Abating Ambivalence: Motivating Depressed Patients for Treatment

Dorothy E. Stubbe, M.D.

> The ultimate goal of health care—to have the most engaged patient you possibly can, to get the best possible outcome.
>
> Greg Burke, M.D. (1)

Major depressive disorder is common, affecting about 7% of the population at any given time, with an estimated lifetime prevalence of 16.2% (2, 3). Despite evidence for effective psychotherapeutic and pharmacotherapeutic treatments for depression, most depressed patients do not receive treatment of either sufficient duration or sufficient intensity to adequately treat the disorder (4, 5). Racial and ethnic minority groups are at especially high risk for nonutilization or underutilization of mental health services (6, 7). Even after adjustment for demographic characteristics and insurance status, underserved racial and ethnic minority groups have demonstrated poorer rates of treatment adherence and higher rates of dropout than matched non-Hispanic white peers (5, 7, 8).

Depressed patients struggle with a wide range of potential barriers to psychiatric treatment. The symptoms that are associated with depression—lack of motivation, low energy and fatigue, reduced problem-solving ability and concentration, and low self-esteem—all pose challenges to the initiation of treatment and optimal engagement in the therapeutic process (8, 9). Racial and ethnic minority groups may also underutilize mental health services because of historic failures on the part of mental health professionals to provide culturally sensitive therapy (10, 11). Language may also be a barrier. Sociodemographically challenged individuals may struggle with practical barriers to accessing treatment, such as transportation. Pragmatic, psychological, and cultural barriers may contribute to an individual's overall ambivalence about seeking and following through with treatment. (7–9)

Engaging Depressed Individuals: Principles of Ethnographic Interviewing (EI) and Motivational Interviewing (MI)

Swartz and colleagues (12) have recommended utilizing principles of EI (13) and MI (14) to engage patients at risk of poor treatment adherence. In EI sessions, an interviewer (clinician) seeks to understand the perspectives, experiences, and values of an individual from a different culture without bias (12). That is, ethnography is used to learn how individuals view and make meaning of their experiences. The ultimate goal of EI is for the clinician to encourage interviewees to tell their story and clarify experiences but also to uncover how the individual integrates these experiences to create a sense of meaning and coherence (12, 13). To conduct the ethnographic interview effectively, the clinician assumes the role of open, interested learner, relinquishing control to the patient and inviting him or her to be the expert teacher. This method may be particularly useful when the treating clinician differs from the patient in cultural and sociodemographic background and where implicit cultural bias may affect engagement. This approach seeks to make explicit those factors that may interfere with the clinician gaining a full understanding of goals and priorities of the patient (9, 12, 13).

MI is a patient-centered, directive, therapeutic method for enhancing intrinsic motivation for change by helping patients explore and resolve ambivalence (14). MI elicits the patient's own motivations for change. Although MI was originally developed as a brief intervention to address ambivalence for change in the treatment of substance use disorders, evidence is accumulating about the benefit of MI for engaging individuals who are in treatment for mood (14, 15) and other disorders. The mean effect size for MI has been found to be significantly larger for racial and ethnic minority patients than for white patients in treatment (16). Research is accumulating that MI may enhance depressed patients' engagement in treatment (9, 12, 15, 17).

Swartz, Grote, and colleagues (9, 12) have promoted the use of an "engagement session" to improve motivation for the treatment of mothers with depression. A key principle on which the engagement interview is based is the suspension of clinician biases and assumptions about what constitutes "healthy" or "adaptive" behavior. The clinician takes on the role of curious student, eliciting the woman's views about her depression experience and the problems that she is facing. At specific points during the interview, however, the clinician temporarily takes on an "informed" expert role

providing psychoeducation about depression and the various treatment options. The clinician, however, does not insist on her own perspective. She continually acknowledges and attempts to incorporate the woman's beliefs and experience of depression. In the initial engagement session, the clinician uses both MI and EI techniques to enhance their capacity to elicit a culturally sensitive dialogue about treatment seeking with individuals from diverse backgrounds. "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, to recognize how participation in appropriate treatment can facilitate her achievement of her own valued goals" (p. 433) (12).

