's understanding of the word *depression* and conveys to the patient information about the scientific basis of depression. The label itself is not stressed, except to the extent that it provides a short-hand way of talking about the patient's symptoms and experiences. This section may be quite brief if the patient is already convinced that she suffers from depression and understands the medical model. If not, it is important to educate the patient about depression using the medical model. The clinician explains depression as a medical illness ("like diabetes") that impairs functioning ("like when you have the flu") and can be successfully treated with appropriate therapy. If the medical model is incompatible with the patient's viewpoint (which should have become apparent during the initial phase of the intervention), the clinician would use other metaphors that are likely to make sense to the patients, such as

It's not uncommon for the body to have strong reactions to severe stresses. You told me that when you learned your partner was HIV-positive, you immediately developed a lot of stomach problems. In a similar way, your body is reacting to all the demands you are currently facing by going into "stress mode" which, for you, includes more stomach problems, fatigue, crying, and sleep problems. It makes it very hard for you to do what you need to do. There are lots of ways we can help you reduce or better manage your current stress levels which, in turn, will help your body to heal.

If the patient has expressed a strongly culturally bound understanding of her experiences, the clinician should invite a collaboration with the patient's preferred method of healing. For instance, a clinician working with a patient who voices strong religious beliefs may say

Your faith is a very important part of your life and affects your current experiences profoundly. Your lapsed involvement with the church seems to be making the stress of handling your children almost unbearable. I agree with you that it is very important for you to reconnect with the church. In fact, one of the things we can work on together is understanding how caring for a child with bipolar disorder makes it more difficult for you to be involved with your church. I, too, believe that if you can reclaim this central part of your life, you will feel a lot better. But it sounds like right now you could use some help getting many aspects of your life—including your spiritual life—back on track.

Treatment History and Hopes for Treatment

Because so many patients have had prior experiences with treatment—both good and bad—it is imperative to explore these

prior experiences and help the patient voice her hopes for current treatment, either as a contrast to prior negative experiences or as a follow-up to prior favorable experiences. This should include an exploration of formal mental health treatment as well as other mechanisms of help, such as pastoral support, traditional healers, and self-directed activities. In addition, a discussion of experiences with other social agencies is also important, as patients often conflate mental health providers with other helping professionals. The clinician is careful to listen to the patient's prior treatment experiences without passing judgment, allowing the patient's perspective to be fully voiced and explored. This section ends as the clinician encourages the patient to "look forward" and to voice her wishes for treatment, linking her goals with treatments available to her in the clinic.

Barriers to Treatment Seeking

The clinician asks, "What might make it hard for you to come to treatment, even if you wanted to?" This moves the session to a systematic exploration of potential barriers to treatment seeking. Typically, the patient will volunteer practical concerns first (time, money, transportation) because these are easiest to discuss. However, before attempting to problem solve with the patient about practical barriers, the clinician explores potential psychological and cultural treatment barriers. The clinician might ask, "If I had a magic wand and could make all of your practical problems disappear, what else might make it hard for you to come to treatment?" If the patient does not volunteer this information spontaneously, the clinician probes for unspoken concerns such as fears of being labeled as "crazy," negative experiences of friends or family members, guilt about taking time or resources away from other family members, discomfort with a clinician of a different ethnic or racial background, and so on. The treatment manual contains a list of specific probes that are used to explore the concerns typical of our treatment population (Zuckoff et al., 2004). For instance, the mothers we see are often concerned that being in treatment will make it more likely that their child(ren) will be taken away from them by social agencies. Even if the patient does not volunteer this worry, we routinely ask about it. After the psychological and cultural issues have been discussed, the clinician returns to the practical problems and helps the patient problem solve.

Elicit Commitment

The session ends with an outline of the next steps in seeking treatment. If the patient resists making a commitment, the clinician rolls with the resistance, avoiding efforts at direct persuasion that might lead the patient to dig in against treatment and leaving the door open for the patient to consider help in the future. If the patient affirms that the plans are satisfactory, the clinician helps the patient anticipate potential adherence setbacks and encourages the patient to call, even if the next session is missed for reasons beyond her control. The session concludes with an affirmation of the patient's strengths (e.g., "I appreciate your honesty with me today; I am sure it wasn't easy for you to be direct with me about these concerns") and instillation of hope (e.g., "You've taken the first steps toward feeling better"). When possible, the clinician provides the patient with a written personal summary of the

session that records (using the first person from the perspective of the patient) "What I want," "What I don't want," "Steps I will take to get what I want," "Obstacles that may prevent me from taking steps to get what I want," and "Strategies that I will use to overcome these obstacles."

