UNC-CH School of Social Work
Clinical Lecture Series
presents

Engagement Interviewing:
Increasing Engagement and Retention of Clients in Mental Health Services

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Acknowledgements

- Zuckoff, A., Swartz, H.A., Grote, N.K., **Bledsoe, S.E.**, Spielvogle, H. (2004). *Engagement Session Treatment Manual.* Department of Psychiatry, University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic, Pittsburgh, PA.
- Holly Swartz, M.D.
  - presentation development

Background

Problem:

Mother with depression are difficult to engage and retain in treatment.

- Promoting Healthy Families Project (N. Grote, PI)
- IPT-B/IPT-MOMS (H.Swartz, PI)

- Combined techniques from:
  - Ethnographic Interviewing
  - Motivational Interviewing
  - Psychoeducation

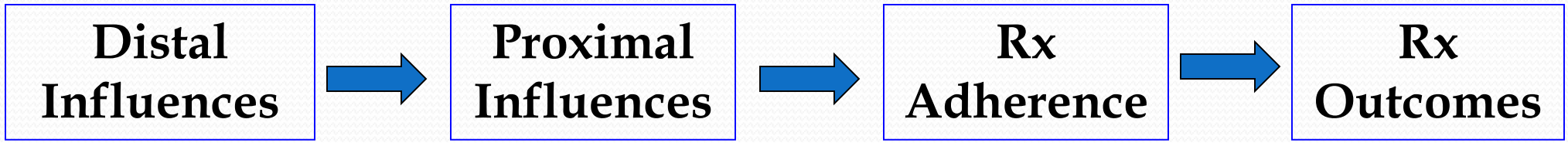
Why Would a Depressed Person Refuse Treatment for Depression?

- Their understanding of depression doesn't match their perception of themselves
- They've known someone else who was depressed, and aren't like that
- They were depressed before, and aren't like that now
- They'd feel guilty about being depressed
- They don't feel that "treatment" is the best way to handle how they are feeling

Why Would a Depressed Person Refuse Treatment for Depression? (cont.)

- They'd feel stigmatized or ashamed: being depressed would mean there's something wrong with them
- When they sought help for depression in the past, they didn't get helped
- They resent having their behavior labeled and pathologized
- They don't know/think they are depressed
- Other obligations make it hard to come

An Ecological Model of Barriers to Treatment Engagement and Retention



Barriers to Treatment Engagement /Retention

Community Barriers **violence, safety concerns, lack of support services, unemployment, poverty, lack of access to mental health services**	***Helping System Barriers*** **bias or cultural insensitivity in environment, procedures, providers; lack of evidence-based treatments; lack of diversity in clients & staff; provider overload and burn-out**
Social Network Barriers **negative attitudes toward treatment, social network strain**	***Client Barriers*** **practical - time, financial, transportation, child care** **psychological - stigma, low energy, race/ethnicity** **cultural – women's view of depression, multiple stressors/coping strategies**

Barriers to Care

- **Practical**
- **Psychological**
- **Cultural**

Practical Barriers to Care

- Costs
  - Lack of health insurance
  - Loss of pay for missing work
- Access
  - Inconvenient or inaccessible clinic locations
  - Limited clinic hours
  - Transportation problems
- Competing Obligations
  - Child/dependent care and social network
  - Unable to miss work
  - Time in dealing with chronic stressors

Psychological Barriers to Care

- It's stress, not depression
  - "I'm not like that!"
- Stigma
  - feeling labeled, ashamed, guilty
- Stigmatizing treatment settings
- Previous negative experiences with treatment or negative attitudes from family and friends
- Therapist characteristics
  - lack of caring, warmth
- Burden of depression

Cultural Barriers to Care: The Culture of Poverty

- **"No one can understand what my depression is like 'til they have walked in my shoes and had no money."**
- **"My therapist seemed overwhelmed by all my practical problems, so how could she help me?"**
- **"I don't see how just talking about something can change it. How is me talking about losing my job going to get me another job?"**

Cultural Barriers to Care: The Culture of Race

- "Sitting in front of a white therapist isn't necessarily like she thinks she is better than me, BUT there are some white people who think they can look down on you and show favoritism to people of their nature and culture and treat you any kind of way."

