Engaging Women Who Are Depressed and Economically Disadvantaged in Mental Health Treatment

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Abstract

Women disadvantaged by poverty, as well as racial or ethnic minority status, are more likely to experience depression than the rest of the U.S. population. At the same time, they are less likely to seek or remain in treatment for depression in traditional mental health settings. This article explores a therapeutic, psychosocial engagement strategy developed to address the barriers to treatment engagement and the application of this strategy to a special population—women of color and white women who are depressed and living on low incomes. The conceptual foundations of this intervention—ethnographic and motivational interviewing—as well as its key techniques and structure are reviewed. Finally, a case example description and promising pilot data demonstrate the usefulness of this strategy.

Keywords

depression; ethnographic interviewing; motivational interviewing; poverty; racial minority; treatment engagement

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Converging evidence suggests that women disadvantaged by poverty or racial and ethnic minority status are more likely to experience depression than the rest of the U.S. population (Bruce, Takeuchi, & Leaf, 1991;Kessler, 2003; Kessler & Neighbors, 1986) .At the same time, they are less likely to seek or remain in treatment for depression in traditional mental health settings. What might account for this problem, and what can mental health clinicians do about it? Here we briefly describe the problem and then discuss the practical, psychological, and cultural barriers to seeking and remaining in mental health care for women of color and white women who are depressed and economically disadvantaged. Also presented is a description of the engagement interview—not a therapy, per se, but a brief, therapeutic strategy designed to be implemented **before** treatment to address and resolve barriers to treatment seeking.

DEPRESSION AND LACK OF TREATMENT ENGAGEMENT AMONG ECONOMICALLY DISADVANTAGED WOMEN

Individuals living on low incomes have higher prevalence rates of mental health problems than the general population (U.S. Department of Health and Human Services [HHS], 1999;Williams & Collins, 1995). Longitudinal data, for example, have indicated that poor individuals have twice the risk of major depression, controlling for age, race, socioeconomic status, and history of psychiatric episodes (Bruce et al., 1991). Moreover, being a woman with low socioeconomic status is associated with increased risk of depression. Depression is the leading cause of disability among women in the world today (Murray & Lopez, 1996), with women having twice the risk of depression as men (Kessler, 2003).

For women disadvantaged by poverty and racial or minority status, however, findings are even more disturbing. Nearly one-fourth of African American and Latina women live in poverty, and more than 33 percent of women who head their own household are poor (U.S. Census Bureau, 2004).Women of color and white women who live at or near the poverty line experience at least twice die rate of depression as do women at the middle income level (Hobfall, Ritter, Lavin, Hulszier, & Cameron, 1995). More specifically, high levels of depressive symptoms are common in young minority women who are economically disadvantaged and in mothers with young children who are living on welfare or low incomes, with 25 percent meeting the criteria for major depression (Miranda, Chung, et al., 2003; Siefert, Bowman, Heflin, Danziger, & Williams, 2000). Indeed, epidemiologic studies have documented a peak in first onsets of depression for women in their childbearing and childrearing years (Kessler et al., 1994), which confers a profound mental health risk on child mental health and functioning (Field, 2000).

Despite this increased risk and prevalence of mental health disorders among disadvantaged individuals, many either do not seek mental health services or drop out after an initial visit or after their distress is alleviated (Greeno, Anderson, Shear, & Mike, 1999; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). One study of 1,636 patients with depressive and anxiety disorders observed that over a one-year period, only 25 percent of patients with depressive disorders received appropriate treatment (either pharmacotherapy or psychotherapy). African Americans were less likely to receive appropriate treatment, and among those entering psychotherapy, only half attended at least four sessions (Young, Klap, Sherbourne, & Wells, 2001). In a 2001 supplement to his mental health report (HHS, 1999), the Surgeon General indicated that racial and ethnic minorities, compared with whites, were less likely to receive mental health care, and when they did receive care, it was more likely to be poor in quality. Similarly, in a recent National Comorbidity Survey replication. Wang and associates (2005) found that most people with mental disorders, especially racial and ethnic minorities and those with low incomes, remained either untreated or did not receive minimally adequate treatment.

More specifically, we know that women who are depressed and economically disadvantaged rarely seek or receive treatment in mental health settings (Miranda, Azocar, Komaromy, & Golding, 1998; Siefert et al., 2000), particularly minority women (HHS, 2001), despite the availability of specific and effective treatments. This service underutilization by the most vulnerable women is of great concern because the course of depression becomes recurrent in 50 percent to 70 percent of new cases, the risk of recurrence rises with each successive episode, and the severity of subsequent episodes tends to increase (Kupfer, 1991).Thus, failure to engage and retain women who are economically disadvantaged in potentially beneficial and efficacious mental health services constitutes a significant public health problem. What are some of the factors that account for this failure?.

