ENGAGEMENT SESSION[1]

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THE CLINICAL PROBLEM AND USUAL INTERVENTIONS

Mothers of psychiatrically ill children and economically disadvantaged pregnant women are two groups who have especially high rates of depression and low rates of treatment. Swartz and colleagues (2005) found that 61% of mothers bringing their children to a pediatric mental health clinic met DSM-IV (American Psychiatric Association, 1994) criteria for a current Axis I disorder, most commonly depression (35%); two-thirds of those with a psychiatric diagnosis were not receiving psychiatric treatment. Most pregnant (Flynn, Blow, & Marcus, 2006; Marcus, Flynn, Blow, & Barry, 2003) and low-income (Levy & O'Hara, 2010; Lorant, et al., 2003; Miranda, Azocar, Komaromy, & Golding, 1998) women suffering from depression go untreated despite being at high risk for depression compared with the general population.

Practical barriers to treatment participation by depressed and vulnerable women include cost, clinic inaccessibility, and problems with child care. Depressed people suffer, by definition, from low energy, hopelessness, and cognitive slowing, symptoms that may make them more vulnerable to the "time and hassle" factors associated with participating in treatment. Worry or embarrassment about acknowledging depression and doubts that treatment could be helpful (Scholle, Hasket, Hanusa, Pincus, & Kupfer, 2003) as well as previous negative experiences of mental health services (McKay & Bannon, 2004) inhibit initial engagement, and feeling misunderstood or unhelped predicts premature discontinuation (Garcia & Weisz, 2002). Mismatches between the type of treatment offered and that desired (McCarthy et al., 2005), incompatible views of the nature of the problem, negative attitudes about the legitimacy of

accepting help, disclosing private experiences, or taking care of oneself (e.g., Mackenzie, Knox, Gekoski, & Macaulay, 2004), and negative relationship expectancies are also inhibitory. Cultural insensitivity or ignorance on the part of therapists may also present a significant barrier (Miranda, Azocar, Organista, Munoz, & Lieberman, 1996). Low perceived need for services, especially among those with mild to moderate depression (Mojtabai, et al., 2011), suggests that some may feel resigned, assuming that there is nothing to be done about their low mood.

Interventions to improve engagement in mental health treatment include psychotherapy preparation strategies such as role induction, vicarious therapy pretraining, experiential pretraining, and use of cognitive therapy techniques (Pollard, 2006; Walitzer, Dermen, & Connors, 1999). Case management has been employed to engage depressed women in primary care into depression treatment (Miranda, Azocar, Organista, Dwyer, & Areane, 2003). None of these approaches has been widely used.

THE RATIONALE FOR ADAPTING MI TO ENHANCE ENGAGEMENT IN DEPRESSION TREATMENT

Treatment preparation interventions have rarely attended to clients' agendas—including a wish to tell their story, understand the nature of their problems, and specify the kind of help they wish to receive—or to the psychological and cultural barriers they might face. Motivational interviewing (MI; Miller & Rollnick, 2013) emphasizes the meeting of the treatment aspirations of client and therapist within a client-centered relationship. Furthermore, many barriers to treatment can be understood in terms of ambivalence about change, participating in treatment, or both. As a counseling style for resolving ambivalence in the context of an accepting, compassionate, and autonomy-supportive understanding of individuals' perspectives, hopes, and concerns, MI provides a promising framework for engagement intervention. A substantial body

of research supports the use of MI for this purpose (Lundahl, et al., 2010; Zuckoff & Hettema, 2007, November), with evidence suggesting that the effects of adding MI to lengthier or more intensive treatments are meaningful and lasting (Hettema, Steele, & Miller, 2005).