Cultural Barriers to Care: The Culture of Race

- The client may feel that a therapist of a different race/culture may not understand her life or know how to help.
- The client may feel that a therapist does not appreciate the personal resources that women of color with low incomes have relied on to cope with stress.
- Spirituality and religion are often important psychological coping mechanisms and sources of resilience in Latina and African American women. (Mays, Caldwell, & Jackson, 1996; Miranda et al., 1996)
- 'Treatment' may not be culturally acceptable or the traditional way problems related to depression are handled

Dimensions of Clinical Motivation

- Motivation for Change
- Motivation for Treatment

- 3 motivations for action:
  - this will be inherently rewarding
  - this will help me avoid negative external consequences or bring positive external consequences
  - I feel inspired by this person and want to act as s/he does and recommends

Stages of Change for Treatment Seeking

- **Precontemplation** – not important; not able
  I don't have a problem with depression. I'm just stressed. I can handle it.
  Treatment won't help – it made it worse in past. My life can't get better.
- **Contemplation** – maybe important, maybe able
  I might benefit from talking with someone. It may be too hard right now.
- **Preparation** – important, becoming able
  It's time for me to do something different. I can't live this way anymore.
- **Action** – important and able
  I'm taking care of me. Treatment can work for others like me.
- **Maintenance** – important and able
  I'm no longer depressed and I know how to keep it that way.

Motivation for Change

"Ready, Willing & Able"

- Willing
  - Importance of Change
    - Problem Recognition; Expectations of Change (Pros/Cons)
- Able
  - Confidence for Change
    - Global; Specific
- Ready
  - Relative Priority for Change; Intention

The Decisional Balance

- People tend to move towards health/well-being
- But the optimal choice may not be obvious
- So we face difficult life decisions
- We get stuck in ambivalence when
  - we can't decide what we want to do (conflicting options have advantages/disadvantages) and/or
  - we don't believe we can do what we want to do (succeed at accomplishing a desired choice)

Conceptual Justification of the need for MI (Miller & Rollnick)

Interpersonal Interactions

- When stuck in ambivalence, people often need help to move forward
- But pressure / persuasion / direction to move forward triggers resistance in the form of "reactance," or protection of freedom, which maintains the status quo
- Motivation for change is a fluctuating state … influenced by interpersonal interactions
- Constructive conversations about change involve understanding and resolution of ambivalence

Conceptual Justification of the need for MI (Miller & Rollnick)

Development of an Engagement Strategy

- Deal with barriers to care and ambivalence about depression and treatment
- Conduct individualized, therapeutic, psychosocial intervention before treatment starts
- Integration of three theoretical approaches
  - Ethnographic interviewing
  - Motivational interviewing
  - Psychoeducation

Motivational Interviewing (MI)

- Client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence (Miller & Rollnick, 2002)
- Clinical Adaptations
  - Check-up (Assessment + MI Feedback Session)
  - Motivational Enhancement Therapy
    - Check-up, Change Plan, Follow-up
  - Behavior Change Counseling (Brief Negotiation)
    - Medical settings / Non-specialist interventions

Ethnographic Interviewing (EI)

- 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)
- Anthropological Uses
  - Foreign cultures
  - Sub-cultures

Engagement Strategy

"By understanding patients' individual and culturally-embedded needs and perspectives, and by communicating this understanding to them, a clinician can increase the likelihood that patients will accept the information and treatment recommendations they are offered—especially if the clinician is able to align potential treatment benefits with priorities expressed by or elicited from the patient"

-Zuckoff et al., 2004

Enhancing Treatment Acceptance

- Goals
  - Resolve ambivalence about treatment
  - Encourage patient to return for the next session
- Spirit of EI
- Principles, strategies of MI
- Decision to seek/accept referral for treatment
  - Past treatment experiences
  - Wishes for current treatment
  - Hopes for future
- Exploration of barriers to treatment

Principles of Motivational Interviewing (MI)