Clinical Vignette

Ms. Adebayo entered the mental health clinic for her initial visit with a psychiatrist. She had been reluctant to keep the appointment, but her sister insisted. Her sister held the door open, as Ms. Adebayo warily stepped in. Although she was dressed in the colorful garb of her native Nigeria, her face was drawn, and her forehead showed lines of worry that made her look older than her 35 years. Her four children were at school, and Ms. Adebayo's depleted countenance was evidence of her earlier struggle to get them to the bus on time. Her eyes appeared dull and bordered by dark circles, a sign of one who is not sleeping well. Her red nail polish was chipping. The traditional elegant gele head wrap that had been hastily wrapped around her hair was slipping back on her head, allowing the wisps of hair in front to protrude out in an unruly fashion. Her appearance was a marked contrast to the impeccable style and grooming of her sister standing by her side. Dr. McCarthy knew that Ms. Adebayo's chief complaint was depression, but she was taken aback by how completely dejected Ms. Adebayo appeared.

"Hello, Ms. Adebayo," Dr. McCarthy said, with a welcoming smile. Ms. Adebayo did not look up but shuffled into the office on cue. She did not shake hands, and Dr. McCarthy was uncertain whether she had not seen her outstretched hand or had chosen not to shake it. Dr. McCarthy felt relieved that she had recently received training in the engagement interview using EI and MI techniques. She was certain that she would need all of the clinical tools at her disposal to engage Ms. Adebayo.

Once they were seated, Dr. McCarthy began. "I'm sure coming here must have been a big effort—but I'm glad you came. 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 want from treatment. Can you tell me what's been going on?"

Ms. Adebayo stared blankly at the ground for a long while before answering. "Yes, it was hard. It was my sister that made me come, really," she said, looking at Dr. McCarthy directly for the first time.

Dr. McCarthy held her gaze and noted, "The depression inventory you completed before coming in describes many symptoms that suggest that you are in pain. Can you tell me what you have been experiencing?"

After another long pause, Ms. Adebayo said, "I just don't have any energy and I can't fall asleep. My sister says that means I'm crazy. Do you think so?"

Dr. McCarthy thought for a moment. "I don't think of depression that way. But what does it mean to you when your sister thinks you are crazy?"

Ms. Adebayo went on to say that she has been in the United States for 8 years. In Nigeria, at least in her town, mental illness was not discussed much. When it was, it was in derogatory terms. Often, the person was homeless and on the streets. Ms. Adebayo said that she did not like to think that she has a mental illness. To her, that meant that she wouldn't be able to take care of her children and might end up homeless and alone.

"No wonder you didn't want to come here," Dr. McCarthy said empathically. "The thought of having a mental illness is frightening. I don't want to label your experience—I would just like to hear from your point of view what you are experiencing."

At that, Ms. Adebayo began to tell her story. She had come to the United States with her husband and a small child. Now, she had four children whom she loved dearly, but they were "wilder than kids in Nigeria." She was the homemaker, and she felt that her husband was critical of her because the children didn't behave properly and could be demanding. "You know—they want cell phones and PlayStation." Ms. Adebayo suspected that her husband was having an affair. She found herself feeling more and more hopeless and unappreciated. That's when her energy "left me" and "sleep wouldn't come," she noted. "Now my sister thinks I'm crazy, and probably worthless, too," Ms. Adebayo moaned, her tears starting to flow.

Dr. McCarthy passed the tissue box. She summarized, "This has been a hard time for you, and you are feeling hopeless and worry that your sister thinks you are crazy and your husband doesn't appreciate you. And you also came to the clinic to seek help, which took a lot of strength. You want to have a better life for you and your family, and having no energy and not sleeping well is getting in the way. But you have taken the first difficult step to feeling better by coming here. I'm glad you came today. Would you be willing to come back and discuss your goals for treatment and how we might work together to help you achieve them?"