CLINICAL APPLICATION OF MI TO ENGAGEMENT OF DEPRESSED WOMEN INTO PSYCHOTHERAPY

Development of the Engagement Session

Seeking effective yet feasible ways to reach out to difficult-to-engage populations, Swartz, who had developed a brief form of interpersonal psychotherapy for depressed mothers of psychiatrically ill children (IPT-B; Swartz et al., 2004; Swartz, Grote, & Graham, 2014), and Grote, who adapted IPT-B for depressed, socio-economically disadvantaged pregnant women (Grote, Bledsoe, Swartz, & Frank, 2004), initiated a collaboration with Zuckoff (Grote, Swartz, & Zuckoff, 2008; Swartz, et al., 2007), who with colleagues had described (Daley & Zuckoff, 1999; Zuckoff & Daley, 2001; Zweben & Zuckoff, 2002) and pilot-tested (Daley, Salloum, Zuckoff, Kirisci, & Thase, 1998; Daley & Zuckoff, 1998) an MI-based approach to adherence intervention targeting motivation for treatment as well as motivation for change. From ethnographic interviewing (Schensul, Schensul, & LeCompte, 1999) we incorporated an emphasis on the potential for interviewers' culturally specific values, ways of understanding others, and judgments about what constitutes "rational" behavior to interfere with their ability to grasp and support those of the interviewee. From IPT we incorporated psychoeducation about depression, provided in an MI-consistent style: remaining sensitive to the potential for the discord-triggering "labeling trap" but also recognizing that the diagnostic language of "major depression" can provide the client some relief by conveying that changes in behavior are attributable not to personal weakness or moral failings, but to an illness for which clients are not

to blame and which can be effectively treated.

The "engagement session" we developed is a single-session pre-therapy intervention focused on communicating the therapist's understanding of clients' individual and culturally embedded perspectives, helping clients see how the potential benefits of treatment align with their own priorities and concerns, facilitating identification and resolution of ambivalence, and problem-solving barriers to engagement. We named our intervention prior to the development of the "four processes" model of MI (Miller & Rollnick, 2013), which describes "engaging" as one MI process. While the goal of the intervention is to increase engagement of depressed persons into an effective therapy for that condition, the provider of the intervention employs all four MI processes: engaging the client, developing a collaborative focus for the session, evoking talk in favor of participating in treatment for depression, and planning for the initiation of treatment.

Research on the Engagement Session

In an open prospective pilot study (Swartz et al., 2006), depressed, nonsuicidal mothers of adolescents receiving mental health treatment were offered the engagement session and eight sessions of IPT-B. Of 13 mothers who met DSM-IV criteria for major depressive disorder and were not in treatment, 11 received an engagement session. Following the session, all completed the Client Satisfaction Questionnaire (CSQ), an eight-item instrument assessing subjective satisfaction with treatment, with possible scores ranging from 8 to 32 (Attkisson & Greenfield, 1994). The mean CSQ score for the engagement session was 27.2 (±4.0), indicating high levels of satisfaction. All 11 participants subsequently scheduled an initial treatment appointment, and all but 1 completed a full course of therapy. The one noncompleter, who attended seven of the eight sessions, had also clearly "engaged."

In the randomized controlled trial that followed (Swartz, et al., 2008), depressed mothers of

youth in psychiatric treatment (N=47) attended twice as many sessions at the 3-month treatment endpoint (9.0 vs. 4.5, $p < 0.05$) when randomly assigned to receive the engagement session and eight sessions of IPT-B ("ES + IPT-MOMS") versus referral to treatment as usual in the community. Clients receiving ES + IPT-MOMS also showed superior depression outcomes at treatment completion and 9-month follow-up.

In a randomized pilot study in the public obstetrics clinic of a large urban women's hospital (Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007), 64 depressed, socio-economically disadvantaged pregnant women (63% African American) who were not seeking depression treatment but agreed to accept treatment through the study were offered either the engagement session and eight sessions of IPT-B provided by the same therapist in the prenatal clinic ("Engagement and IPT-B") or a referral for standard depression treatment by a community mental health provider in the prenatal clinic or their neighborhood ("Enhanced Usual Care," EUC). Of 31 women assigned to Engagement and IPT-B, 25 entered the study and received an engagement session; 24 women (96%) attended an initial treatment session, and 17 (68%) completed a full course of IPT-B. Of 33 women assigned to EUC, 28 entered the study, 10 (36%) attended an initial treatment session, and 2 (7%) completed a course of standard depression treatment. Treatment entry and retention were significantly superior in Engagement and IPT-B as compared to EUC ($p < .001$). Clients receiving Engagement and IPT-B also showed superior depression outcomes before childbirth (three months postbaseline) and at six months postpartum (Grote, et al., 2009).