- Express Empathy
- Develop Discrepancy
- Roll with Resistance
- Support Self-efficacy

Express Empathy

- Accurate understanding of clients' experience, communicated in warm, nonjudgmental manner
- Therapist's Task: Listen reflectively
- Key Points
  - Ambivalence is normal—explore & understand it
  - Acceptance facilitates change, while pressure to change elicits resistance

Roll with Resistance

- Dissonance between therapist and client
- Therapist's Tasks
  - Avoid provoking resistance
  - When resistance emerges, reduce it
- Key Points
  - Avoid arguing for change or defending a position
  - Challenging resistance increases reactance
  - Resistance is a signal to respond differently
  - Invite new perspectives; do not impose them

Develop Discrepancy

- Perceived distance between present behavior and important goals or values
- Therapist's Task
  - Evoke awareness of gap between where clients are and where they want to be (goals), and/or who clients are and who they want to be (values)
- Key Points
  - We learn what we think as we hear ourselves speak, so clients should argue for change
  - Awareness of behavior's consequences is crucial
  - Objective information is valuable feedback

Support Self-Efficacy

- Belief in the ability to succeed
- Therapist's Task
  - Evoke clients' belief in their ability to change
- Key Points
  - Problem Recognition + Low S-E = Denial/Despair
  - Hope is found in the range of effective alternatives
  - Therapists' beliefs about clients' ability to change become self-fulfilling prophecies
  - Clients are a primary resource for solutions

Change Talk (DARN-CT)

Desire	*I want to change / get treatment*
Ability	*I can change / get treatment*
Reasons	*It would be good to change / get treatment because…*
Need	*I must change / get treatment*
Commitment	*I won't → I might → I will change / get treatment*
Taking Steps	*I've begun to change / seek treatment*

Engagement Session Components

- Eliciting “The Story”
- Exploring Past Efforts at Coping and Attitudes Toward Treatment
- Feedback and Psychoeducation
- Barriers to Treatment Seeking
- Eliciting Commitment

Principles of Engagement

Based on EI and MI and on our work with clients who are reluctant to seek treatment:

1) **Goal = understand perspectives and values without bias – listen without agenda (avoid arguing)**
2) **Interviewer adopts "one-down" position as learner**
3) **Interviewee feels safe to tell story (what's bothering him/her) without fear of judgment**
4) **Emphasize client's strengths and coping capacities (e.g., spirituality, importance of family)**

Principles of Engagement (cont.)

5) Ask permission before giving information to client (about diagnosis and its treatment)
6) Provide psychoeducation about diagnosis and effective treatments – elicit client's reaction
7) Identifying pros and cons about getting treatment – ambivalence (pull for the negatives – what else?)
8) Expressing empathy, especially for the reasons AGAINST seeking treatment (as well as reasons for seeking treatment)

Principles of Engagement (cont.)

9) Fostering personal choice and control -- "It's up to you!" "What do you want to do?"

10) Problem solving the barriers (practical, psychological, cultural) "How can you make time to take care of you?"

11) **If client commits, collaborate to make connection with mental health services**

12) **Offer hope – "I think you bring a lot of strengths to treatment (name them)"; "I've seen treatment help others similar to you"**

(Swartz, Zuckoff, Grote, et al 2007)

Engagement Session: What it is & is not

- Engagement Session is not a treatment.
- It is designed to be used with a referral to treatment, and before treatment begins.
- It is not the same as a psychosocial assessment; ideally it comes BEFORE psychosocial assessment.
- It is not intended for use in crisis (suicidal, homicidal or severely stressed)
- Portions of the ES can be used to fit in with an agency's intake and assessment procedures

Key Strategies and Techniques

- Suspension of clinician biases and assumptions
- Open-ended questions
- Expression of empathy via reflective listening
- Affirmation
- Summarizing
- Working with resistance talk
- Working with change and adherence talk
- Supporting self-efficacy
- Working with race and culture

Engagement Session Component 1: The Story (20-25 minutes)

- Introduce session
- **"During this time I would like to get to know you better – how you see your depression (or stress) and how you see treatment for depression and what you would want out of treatment."**
- **"How have you been feeling lately and what do you think has been contributing to your mood?"**

Engagement Session Component 1:

The Story (20-25 minutes) cont.