After discussing safety issues, ensuring that there were no weapons in the home, and making a safety plan, it was agreed that it was safe for Ms. Adebayo to go home. She made a second appointment to come back in several days. As she left the office, a glint of hope entered Ms. Adebayo's eyes for the first time.

Tips for Addressing Ambivalence Toward Treatment

An individual with depression presents with self-deprecation; lack of motivation; and feelings of helplessness, hopelessness,

and social withdrawal—all potential obstacles to forming a beneficial therapeutic alliance. Barriers may be exacerbated by cultural, socioeconomic, and practical life considerations for individuals with limited resources (5, 7, 8).

Using methods of EI and MI for treatment engagement has demonstrated improved retention for individuals with depression. Grote et al. have advocated for an initial engagement interview, which sets the stage for clinician-patient collaboration in identifying and working toward the patient's goals (9, 12). "Motivational pharmacology" combines MI, standard pharmacotherapy, and attention to cultural concerns about antidepressants. With this approach, treatment retention in antidepressant therapy was significantly improved in a sample of Latino individuals with depression (18, 19).

Ambivalence toward treatment is a pervasive issue that can diminish adherence and worsen outcomes in multiple health, mental health, and addiction disorders. Methods that improve engagement and acknowledge patients as the drivers of their own recovery, such as MI, may serve as powerful tools to help patients remain motivated for, and engaged in, treatment. Enhancing patient control over goals and methods of treatment empowers more permanent life changes (11, 15).

Early engagement using an identified engagement interview may set the stage for improved adherence and better outcomes for depressed individuals of all cultural backgrounds. An engagement interview may be structured into five sections that may be delivered flexibly over the course of 45 to 60 minutes to meet the specific needs of the patient (9, 12). Begin the interview with a brief explanation of the reason for the engagement interview to set the stage for addressing patient goals. For example, "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. [. . .] How have you been feeling lately?" (9).

1. Eliciting the story. This section includes open-ended questions, expressions of empathy, and affirmation of strengths to elicit the patient's experience of symptoms in their sociocultural context. This includes stimulating a discussion of the patient's understanding of symptoms being experienced as well as chronicling psychosocial stressors that may exacerbate depression and interfere with treatment adherence.

2. Treatment history and hopes for treatment. This section of the interview seeks to understand prior psychiatric symptoms, coping mechanisms, and sources of support (family, friends, spirituality, treatment, etc.) and the patient's perceptions of the positive and negative aspects of these coping mechanisms. This section ends with the clinician inquiring directly about what the patient would want to be different at the end of treatment and what attributes the patient would want in a therapist. Racially or culturally related barriers to treatment may be elicited and explored.

3. Feedback and psychoeducation. The goals of this section are to give the patient feedback about depressive symptoms being experienced and psychoeducation about the nature of depression. This may be initiated by reviewing the patient's answers to a depression questionnaire. The use of the MI technique of elicit-provide-elicit (asking permission to give information, providing the information, and eliciting the patient's reaction once the information is given) may engage the patient. Psychoeducation is designed to help the patient understand his or her experience of depression from a biopsychosocial point of view and, thus, decrease stigma. In the case described in the Clinical Vignette, this may help address Ms. Adebayo's concern about being labeled "crazy."

4. Address barriers to treatment seeking. The goals of this section of the interview are to elicit or reiterate current barriers that may impede the patient from engaging in treatment and to address them through problem solving. These barriers may be practical, psychological, or cultural. This is a time to explore both sides of the patient's ambivalence, offering alternate perspectives and emphasizing the patient's personal choice and control over the treatment. This is also a time to address issues of safety and the limits of the patient's autonomy if there are active concerns about the patient's safety to self or others.

5. Eliciting commitment. The goal of this final section of the engagement interview is to shift from enhancing motivation to change through treatment to eliciting the patient's commitment (at least short-term) to treatment. The clinician summarizes the patient's story, addresses ambivalence about treatment directly, highlights strengths and attributes, outlines the next steps for treatment, and seeks to elicit commitment. Unless there are safety issues, the clinician acquiesces to the patient on the choice of ongoing treatment. The clinician clearly expresses a belief in, and hope for, the patient's engaging in a plan of action to become healthier, happier, and able to make progress toward the identified goals.