In a pilot randomized controlled trial (O'Mahen, Himle, Fedock, Henshaw, & Flynn, 2013), 55 racially diverse and low-income pregnant women with major depressive disorder were offered either 12 sessions of modified cognitive behavioral therapy that included an engagement session

(mCBT) or referral for treatment as usual in the community (TAU). Of women assigned to mCBT, 83% attended the engagement session, 72% returned for the second session, and 60% attended at least four sessions. Of women assigned to TAU, 17% received any psychotherapy. Women assigned to mCBT showed a greater decrease in depressive symptoms than those assigned to TAU at posttreatment and 3-month follow-up, although there were no differences on reliable and clinically significant change.

Key Strategies and Techniques in the Engagement Session[2]

Suspension of Therapist Biases and Assumptions

Therapists inevitably bring a set of values and beliefs about what constitutes "healthy" or "adaptive" behavior or ways of being, based on some combination of their upbringing, cultural context, and training and experience, to the clinical encounter. While these values and beliefs cannot (and should not) be eliminated, the therapist must work to "bracket" or suspend them during the encounter with the client in the engagement session. Eschewing the role of "expert," the therapist takes on the role of student, allowing the client to teach the therapist about her life and her views of the problems she is facing. This stance encourages the therapist to develop an accurate understanding of the client's experience from the client's own perspective, and conveys respect for the client's autonomy (i.e., her right to guide her own life and make her own decisions). At specific points during the interview the therapist does take on an expert role, providing psychoeducation about depression and the nature of IPT-B. However, even at these moments, the therapist does not insist on her own perspective, but either defers to the client's expertise on her own life or offers her views as alternatives for the client to consider if she is willing to do so.

Open Questions

The therapist employs open-ended questions throughout the engagement session. Unlike "closed" questions, open questions cannot be answered "yes/no," and do not pull for specific information; rather, they draw the client out and encourage her to express her thoughts, feelings, concerns, or world-view. In general, when a therapist asks mainly open questions, the client will end up speaking more than the therapist, a sign that the session is going well; if a therapist asks more closed questions, the client will tend to offer brief answers and the therapist will do most of the talking—a sign that the interview is off-track. Open questions can be used both to gently guide the direction of the session, and to encourage the client to elaborate upon something the therapist believes is important.

Expression of Empathy via Reflective Listening

Empathy is defined as accurate understanding of the client's communications and experience, as if from inside the client's world. The therapist expresses empathy through the technique of reflective listening, in which the client's words, meanings, and/or feelings are communicated back to the client in the form of a statement. These statements are made with due humility, given that the therapist can never be certain that her understanding is correct, and presented in a warm, accepting, non-judgmental manner. While the therapist goes beyond the explicit statements the client makes, and conveys her understanding of the underlying meanings or feelings that the client is expressing, the therapist does not make interpretations of the client's hidden motives or of the presumptive causes of the client's behavior. A useful guideline is that accurate empathic statements by the therapist are quickly recognized and felt to be true by the client, even if the client hasn't said as much in so many words. Interpretations, by contrast, are experienced as coming from outside the client's perspective, and either can't immediately be

recognized as true or false, or are felt to be intrusive or unsettling. Before a therapeutic alliance is established, interpretations often generate defensiveness rather than insight in clients, and thus they are counter-productive to the purposes of the engagement session.

Affirming

In the engagement session, as in IPT-B, the therapist is not neutral, but is a supportive advocate for the client's well-being. Affirmation, or expression of sincere and humble appreciation by the therapist of the client's efforts and strengths in coping with her life challenges or her participation in the treatment process, is an effective way of communicating this supportive and caring stance.

Summarizing

Bringing together of several of client's previously expressed thoughts, feelings, or concerns, often including the therapist's understanding of how these fit together, has several important functions. Summarizing can help the therapist ensure that she is understanding the client's situation ("collecting" summaries), help the client see connections between things she has been saying ("linking" summaries), and prepare the way for the therapist to shift focus or move on to the next part of the engagement session ("transitional" summaries). Clients are almost always more willing to follow the therapist once they feel confident that their own agenda and concerns have been taken seriously and understood.

Working with Sustain Talk and Discord

Clients are expected to be ambivalent about whether or not they are really depressed, whether or not they need treatment, or both. That is, they will often feel both ways about these questions. While the goal of the engagement session is to help them make a commitment to treatment strong enough to ensure that they receive the help they need, the method used to

accomplish this involves accepting the normality of ambivalence and working with clients to resolve it. From this perspective, clients should be expected to express *sustain talk,* or talk in favor of the status quo, as one side of their ambivalence.