- **The Story**

  A. Mood – understanding of depressive symptoms and how they interfere with client's life; what is contributing

  B. Context: social context of the depression: acute stressors (pregnancy, birth) and chronic stressors (e.g., poverty)

  C. Summary: empathically summarize client's story; highlight concerns and wishes; identify and affirm strengths

Skills Needed for Component 1 - "OARS"

- **O**pen-ended Questions
  - Answered with a wide range of responses
  - Invites client perspective or self-exploration
- **A**ffirmation
  - Expresses appreciation, provides support
- **R**eflection
  - Statements that check and/or extend understanding
- **S**ummarizing
  - Collects, links, facilitates transitions

Listening Empathically

- Making a statement that…
  - Checks understandings
  - Tests hypotheses
  - Continues the paragraph
- Types of Reflection
  - Simple (Repetition, Rephrasing)
  - Complex (Implicit meaning or feeling)

Engagement Session Component 2: Treatment History & Hopes for Treatment (10-15 minutes)

- Depression history: ask about previous depressions; past or current efforts to cope, especially spirituality; identify and affirm strengths – empathically summarize
- Treatment history: ask about client's or family's experiences with or ideas about treatment; get positive and negative; ask about experiences with social agencies/health care providers
- Treatment hopes/expectations:
  1) "What would you like to be doing if treatment worked?"
  2) "What do you want/not want in treatment or in a therapist?"
- Empathically summarize the pros and cons of treatment, capturing the client's ambivalence

Skills Needed for Component 2

- Reinforcing self-efficacy, identifying and affirming strengths
- Double-sided reflection

Engagement Session Component 3: Feedback and Psychoeducation (15 minutes)

- **Feedback**

  A. Elicit – "Would it be OK if I shared some of the results from the questionnaire you filled out?"

  B. Provide – symptom severity and/or probable diagnosis

  C. Elicit – "What do you make of this?" "How does this sound?"

- **Psychoeducation**

  A. Elicit – "What is your view of depression?" "Would it be OK if I gave you some information about depression and treatment options?"

  B. Provide – see points on next page

  C. Elicit – "After each point under provide, ask how does this sound to you?" 'Does this make sense?"

Skills Needed for Component 3

- Giving feedback
- Providing accurate information about depression and treatment options
- Elicit – Provide - Elicit
- Exercise

Giving Feedback

- Offer information objectively
  - Avoid scare tactics, veiled threats, etc.
- Use everyday language
  - Avoid jargon
  - Explain technical terms
- Give examples and explanations
  - Be concrete and specific

Giving Feedback

- Prepare to "agree to disagree"
  - Respond skillfully to resistance
- Recognize the limits of assessment instruments
  - Not the "whole truth," but one (useful) perspective
- Highlight exceptions to support self-efficacy
  - Be open to the "when-nots"
- Take a collaborative approach
  - Team up to understand problems and solutions

The Nature of Depression

- Depression is a medical illness, like asthma or pneumonia.
- Depression has a physical component, a feeling component, and a behavior or acting component.
- It runs in families – genetic component.
- Too much stress can lead to depression, especially with genetic component.

ELICIT – **"What do you think about this?"**

The Nature of Depression

- Problems in life can lead to depression and depression can make solving problems more difficult.
- It makes relationships, parenting, and working more difficult.
- It makes going for treatment more difficult.
- It often occurs with anxiety, trauma symptoms, alcohol/drug problems.

ELICIT – "What do you think about this?"

The Nature of Depression

<u>Most importantly</u>,

- Depression is NOT the depressed person's fault.
- Depression can be successfully treated. There are effective depression treatments that take about 6-8 weeks to work– talk therapy and/or newer medications that have fewer side effects.
- When depression is relieved, the person can more effectively manage his or her life (like solving problems, parenting, relating to others, working).