PRACTICAL BARRIERS TO CARE

Epidemiologic and qualitative research studies (Armstrong, Ishike, Heiman, Mundt, & Womack, 1984; Maynard, Ehreth, Cox, Peterson, & McGann, 1997) have identified cost, not being insured, limited time and competing priorities, loss of pay from missing work, inconvenient or inaccessible clinic locations, limited clinic hours, transportation problems, and child care difficulties as practical barriers to service use by people living on low incomes. Many individuals with low incomes experience so many economic and practical difficulties that seeking treatment may be seen as just one more burden (Hall, 2001).Thus, an engagement strategy for women of color and white women who are depressed and economically disadvantaged will need to include problem solving to address practical barriers to care.

PSYCHOLOGICAL BARRIERS TO CARE

Perceived stigma about depression may pose another significant psychological barrier that prevents white and minority women who are depressed and living on low incomes from seeking or staying in mental health care. Stigmas about mental illness are widely endorsed by the general public. People with depression or mental illness have been portrayed as incompetent, crazy, or violent, but nonetheless in control of and responsible for causing their condition (Corrigan et al., 2000). Individuals with depression may internalize these attitudes and avoid seeking treatment or discontinue treatment prematurely. Sirey and colleagues (1999) found that perceived stigma toward individuals with mental illness was significantly associated with treatment discontinuation in elderly patients with depression. In a study of perceived stigma and barriers to seeking mental health treatment in women who were depressed, economically disadvantaged, and attending a public care obstetrics and gynecology clinic, 51 percent of these women reported worrying about what their family or friends would think about their depression, 40 percent said they were embarrassed to discuss their depression with anyone, and 26 percent didn't think they could be helped by mental health care (Scholle, Hasket, Hanusa, Pincus, & Kupfer, 2003). Because women with depression may have two or three stigmatizing conditions, they may be even more likely to avoid treatment. Thus, an engagement strategy for women of color and white women who are depressed and economically disadvantaged will address stigma and provide adequate information about the causes and treatability of depression—that depression is not the woman's fault and that a variety treatments are effective in alleviating depression.

Individuals with depression suffer from low energy and fatigue, reduced problem-solving ability and concentration, and low self-esteem, symptoms that interfere with treatment seeking. Research suggests that when women who are depressed report past physical or sexual abuse, they may be even less motivated to engage in treatment. Recent evidence obtained in public primary care clinics (Miranda et al, 1998; Scholle et al., 2003) suggests that women living in poverty (about 20 percent of whom have major depression) report high levels of sexual or physical abuse in both childhood and adulthood. Moreover, interpersonal trauma during childhood was associated with an avoidant attachment style in relationships (Mickelson, Kessler, & Shaver, 1997), a style characterized by strong self-reliance and mistrust of depending on others. Although a helpful strategy for dealing with adversity, strong self-reliance has been linked with difficulties in engagement, collaboration, and adherence in psychotherapy (Tyrell, Dozier, Teague, & Fallot, 2001) and in health care regimens (Ciechanowski, Katon, Russo, & Walker, 2001). Thus, an engagement strategy for women of color and white women who are depressed and economically disadvantaged and report physical or sexual abuse will recognize and accommodate an interpersonal style of strong self-reliance.

CULTURAL BARRIERS TO CARE

As Belle (1990) suggested, women living in poverty are exposed to more chronic stressors than the general population, but have fewer familial, social, and community resources to manage them. They experience more frequent, more threatening, and more uncontrollable life events, including community crime and violence, substance abuse and addiction in their families and neighborhoods, discrimination, unstable employment, crowded living arrangements, physical health problems, and imprisonment or unavailability of their partners or husbands. Moreover, their social networks can serve as conduits of stress, just as well as they can serve as sources of support (Riley & Eckenrode, 1986). Thus, an engagement strategy for women of color and white women who are depressed and economically disadvantaged requires a scope broad enough to conceptualize depression in these women as critically linked with multiple social problems and chronic stress.

Furthermore, cultural insensitivity or ignorance on the part of mental health clinicians presents a significant barrier to treatment engagement and retention in women of color living on low incomes (Miranda, Azocar, Organista, Muñoz, & Lieberman, 1996). Clinicians may lack proficiency in recognizing the cultural context of a woman's depression and in understanding her culturally endorsed symptoms of distress (including somatic complaints) and explanations for depression (Brown, Abe-Kim, & Bario, 2003). They may fail to operate from a "strengths perspective" (Saleebey, 1997), seeing only their clients' deficits and not appreciating their personal resources and the adaptive ways they have coped. For example, spirituality and religion are often important psychological coping mechanisms in Latina (Miranda et al., 1996) and African American women (Mays, Caldwell, & Jackson, 1996) and constitute vital sources of resilience (Banerjee & Pyles, 2004). Thus, an engagement strategy for women of color and white women who are depressed and economically disadvantaged will consider clients' understanding of and explanation for their depression, as well as the personal and cultural resources they have relied on for coping.