Case Example A

(Note. Identifying features have been altered to protect the confidentiality of patients.)

Ms. A is a 50-year-old, African American, single mother of five children. Her youngest child, Keisha, age 14, was brought to the outpatient clinic following psychiatric hospitalization for a serious suicide attempt. Ms. A was referred to the adult clinic for an evaluation of her own mental health because her daughter's therapist felt that she, too, suffered from depression.

An engagement session was conducted as the first step in Ms. A's treatment. When Ms. A was asked to tell her story, she focused initially on her dissatisfaction with her daughter's treatment as well as on her belief that her own suffering was directly related to her daughter's behavior over the past few months. It emerged that Ms. A was a member of a fundamentalist church that forbade alcohol, dancing, and socializing between unmarried church members of the opposite sex, whether adolescent or adult. The church also viewed seeking mental health treatment, be it psychotherapy or medication, as betraying faith in the power of God to heal, making Ms. A hesitant to bring her daughter to the mental health clinic. Nonetheless, the inpatient treatment team convinced Ms. A that there was a good likelihood that her daughter would make another suicide attempt if outpatient aftercare, including medication, was not provided, so she reluctantly acquiesced. Many of Keisha's concerns revolved around feeling "different" from her public school classmates and a desire to deviate from her mother's strict rules about socializing, music, and dress. Keisha's therapist viewed these wishes as developmentally typical and not unreasonable and therefore normalized them and tried to convince Ms. A to "loosen up." Ms. A experienced the therapist as someone who was attempting to undermine her parental authority and devalue her religious beliefs; whereas she had not voiced these feelings directly to the therapist, she had refused to medicate the child as the psychiatrist recommended.

The clinician's main emphasis during the this initial part of the session was on expressing empathy with Ms. A's dilemma: She loved her daughter and wanted desperately for her to stop being depressed and suicidal, and at the same time, she was being told that helping her daughter would require her to violate her most dearly held beliefs about what kind of mother she ought to be for the sake of her daughter's spiritual well-being. The clinician validated Ms. A's feelings about Keisha's treatment, leaving aside the question as to whether the clinician agreed with Ms. A's decisions, while also affirming her courage and self-sacrifice in trying her best to get her daughter help. The clinician also recognized, in the context of offering Ms. A feedback from a depression inventory Ms. A had completed before the session, that it would be important to differentiate Keisha's (suicidal) depression from the depressive symptoms (poor sleep, low interest, decreased appetite, feelings of guilt, poor concentration) Ms. A experienced. Ms. A felt more comfortable labeling her symptoms as stress. In addition, it was

important for the clinician to differentiate Ms. A's potential treatment from her daughter's therapy.

The clinician then gently guided the session toward Ms. A's hopes and fears with regard to her own treatment. As they explored her church's disapproval of mental health treatment and feelings about working with a therapist of a different religion and race, Ms. A revealed that she would prefer to work with a therapist outside of her church to ensure confidentiality and protect herself from the anticipated disapproval of fellow church members. Although she was overtly opposed to mental health treatment, she admitted that she was scared that her daughter would die without it. She also increasingly felt a need to talk to someone who was both objective and caring. The clinician then offered a brief account of the kind of therapy Ms. A could expect, highlighting the importance of finding ways of helping her with her "stress" that would fit with her beliefs as well as the option of working to figure out how to approach her daughter's therapist directly about her concerns over her daughter's treatment. When asked what things might be like a few months down the road if the therapy was indeed helpful to her, Ms. A began to cry and spoke movingly of her dreams of her daughter and her once again happily participating in the life of her church.