ELICIT – **"How does this sound to you?"**

Engagement Session Component 4: Problem-solving Barriers to Care (15-20 min)

- **Practical – "What might make it hard for you to come even if you wanted to?" Transportation? Childcare? Scheduling? Finances?**
- **Psychological–"Beyond these concerns, what else might keep you from coming?" Keep asking, "what else"?**

  1) Negative attitudes about treatment?

  2) The burden of depressive symptoms?

  3) Guilt about taking time for self?

  4) Concerns that child protective services might become involved?

  5) Doubts about whether treatment will help?

Engagement Session Component 4: Problem-solving Barriers to Care (15-20 min)

- Cultural – "If I could wave a magic wand and do away with the practical and other barriers we discussed, what else might keep you from coming?"

  1) Perceived stigma from family and friends?

  2) Preferred community approaches for treatment (e.g., church)?

  **3) Therapist differences in race, class, gender? (therapist would judge, not understand, act disrespectful, not care, or does not know how to cope with client's problems – has no experience)

Skills Needed for Component 4

- Dealing with resistance, including pseudo-compliance
- Decisional balance exercise
- Problem-solving exercises with “elicit-provide-elicit”
- Addressing issues of race/ethnicity, nationality, culture

Resistance Behaviors

- **Arguing**
  - Challenging
  - Discounting
  - Hostility
- **Interrupting**
  - Talking Over
  - Cutting Off
- **Ignoring**
  - Inattention
  - Nonanswer
  - No Response
  - Sidetracking
- **Negating**
  - Denying
  - Blaming
  - Disagreeing
  - Excusing
  - Claiming Impunity
  - Minimizing
  - Pessimism
  - Reluctance
  - Unwillingness To Change

Pseudo-Compliance

- Deceptive
  - "Smooth" session tone
  - Blanket agreement
  - Passivity
  - Absence of action or active participation
- Subversive
  - Power differential: direct resistance is dangerous
  - Undermines authority and preserves autonomy
  - Avoids punitive reaction

Resistance Strategies

- Simple or Complex Reflection
- Double-sided Reflection
- Amplified Reflection
- Shifting Focus
- Emphasizing Personal Choice and Control
- Reframing

Problem-Solving
Elicit / Provide / Elicit

- Elicit Client's Ideas and Experience
  - Clarify existing knowledge
  - Explore viability of options
- Provide Advice
  - Ask permission
  - Qualify suggestions
  - Offer alternatives
- Elicit Client's Reactions
  - Revise Accordingly

Engagement Session Component 5: Elicit Commitment (5 min)

- **Grand Summary: summarize story, ambivalence, barriers and solutions; highlight change talk – "I can't take this anymore."**
- **Change Plan: outline next steps, e.g., scheduling an appointment, number of sessions**
- **Elicit Commitment: "What would you like to do?"**
- **Leave Door Open: "It's fine if you want to think about it, you can give me a call."**
- **Instill Hope: Affirm client's participation in the session and the strengths client brings to treatment; express optimism about treatment – "I think 8 sessions of this treatment might help you feel better."**

Skills Needed for Component 5

- Highlighting change/commitment talk
- Emphasizing personal choice and control
- Leaving the door open
- Cultivating community resources and relationships

Written Personal Summary

- For the client to take to first treatment session
- Completed either by the client or the engagement interviewer
- Components:
  - What I want
  - What I don't want
  - The steps I'm going to take are (when)
  - Things that might get in my way
  - What I will do about these obstacles

Additional Resources

- Grote, N.K., Zuckoff, A., Swartz, H.A., **Bledsoe, S.E.**, & Geibel, S.L. (2007). Engaging women who are depressed and economically disadvantaged in mental health treatment. *Social Work*, 52, 295-308.
- Swartz, H.A., Zuckoff, A., Grote, N.K., Spielvogle, H., **Bledsoe, S.E.**, Shear, M.K., & Frank, E. (2007). Engaging depressed patients in psychotherapy: integrating techniques from motivational interviewing and ethnographic interviewing to improve treatment participation. *Professional Psychology*, 38, 430-439.

Thank You!