EARLIER ENGAGEMENT PRACTICES

Despite the practical, psychological, and cultural barriers to accessing mental health services, some racial minority clients on low incomes can be engaged in treatment if their unique needs and issues are addressed by service providers (McKay & Bannon, 2004). McKay and colleagues (McKay, McCadam, & Gonzales, 1996; McKay et al., 2004) developed a pre-therapy telephone-engagement intervention and a combined-engagement intervention (telephone interview and first treatment interview) to address these barriers to care in mostly African American youths and their families, and increased attendance at a first mental health intake appointment. Other studies demonstrated improved retention for Latina women in primary care and community clinics by reducing practical barriers and by adapting cognitive—behavioral therapy to fit their clients' culture, including adding a case management component (Azocar, Miranda, & Dwyer, 1996; Miranda et al., 1996) and an optional psychoeducation session before treatment (Miranda, Chung, et al., 2003).

The psychoeducational approach with multifamily groups (Anderson, Reiss, & Hogarty, 1986) offers another effective strategy to increase treatment engagement and adherence in African American and white individuals disadvantaged by poverty. Originally developed for families of patients with schizophrenia, it has since been applied to the treatment of many psychiatric and medical illnesses with considerable success (Miklowitz & Hooley, 1998; Pollio, North, & Osborne, 2002; Simms & Kazak, 1998). It offers information and advice about a disorder only after a genuine collaborative relationship has begun with patients and their families and after demonstrating an understanding and appreciation of their stressful experiences and problem-solving efforts. In eight years of research using psychoeducation

as part of psychological and medical treatments for patients with schizophrenia, Anderson and colleagues found that no family who received psychoeducation dropped out of treatment. Psychoeducation, in effect, may be useful in bridging the gap between the different perspectives of clients with depression and their mental health providers by providing accurate information about depression.

Considering the contributions of the aforementioned engagement practices and drawing from recent research on ethnographic interviewing (Schensul, Schensul, & LeCompte, 1999) and motivational interviewing (Miller & Rollnick, 2002), we developed and pilot tested an engagement interview for engaging individuals with depression in treatment. We developed this engagement strategy to address some of the practical, psychological, and cultural barriers to care faced by women of color and white women who are depressed and living on low incomes. Our engagement strategy shares some similarity with McKay and associates' (1996, 2004) engagement intervention for engaging youths and their families in mental health care—namely, a focus on identifying and problem solving practical barriers (that is, transportation, child care); psychological barriers (that is, attitudes about and earlier experiences with mental health care); and cultural barriers (that is, issues related to race or ethnicity and poverty) that serve as barriers to treatment engagement. Our engagement strategy also contains several novel components that have not been evaluated in the context of engaging in treatment women of color and white women who are depressed and economically disadvantaged. For example, the engagement interview includes using principles of ethnographic interviewing (EI) and motivational interviewing (MI) **in combination** to elicit and resolve the woman's ambivalence about coming for treatment; seeking to understand the woman's cultural view of her depression and the acute and chronic stressors linked to it; uncovering and highlighting the woman's strengths and previous coping mechanisms in dealing with adversity, including spirituality and prayer; and integrating psychoeducation about depression and its treatment into the engagement strategy, rather than keeping it as a separate session, to address the woman's perceived stigma and other concerns associated with depression and mental health care.

THE ENGAGEMENT INTERVIEW: CONCEPTUAL FOUNDATIONS

In the design of the engagement strategy, we were guided primarily by principles of EI and MI (Miller & Rollnick, 2002). During EI sessions, an interviewer seeks to understand the perspectives, experiences, and values of an individual from a different culture without bias (Schensul et al., 1999). That is, ethnography is used to learn how individuals from a particular culture see, understand, and organize their experiences. Ethnography assumes that dimensions of meaning in cultural experience can be discovered explicitly through the study of the language, despite the fact that some cultural knowledge is tacit or hidden from view (Spradley, 1979). The ultimate goal of EI is for the interviewee to provide a vivid description of his or her life experiences. To achieve this goal, the interviewer must ask the right kinds of questions in the right way. Different types of open-ended ethnographic questions and probes, therefore, are designed not only to encourage the interviewee to tell his or her story and clarify his or her experiences, but also to uncover how the interviewee integrates these experiences to create a sense of meaning and coherence. To conduct the ethnographic interview effectively, the interviewer assumes the role of friendly, interested learner, relinquishing control to the interviewee and inviting the interviewee to be the expert or teacher.

Because many women who are depressed and disadvantaged by poverty or minority status may differ from their treating clinician in cultural background and chronically stressful life circumstances, we thought it important to specifically address potential sources of cultural bias in our engagement intervention. EI provides a rationale and a culturally relevant method

for exploring, in a nonjudgmental manner, the experiences and values of our clients. Moreover, EI facilitates empowerment of these women by encouraging them to be the expert on their own depression experiences, to identify culturally relevant supports, and to express what they might want from treatment. Finally, we thought that acquiring increased understanding of the needs, preferences, and worldview of these women would enable us to engage and collaborate with them in treatment to set meaningful and realistic treatment goals.