At this point, the clinician shifted the focus again, to the question of what else, other than her mixed feelings about mental health treatment in general, might make it hard for Ms. A to come consistently for therapy. It became apparent that travel to the clinic was financially difficult for Ms. A, so they concluded that it would be important to coordinate Ms. A's sessions with Keisha's sessions. Ms. A then began to talk spontaneously about how it would be a relief to feel better and have an outside person with whom she could discuss the stress associated with her daughter's illness. When asked by the clinician if she would like to schedule a follow-up appointment, Ms. A agreed. The clinician expressed admiration for Ms. A's willingness to talk openly about the difficult feelings she'd been having and let her know that she expected that further treatment would give her some of the relief she hoped for. The clinician also reminded Ms. A that she would be in control of her treatment and that she should feel free to let her therapist know any time she felt that the therapy conflicted with her values. Ms. A ultimately completed a full course of brief psychotherapy for depression.

Case Example B

(*Note.* Identifying features have been altered to protect the confidentiality of patients.)

Ms. B is a Caucasian single mother of three children whose husband had committed suicide 2 years previously. At the time of her husband's suicide, Ms. B was pregnant with their third child. Ms. B came for treatment because she felt overwhelmed by the demands of being a single parent of three children, the eldest of whom was recently diagnosed with attention-deficit/hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD).

Although Ms. B initially presented her problem as feeling overwhelmed by the demands of being a single parent, as her story unfolded, she focused primarily on her relationship with her mother and sister. Ms. B responded to the therapist's open-ended query, "Tell me about what has been going on," by describing her family-of-origin's relationship with her deceased husband. She

explained that they had never approved of him because he was of a different ethnic background and worked as a shoe salesman, a job that the family considered menial. When he became depressed and eventually committed suicide, they used this as evidence of his inadequacies. Although it was not initially apparent to the therapist how this affected Ms. B's current circumstances, the therapist carefully communicated his understanding of the situation to Ms. B using reflective listening: "It sounds like you were torn between your husband and your own family. They were very critical of him, which put you in a very difficult position." Ms. B nodded emphatically and said, "I was in a difficult position then, but I am in an impossible position now!" She went on to explain that, since her husband's death, she had been increasingly dependent on both her mother and her sister for financial support and help with childcare. Although they helped her a great deal, they were also very critical. For instance, they implied that her husband was to blame for the fact that Ms. B's oldest child needed treatment for ADHD and ODD. They did not support her efforts to bring her son to mental health treatment, saying, "What's the use? He's just like his father." The therapist was then in a position to reflect that Ms. B felt very ambivalent about accepting their help because, on one hand, she was unable to survive without them but, on the other hand, felt belittled by their constant criticisms of her husband and children. Ms. B again nodded her head and elaborated slightly, "You're right. I can't make it without their help, but getting help from them comes with a heavy price." The therapist summarized the dilemma by saying, "So it's not only being a single parent that takes its toll on you, but being a single parent who is dependent on an emotionally unsupportive sister and mother makes it almost unbearable."

The therapist then asked Ms. B how this dilemma was affecting her. Ms. B described her deteriorating mood, sleep, appetite, energy, and concentration, which in turn allowed the therapist an opportunity to explore Ms. B's understanding of these symptoms. Ms. B was quick to point out that "if this is depression, it's not like my husband's depression." She clearly differentiated her experiences (fatigue, sadness, and loss of interest) from her husband's experiences (increased drinking and suicidal tendencies that ultimately led to suicide). Ms. B denied suicide plans, stating that she could never impose a second parental suicide on her children. This information was essential for the therapist, leading him (a) to reflect back to the patient a clear understanding of this important distinction and (b) to provide psychoeducation about how depression can manifest differently in different individuals and to clarify that the label of depression was not intended to imply that she would become like her husband. Ms. B was very relieved by this information.

The therapist inquired about prior episodes of depression, and Ms. B revealed that she had experienced similar symptoms after the births of all her children but that she had never received treatment. Ms. B admitted that she wished she had had help at that time but was so overwhelmed by the demands of childcare that she felt incapable of leaving the house for therapy. An exploration of potential barriers suggested that active opposition from her mother and sister (in the form of snide comments and refusal to babysit) and the demands of caring for three young children may have made it very difficult for her to attend regular sessions. In addition, Ms. B revealed that her sister had derided her wish to see a therapist, saying, "Therapy was real helpful for that idiot [Ms. B's

husband]. He saw a therapist and went out and killed himself." She admitted to agreeing partially with her sister's belief that therapy was not likely to be very helpful because it did not stop her husband from killing himself.