AUTHOR AND ARTICLE INFORMATION

Child Study Center, Yale University School of Medicine, New Haven, Connecticut. Send correspondence to Dr. Stubbe (dorothy.stubbe@yale.edu).

Dr. Stubbe reports no financial relationships with commercial interests.

Focus 2020; 18:197–200; doi: 10.1176/appi.focus.20200005

REFERENCES

1. Zimmerman B: Seven Quotes from Geisinger's Greg Burke on Engaging Patients and Improving Clinical Hospitality. Becker's Hospital Review, November 4th, 2016. https://www.beckershospitalreview.com/patient-engagement/7-quotes-from-geisinger-s-greg-burke-on-engaging-patients-and-improving-clinical-hospitality.html
2. Diagnostic and Statistical Manual of Mental Disorders, 5th ed. Arlington, VA, American Psychiatric Publishing, 2013
3. Kessler RC, Berglund P, Demler O, et al: The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). JAMA 2003; 289:3095–3105

4. Young AS, Klap R, Sherbourne CD, et al: The quality of care for depressive and anxiety disorders in the United States. Arch Gen Psychiatry 2001; 58:55–61
5. Warden D, Trivedi MH, Wisniewski SR, et al: Predictors of attrition during initial (citalopram) treatment for depression: a STAR*D report. Am J Psychiatry 2007; 164:1189–1197
6. Mental Health, Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2001
7. Miranda J, Azocar F, Organista KC, et al: Treatment of depression among impoverished primary care patients from ethnic minority groups. Psychiatr Serv 2003; 54:219–225
8. Schraufnagel TJ, Wagner AW, Miranda J, et al: Treating minority patients with depression and anxiety: what does the evidence tell us? Gen Hosp Psychiatry 2006; 28:27–36
9. Grote NK, Zuckoff A, Swartz H, et al: Engaging women who are depressed and economically disadvantaged in mental health treatment. Soc Work 2007; 52:295–308
10. Sue S: In defense of cultural competency in psychotherapy and treatment. Am Psychol 2003; 58:964–970
11. Aggarwal NK, Pieh MC, Dixon L, et al: Clinician descriptions of communication strategies to improve treatment engagement by racial/ethnic minorities in mental health services: A systematic review. Patient Educ Couns 2016; 99:198–209
12. Swartz HA, Zuckoff A, Grote NK, et al: Engaging depressed patients in psychotherapy: integrating techniques from motivational interviewing and ethnographic interviewing to improve treatment participation. Prof Psychol Res Pr 2007; 38:430–439
13. Schensul SL, Schensul JJ, LeCompte MD: Ethnographer's Toolkit, Vol. 2. Walnut Creek, CA, AltaMira Press, 1999
14. Miller WR, Rollnick S: Motivational Interviewing: Helping People Change, 3rd ed. New York, Guilford Press, 2012
15. Arkowitz H, Burke BL: Motivational interviewing as an integrative framework for the treatment of depression; in Applications of Motivational Interviewing. Motivational Interviewing in the Treatment of Psychological Programs. Edited by Arkowitz H, Westra HA, Miller WR, et al. New York, Guilford Press, 2008
16. Hettema J, Steele J, Miller WR: Motivational interviewing. Annu Rev Clin Psychol 2001; 69:502–510
17. Holt C, Milgrom J, Gemmill AW: Improving help-seeking for postnatal depression and anxiety: a cluster randomised controlled trial of motivational interviewing. Arch Women Ment Health 2017; 20:791–801
18. Lewis-Fernández R, Balán IC, Patel SR, et al: Impact of motivational pharmacotherapy on treatment retention among depressed Latinos. Psychiatry 2013; 76:210–222
19. Interian A, Martinez I, Rios LI, et al: Adaptation of a motivational interviewing intervention to improve antidepressant adherence among Latinos. Cultur Divers Ethnic Minor Psychol 2010; 16:215–225