A considerable body of evidence supports the use of EI in understanding the worldviews and concerns of diverse populations, including recent ethnographic research with adolescent mothers surviving partner violence (Kulkami, 2006), women who have experienced trauma (Stenius & Veysey, 2005), African American women with epilepsy (Paschal, Ablah, Wetta-Hall, Molgaard, & Liow, 2005), and individuals in a multiethnic labor union (Foerster, 2004). More relevant to the question at hand are preliminary data suggesting that EI, as an engagement strategy, has been successful in engaging women of color and white women who were depressed and on low incomes in mental health treatment (Grote, Bledsoe, Swartz, & Frank, 2004). What is missing from an EI approach, however, is a specific focus on the issue of ambivalence (in this case, about whether to seek treatment), which is at the core of motivational interviewing.

MI is a client-centered, directive, therapeutic method for enhancing intrinsic motivation for change by helping clients explore and resolve ambivalence (Miller & Rollnick, 2002). An evolution of Rogers's person-centered counseling approach (Rogers, 1967), MI elicits the client's own motivations for change. Because we expected that women who are depressed and economically disadvantaged would be ambivalent about coming for treatment for a variety of reasons, as we outlined in the discussion of barriers earlier, we saw MI as a potentially valuable element of our engagement strategy.

MI was originally developed as a brief intervention to address ambivalence about changing specific problematic behaviors involved in substance use disorders. It has since accumulated many successful empirical trials targeting those problems (for example, Connors, Walitzer, & Dermen, 2002; Project MATCH Research Group, 1998). Subsequently, MI has been applied to health promotion changes in diet and exercise in African American churches (Resnicow et al., 2001) and adherence to psychotropic medication (Kemp, Kirov, Everitt, Hayward, & David, 1998). More recently, investigators have begun to explore its potential uses for engaging individuals with mood disorders in cognitive—behavioral treatment (Arkowitz & Westra, 2004; Simon, Ludman, Tutty, Operskalski, &Von Korff, 2004) and engaging parents in treatment for child behavior problems (Nock & Kazdin, 2005). The rapidly growing evidence base for MI is summarized in a recent meta-analysis of 72 controlled clinical trials, spanning a range of target problems, including drug and alcohol abuse, smoking, HIV risk, and public health (Hettema, Steele, & Miller, 2005). Results showed that the mean effect size for MI was significantly larger for racial and ethnic minority samples than for white samples.

There is a good deal of overlap between EI and MI 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. MI and EI differ in how each conceptualizes the most likely sources of interference with the interviewer's intention to understand the interviewee, as well as in the ultimate goals of interviewers in each approach. These differences derive from the differing traditions from which each springs: a cultural anthropological and a therapeutic tradition, respectively.

EI emphasizes the potential for interviewers' culturally specific values and perspectives to interfere with their ability to grasp interviewees' culturally specific values and ways of understanding the world. The work of EI is to understand the interviewee's culture and way of life from the interviewee's point of view, thereby suspending expectations derived from the therapist's own cultural norms. MI emphasizes the potential for interviewers' own goals, preferences, values, and ideas about what is "healthy" or "adaptive" to interfere with their ability or willingness to understand interviewees' goals, preferences, values, and ideas about what is good for them or in their own interest. Although the therapist may enter the encounter with ideas about what behavioral changes would be in the client's best interest, the therapist's aspirations for the client must in principle intertwine with and support, rather than supplant, the client's aspirations. Indeed, Miller and Rollnick (2002) have characterized the "spirit" of MI as emphasizing autonomy, collaboration, and evocation, in which the interviewer recognizes the importance of supporting clients' choice of their own directions according to the guidance of personally meaningful values and goals.

In the context of our engagement intervention, then, EI and MI can be seen as complementary. Each approach draws attention to a different source of potential interviewer bias, but both aim for the same goal: to enable the interviewer to understand and support the interviewee's goals, values, and world as she experiences it. This leads to the second key difference: EI seeks solely to understand the worldview and culture of the interviewee; MI seeks to influence the interviewee by highlighting the discrepancies between her current behavior and her own goals and values. To the extent that EI alone could function as an engagement strategy, it would rely on the connection created between interviewer and interviewee as the mechanism of action. MI, in contrast, explicitly builds on that connection to enhance the interviewee's motivation to engage in treatment.

Because EI does not represent any particular theory and uses an inductive approach to arrive at potential research questions (O'Reilly, 2005), it can be used adjunctively with counseling theories before treatment. MI, with its client-centered orientation, is also compatible with a range of conceptual perspectives (that is, cognitive—behavioral, humanistic, solution-focused) and with the current practices of mental health clinicians, including social workers (Cepeda & Davenport, 2006; Miller, Yahne, Moyers, Martinez, & Pirritano, 2004). Among the most intriguing outcomes of meta-analyses of controlled trials of MI has been the finding that the effects of MI are larger (Burke, Arkowitz, & Menchola, 2003) and longer-lasting (Hettema et al., 2005) when it is added to other, more intensive treatment than when it is used as a standalone therapy.