The therapist was quick to identify Ms. B's ambivalence about treatment: "Part of you would really like some help with this problem, while another part of you is concerned that this won't be helpful . . . or that you may even die like your husband did." Ms. B paused, acknowledged the ambivalence, but then said, "I thought that was the case when I came here, but now that I understand that my problem is not the same as my husband's, I feel more hopeful. I'm just worried that no one will watch the kids for me while I come here." The therapist responded both to Ms. B's increased hope and to her concerns about babysitting, saying,

You are feeling more hopeful now. It was a relief to learn that we understand that your depression is different from your husband's, and though you were skeptical when we started, you are beginning to believe that you could be helped. I'm glad, because I think your depression is very treatable, and I feel confident that we will be able to work out a way for you to be able to come here if we put our heads together.

Jointly, the patient and therapist then turned to practical matters, identifying alternate sources of childcare (a neighbor, her children's paternal aunt) and agreeing that it might make sense to conceal her treatment from her mother and sister for now. Because Ms. B's primary concern was finding ways to manage her sister's and mother's criticisms without losing their instrumental support, the therapist also suggested that this would be an excellent focus for psychotherapy.

Although the therapist probed for additional potential barriers—"Some mothers worry that child protective services will try to take their children away from them if they come in for treatment. Would this be a concern for you?" "Sometimes people feel that it is hard to be open with a therapist, especially if the therapist is of a different race or gender. Obviously I am a man. Would this be uncomfortable for you?"—no additional significant issues were uncovered. When asked about her hopes for treatment, Ms. B stated, "I want to feel better so I can be a better mom." When encouraged to describe additional hopes/wishes, Ms. B said that she hoped that she could find a place to talk about these issues without being criticized. The therapist offered encouragement by saying, "Many mothers find that therapy is a safe place to figure out some difficult problems and address feelings. I think that once your depression lifts, you will feel more like yourself, which in turn will help you feel more competent in your activities such as parenting." The therapist concluded by praising Ms. B's willingness to come in for an evaluation in spite of her family's objections and her own skepticism about the efficacy of mental health treatment. The therapist underscored Ms. B's apparent strength and resourcefulness in the face of very difficult circumstances. They agreed to set up a subsequent appointment, and the therapist encouraged Ms. B to call to reschedule if problems arose that were beyond her control.

Potential Applications of the Engagement Session

Although we do not have empirical data supporting additional applications of the engagement session, it is reasonable to assume that this approach may be useful in other populations with other

disorders. For instance, MI-based interventions have strong track records as preludes to treatment for substance abuse (Zweben & Zuckoff, 2002) and preliminary support as pretreatment interventions for patients with problems ranging from eating disorders (Feld, Woodside, Kaplan, Olmsted, & Carter, 2001) to diabetes (Smith, Heckemeyer, Kratt, & Mason, 1997), suggesting potential utility in depressed populations with these comorbidities. It may also have utility in other conditions, such as bipolar disorder, where medications are both central to illness management and associated with high rates of nonadherence.

Conclusion

In our experience, MI and EI strategies work well together to help therapists understand and address barriers to treatment seeking in depressed patients. The model we have developed can be administered as a single session in any office setting and is easily adapted to meet the needs of individuals from diverse socioeconomic, ethnic, and educational backgrounds. Anecdotally, patients find that the session clarifies their treatment goals and facilitates their participation in further psychotherapy. It instills hope in patients and provides therapists with tools to address the difficult issues of race, culture, stigma, and negative prior treatment experiences. One woman stated that it "jump started" her psychotherapy; most report feeling a tremendous amount of relief after the session. In other instances, the therapist can learn of potential "land mines" that might derail psychotherapy ahead of time (e.g., a mother believes that there is nothing wrong with her and that it is all her child's fault) and proceed accordingly. Therapists trained in this model are more comfortable identifying their patients' ambivalence in treatment seeking and may therefore be in a position to address these problems before they interfere with treatment participation.

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