We therefore integrated many of the principles and strategies of EI and MI into a single engagement interview and developed a treatment manual in which we describe this approach in greater detail, illustrated with relevant case material (Zuckoff et al., 2004). As a pretherapy intervention, the engagement interview has the potential to enhance the effects of a wide range of counseling approaches by enhancing clients' motivation for change and for treatment before starting the counseling process.

Therapeutic Principles and Techniques

Techniques, such as the use of open-ended questions and the expression of empathy through reflective listening, are basic social work practice techniques, and therefore speak to the acceptability of this intervention for social work practitioners .What makes the engagement intervention an innovation is that many techniques derived from EI and MI are combined and integrated to address and resolve practical, psychological, and cultural barriers to mental health care and treatment ambivalence.

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. Dismissing the role of "expert," the clinician takes on the role of student, eliciting the woman's views about her depression experience and the problems 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. Even at these moments, the clinician does not insist on her own perspective and tries to acknowledge and incorporate the woman's beliefs about and experience of depression.

Using open-ended questions encourages a woman to tell her own story and express her feelings, thoughts, and worldview. The clinician responds to the woman's communication by expressing accurate empathy in which her feelings and meanings are reflected back to her. These statements are made with due humility, given that clinicians can never be certain that their understanding is correct, and are presented in a warm, accepting, nonjudgmental manner. Summaries that bring together several of the woman's previously expressed thoughts, feelings, or concerns, as well as the clinician's understanding of how these fit together, help the woman see important connections and prepare the way for the clinician to move ahead in the interview.

The clinician actively affirms a woman's strengths, including past attempts at coping with depression and efforts to resolve her current dilemmas. The therapeutic stance of the clinician is not neutral and conveys affirmation or sincere appreciation of a woman's strengths, such as her spiritual coping with depression (Cooper, Brown, Ford, Vu, & Powe, 2001). Recognizing and highlighting a woman's strengths promotes optimism about the possibility of positive change. Therefore, it is critical that the clinician become a supportive advocate of the woman at appropriate points during the interview.

Working with ambivalence is one of the distinctive features of MI. Women of color and white women with depression and living on low incomes are expected to be ambivalent about whether they are really depressed, need treatment, or both. That is, they often feel both ways about these questions. Although the goal of the engagement interview 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 normality of ambivalence and working to resolve it. From this perspective, "treatment resistance" simply reflects the negative side of ambivalence, and rather than "challenging" or "confronting" it, the clinician seeks to understand and work with ambivalence or "roll with the resistance." Some MI techniques (Miller & Rollnick, 2002) for working with ambivalence include:

- *Double-sided reflection*. When the woman has expressed or acknowledged both sides of her ambivalence, the clinician reflects the two ways the woman thinks or feels about an issue, usually starting with the side favoring the status quo and ending with the side favoring change.

- *Amplified reflection*. When the woman has expressed or acknowledged only the negative side of her ambivalence, the clinician exaggerates or intensifies what the woman has said, which usually leads her to correct the distortion by alluding to the side favoring change.

- *Reframing*. The clinician re-presents what the woman has said from a new perspective or offers an alternate way of viewing her situation.

- *Emphasizing personal choice and control*. The clinician assures the woman that any decision is ultimately hers, that the clinician has no wish to take that choice away, and that only the woman can take action if she decides to do so.

Working with "change talk" and "adherence talk" is a technique the clinician uses to highlight the "positive" side of ambivalence—that is, indications that the woman desires to work at overcoming her depression or to receive help from treatment (Zweben & Zuckoff, 2002). Change and adherence talk is what the clinician is looking for in the engagement interview because when a woman hears herself saying these things, she is convincing herself to commit to treatment. The clinician's job is to highlight change and adherence talk (through reflection and summarizing) and to ask for elaboration.

Working with race, culture, and gender is a key feature of the engagement interview. Because of the history of racial, ethnic, and gender prejudice in our society, many clients may have misgivings about the process and be hesitant to frankly bring up issues of mistrust and misunderstanding. Therefore, the clinician encourages a woman to voice treatment-related concerns that she considers culturally unacceptable. These may include confiding in a therapist of a different race, class, or gender; revealing sensitive information in a professional treatment context (rather than one that is community-based); or other concerns. As a woman may be reluctant to broach these topics, the clinician should (as when working with ambivalence) "pull for the negatives" (personal communication with M. McKay, professor of psychiatry, Mount Sinai School of Medicine, New York, NY, 2003) or ask several times about race, culture, and gender.

Structure of the Engagement Interview

The structure of the engagement interview consists of five sections that should be delivered flexibly over the course of 45 to 60 minutes to meet the specific needs of a given client. If a particular area does not seem relevant to a client, it should be noted briefly and skipped. If the client seems to be addressing topics in an order that differs from that specified here, therapists should follow the client and not the outline. If pressed for time, the therapist should focus primarily on those aspects of the session that seem most relevant to a client. If the therapist observes acute suicidal ideation, psychosis, or uncontrollable agitation, the intervention should be abandoned in favor of making arrangements for the patient's immediate safety and an appropriate level of care. In each of the following sections of the outline, the engagement strategy is individualized for each client.

To begin the interview, the clinician provides the woman with a brief explanation: "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, "How have you been feeling lately?" The clinician's engagement goal is not to gather a psychosocial history but rather to invite the woman to tell her story and explore and resolve ambivalence about treatment seeking. If the woman has already completed a formal intake interview, the clinician can summarize this information, ask for confirmation by the woman, and proceed with the engagement interview. The clinician is expected to use an EI-consistent stance and MI strategies throughout the five sections of the interview.

Eliciting the Story—Initially, the clinician seeks to understand the woman's experience of her depressive symptoms in their sociocultural context, as well as her explanation for why she feels this way and how she has been coping. The clinician pays special attention not only to the woman's account of the stressful life events linked with her depression, but also to the adverse impact of chronic stressors (for example, poverty, discrimination, lack of community resources) that may exacerbate her depression. Using open-ended questions, expressing empathy, and affirming strengths are critical techniques in eliciting the story. Providing a brief summary of the woman's story enables the clinician to check that the woman feels understood and, if so, to move to the next, relevant section of the interview.

Treatment History and Hopes for Treatment—The goals of this section are to understand whether the woman has experienced depressive symptoms in the past and, if so, what coping mechanisms she has relied on, such as formal and informal sources of support, self-reliance, or spirituality. The clinician explores a woman's perceptions of the positive and negative aspects of these coping mechanisms, particularly her experiences with mental health treatment. Furthermore, the clinician must explore the woman's attitudes about the stigma of depression and about receiving mental health care, as well as the attitudes of her family members and friends about these topics. It is also useful to inquire about any negative experiences the woman has had with professionals in various social agencies because she may associate mental health treatment with these transactions. This section ends as the clinician asks the woman what she would want to be different at the end of treatment and what she would want in a therapist. During this section of the interview, working with ambivalence and highlighting change and adherence talk, as well as expressing empathy, are helpful techniques. Also, this is the point where racially or culturally related barriers may surface, either spontaneously or elicited by the clinician.

Feedback and Psychoeducation—The goals in this section are to give the woman feedback about her depressive symptoms and psychoeducation about depression. Before giving accurate information about a psychiatric disorder, experts on psychoeducation recommend that the clinician begin to develop a collaborative relationship with the interviewee (Anderson et al., 1986).To provide a rationale for treatment, the clinician presents the woman with information about her depressive symptoms obtained from an intake procedure or a standardized depression measure, such as the Beck Depression Inventory (Beck & Steer, 1993). Before giving this feedback, the clinician uses the MI technique of elicit–provide–elicit (that is, asking the woman permission to give this information, providing the information, and eliciting her reaction once the information is given).The term "depression" is not emphasized, except to the extent that it provides a short-hand way of describing the woman's symptoms and experience. If the woman prefers another term for her depression experience, such as "stressed," the clinician accommodates her preference.

One of the best ways to combat stigma about depression is for the clinician to provide accurate information about depression through psychoeducation (Davis, 2003; HHS, 2001), using once again the technique of elicit–provide–elicit. First, the clinician elicits or summarizes the woman's perceptions about her depression (that is, as a personal defect, as being labeled crazy, as untreatable), and then asks permission to give her more information. Next, the clinician provides scientific information about depression, explaining that depression is a medical illness, like diabetes or asthma, that impairs functioning, including the cognitive ability to solve problems. The clinician then describes and discusses the biopsychosocial model of depression—that the vulnerability to depression may be related to a biological predisposition, often running in families, and that depression is often triggered or exacerbated by environmental stressors. So described, the clinician insists that depression is not the woman's fault and that there is something she can do about it through seeking effective treatment. At this point, the clinician may describe various treatment options that she may choose, such as evidence-based psychotherapies, like interpersonal psychotherapy or cognitive–behavioral therapy, or antidepressant medication. Providing the woman with an educational orientation to the type of treatment she may receive helps the woman transition from the engagement interview to the treatment phase. Most important, as the clinician provides information about depression and treatment to the woman, the clinician pauses frequently to elicit her reaction, feelings, and thoughts. If the woman discounts or challenges the information, the clinician uses the MI techniques of working with ambivalence and responds empathically.

Addressing Barriers to Treatment Seeking—The goals in this section are to elicit or reiterate the current barriers that keep the woman from engaging in treatment and to address them through problem solving. The clinician encourages the client to voice why it will be difficult to come for treatment and suggests some barriers, if the woman does not offer any. Practical barriers, such as cost, transportation, child care, and scheduling, are usually the first ones offered, because they are safer—that is, they are socially appropriate and don't reveal anything too personal. The clinician works to resolve these barriers, asking the woman for her own ideas about how to overcome them and following the elicit–provide–elicit format while problem solving. If psychological or cultural barriers are raised or are still present, including doubts about whether mental health treatment will help, guilt about taking time away from her children or family, or discomfort with a clinician of a different racial or ethnic background, the clinician responds by empathizing, exploring both sides of her ambivalence, offering alternate perspectives, and emphasizing her personal choice and control.

Eliciting Commitment—The goal in this final section is to shift from enhancing motivation for change through treatment to eliciting commitment to treatment. Increased "change or commitment talk" on the part of the woman at this point are promising indicators of engagement. The clinician summarizes the woman's story and her ambivalence about treatment, highlights change talk, outlines next steps in obtaining treatment, and seeks to elicit commitment by asking, "What would you like to do now?" or "How does that sound to you?" If she indicates an intention to move forward, the clinician begins the transition to treatment. If she remains ambivalent, the clinician does not insist, but "leaves the door open" and again emphasizes that the choice is rightfully hers. In all cases, an affirming stance regarding the woman's strengths and likelihood of gaining benefits ends the interview on a hopeful note.

A Case Example

Ms. B. was a 33-year-old unmarried African American woman who lived at home with her seven-year-old-son and her physically disabled unemployed boyfriend. Ms. B. was the primary breadwinner in the family, working at night at a low-wage job in the inventory department of a large store. At the initial intake interview, she was diagnosed with a moderately severe level of depressive symptoms on the Beck Depression Inventory. Ms. B. was 28 weeks pregnant when she came to the engagement interview.

Story—Ms. B. said that she was not sure she wanted the baby, who was unplanned, but disapproved of abortion for religious reasons. Shortly after she found out she was pregnant, her boyfriend, who periodically cheated on her, resumed his extra-relationship affairs. She did not want to break off the relationship, however, because he did not hit her, was kind to her son, and was the father of her baby. Ms. B. reported living in an unsafe neighborhood that was subject to gang violence and drug trafficking. When asked about how she was feeling, she said she felt overwhelmed and "stressed" about her situation, but she didn't think she was depressed in the way her mother had been. Her mother had been hospitalized many times for depression and was "drugged" on medication for as long as Ms. B. could remember. The clinician asked open-ended questions to elicit her story and expressed empathy during this phase of the interview.

Treatment History and Hopes for Treatment—Ms. B. reported that she had felt "stressed" many times in the past—when living with her mother who had depression and when child protective services removed her infant son (now seven years old) from the home due to "failure to thrive." What had helped her recover from these episodes were her self-reliance, her Baptist faith, support from her sister and a cousin, and her strong commitment

to caring for her children. She had never received mental health treatment for her stress and was skeptical about how it could help her. Ms. B. considered her mother's psychiatric treatment unhelpful because her mother did not get any better, and she viewed antidepressant medication in a negative light. She was also concerned about having to admit to a clinician that she was stressed for fear of having her child or baby taken away again .When asked what she would want out of treatment (if she were reassured that her child would not be taken away and that medication was not the only effective treatment method), Ms. B. said she would like to feel like herself again, to be able to work and take care of her children, and go back to church. During this phase of the interview, the clinician affirmed Ms. B.'s strengths and capabilities and continued asking open-ended questions and expressing empathic understanding of her situation.

Feedback and Psychoeducation—Ms. B. agreed to hear the results of her screening and was surprised to learn that the clinician used the term "depression" as a shorthand way of describing her symptoms. After learning that there were different degrees and types of depression, that depression did not mean "crazy," that depression was a medical illness rather than a personal defect, and that depression was related to a great deal of stress, Ms. B. felt more comfortable using the term. She still preferred "stressed" when talking with her boyfriend and family members. Ms. B. was encouraged by learning more about advances in treating depression, namely interpersonal psychotherapy and cognitive–behavioral therapy. Although she was also interested to learn that antidepressant medications had improved in terms of effectiveness and side effects, she said she would never try them, but might consider brief psychotherapy. During this phase of the interview, the clinician used the elicit–provide–elicit technique when giving information, identified the negative and positive aspects of Ms. B.'s ambivalence about treatment, and highlighted her tentative change talk.

Addressing Barriers to Care—When asked what might make it difficult to come for mental health treatment, Ms. B. first talked about practical barriers—cost and scheduling concerns. She was pleased to find out that Medicaid would cover brief treatment and that she could schedule appointments on the day after her night off from work. Her biggest concern was that the clinician would report her psychological condition to child protective services, an action she feared would result in her children being removed from the home. The clinician addressed Ms. B.'s fear by distinguishing the clinician's role from that of other "helping" professionals in the community and assured her that the content of treatment sessions would be confidential, except in instances where an individual was a clear danger to herself or to others. Ms. B. also said she did not care about the race or ethnicity of the clinician, but did prefer a woman who would listen and not give unwanted advice, such as telling her to kick her boyfriend out of the house. The clinician used the elicit–provide–elicit technique when problem solving during this phase of the interview, as well as empathizing, presenting alternative ways of looking at treatment, and emphasizing her personal choice and control.

Elicit Commitment—Ms. B. agreed to give treatment a try and scheduled another appointment. The clinician affirmed Ms. B. for her strengths and initiative and expressed appreciation of her willingness to talk openly about her problems and treatment concerns. While offering hope about the likely benefits of treatment, the clinician also reminded Ms. B. that she was in control of the treatment process. Ms. B. returned for an initial treatment session, completed a course of brief interpersonal psychotherapy for depression (eight sessions), and ultimately experienced a reduction in her stress and depression.

Preliminary Data on the Engagement Interview

We conducted a randomized pilot treatment study in the public care obstetrics clinic of a large urban women's hospital in Pittsburgh to examine the usefulness of the engagement interview compared with written psychoeducational materials for pregnant women of color and white women with depression and living on low incomes. All procedures were approved by the Institutional Review Board of the University of Pittsburgh. Potential participants included pregnant women who were 18 years or older, between eight and 32 weeks gestation, and depressed (scoring 13 or higher on the Edinburgh Postnatal Depression Scale, which is valid during the prenatal period (Cox, Holden, & Sagovsky, 1987). Typically, these women were receiving prenatal services at the obstetrics clinic, but not seeking depression treatment. Women were excluded from the study if they were currently receiving any kind of treatment for depression or were excluded and referred for appropriate treatment if they suffered from a comorbid psychotic disorder, organic mental disorder, substance abuse or dependence in the past six months, or mania; demonstrated active suicidal ideation; had a concurrent medical condition, such as hypothyroidism that would explain their depressive symptoms; or experienced severe physical or sexual aggression in their relationship with a partner or husband. On the basis of these criteria, 53 participants, all of whom were living on low incomes and almost two-thirds of whom were African American (62.3 percent), were identified as eligible for inclusion in the study and were randomly assigned to receive either a pretreatment engagement interview and eight sessions of brief interpersonal psychotherapy (IPT-B; described in Grote et al., 2004) provided in the same clinic in which they were receiving prenatal care or a referral for standard depression treatment (treatment-as-usual) provided by a community mental health clinic located either in the clinic in which they were receiving prenatal care or in their neighborhood. At the end of the initial screening for depression, women from both groups received written psychoeducational information about depression and its treatment.

Of the 25 women assigned to receive the engagement strategy and IPT-B, 24 women participated in the engagement interview and subsequently attended an initial treatment session (96 percent). Seventeen of the 25 women assigned to the engagement strategy completed a full course of IPT-B treatment (68 percent). Of the 28 women assigned to receive standard treatment for depression, only 10 (36 percent) attended an initial treatment session and only two (7 percent) completed a course of standard depression treatment. A Fisher's exact test indicated that the percentages indicating extent of engagement (96 percent compared with 36 percent) and extent of retention (68 percent compared with 7 percent) were significantly different from each other at $p < .001$ and $p < .001$, respectively.

Similarly, recent pilot data assessing the effectiveness of the engagement interview for mothers with depression, whose adolescents were receiving mental health treatment, showed promising results (Swartz et al., 2006). In this study, mothers who were depressed, but not suicidal, were offered the engagement interview and eight sessions of brief IPT-B. Of the 13 mothers who screened positive for depression, 11 agreed to participate in the engagement interview and all of them attended an initial treatment session. Ten of these 11 mothers (91 percent) completed a full course of IPT-B.

This aforementioned pilot work demonstrates the feasibility of providing the engagement intervention and reveals rates of treatment initiation and retention that compare favorably to those found in typical mental health services (Young et al., 2001). Research on the effects of the engagement interview is still in its preliminary stages. A randomized pilot study is currently underway comparing the engagement interview plus standard treatment referral to standard treatment referral by itself in women who are depressed and economically disadvantaged. Also of interest will be examining the effectiveness of the engagement

interview relative to other therapeutic engagement strategies. This is a matter for future research.

CONCLUSION

We developed an individualized, psychosocial intervention, based on an integration of principles and techniques of EI and MI, to address and resolve treatment ambivalence and some of the practical, psychological, and cultural barriers to care confronted by women who are depressed and disadvantaged by poverty and minority status. Preliminary data indicate that the engagement interview is a promising strategy and worthy of further study. In brief, we hope that the engagement interview will serve as a portable therapeutic strategy to motivate this population of vulnerable women to engage and remain in one of a variety of effective treatments for depression.

Although not a part of the engagement interview itself, additional strategies may be used to enhance treatment engagement and retention. These include using the phone to conduct psychotherapy sessions (Simon et al., 2004), providing mental health services in primary care clinics that are convenient and less stigmatizing (Miranda, Azocar, et al., 2003), integrating a case management component with depression treatment (Azocar et al., 1996), and using appointment reminders by letter or phone (Shivack & Sullivan, 1989).

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