Because people are motivated to feel in control of their own choices and to protect their self-esteem, "challenging" or "confronting" sustain talk is likely to generate *discord,* or the expression of mistrust in the therapist and "resistance" against feeling controlled or criticized. Instead, therapists in the engagement session should accept and understand the client's reasons for feeling hesitant or reluctant to enter treatment while listening for and building upon their reasons for doing so (see "Working with Change Talk and Engagement Talk," below). In addition to straightforward reflective listening, techniques for responding to sustain talk and reducing discord include:

- *Double-Sided Reflection*: When the client has expressed or acknowledged both sides of the ambivalence, the therapist reflects the two ways the client thinks or feels about the issue, usually starting with the side favoring the status quo, and ending with the side favoring change.
- *Amplified Reflection*: When the client has expressed or acknowledged only the status quo side of the ambivalence, the therapist intensifies or "overshoots" what the client has said, which usually leads the client to correct the distortion by articulating the other (pro-change) side.
- *Reframing:* The therapist re-presents what the client has said from a new perspective, one that may favor change.
- *Emphasizing Personal Choice and Control:* The therapist assures the client that any decision is ultimately the client's, that the therapist has no wish to take that choice away,

and that only the client can take action if she decides to do so.

- *Shifting Focus:* The therapist temporarily shifts attention away from a contentious area to one in which common ground can be found.

Clients do not always explicitly express doubts, disagreements, or feelings of reluctance that they are having when talking to a therapist. They may be afraid that the therapist will become angry or dismissive, or will try to talk them out of the thoughts or feelings they are having. Because such "hidden" sources of disengagement can undermine a genuine commitment to treatment, the therapist conducting an engagement session should actively draw them out, let the client know that it's good to discuss these concerns, and work with the client to problem-solve them. Drawing on the work of Mary McKay (McKay & Bannon, 2004) on engaging difficult-to-engage families into treatment, we refer to this as "pulling for the negatives."

Working with Change Talk and Engagement Talk

Change talk and engagement talk express the "pro-change" side of ambivalence—in this context, indications that the client desires to work at overcoming her depression and/or to receive help from treatment, sees a need for treatment and/or change, has reasons for committing to treatment and/or change, or believes she has the ability to succeed at changing or sustaining a commitment to treatment. Change talk and engagement talk are what the engagement session therapist is looking for. We learn what we think when we hear ourselves speak, so when clients hear themselves saying these things, they are talking themselves into committing themselves to treatment. Thus, when clients engage in change talk and/or engagement talk, the therapist's job is to highlight it (through reflection and/or summarizing) and to ask for more (through requests for elaboration or specific examples). The therapist may also invite change or engagement talk by employing "evocative" questions that ask clients to articulate their desire, ability, reasons, or

need for treatment and change; invite clients to look ahead to positive effects of treatment or negative effects of declining to participate; or use other MI techniques designed to highlight the discrepancy between the way things are and the way clients would like them to be.

Supporting Self-efficacy

Self-efficacy refers to clients' beliefs about how likely they are to succeed at something they try to do. This plays a key role in engaging clients in treatment: no matter how much they come to believe they need it, clients who don't believe they can succeed at treatment, or that it will work for them, are unlikely to try very hard to stick with it. However, self-efficacy is often low for clients who are depressed and tend to see everything pessimistically, including their prospects for feeling better. Therefore, in the engagement session, the therapist should actively look for opportunities to point out and support clients' strengths, including past attempts at coping with depression and their current efforts at resolving the dilemmas with which they are struggling. Similarly, when the client expresses any belief in her "ability" to come for treatment, work with her therapist, and/or make changes, the therapist should highlight these statements and ask for elaboration. On the other hand, if the client expresses pessimism about being able to sustain the commitment, the therapist should reframe these doubts, and work with the client to problem-solve until she identifies a solution in which she can feel confident.

Working with Race and Culture

In conducting the engagement session, the therapist must develop an understanding of the cultural context of the client, and allow the client to educate the therapist about her ethno-cultural background. Because of the history of racial and ethnic prejudice in our society, it is often very difficult for individuals of different backgrounds—in particular, whites and people of color—to frankly discuss issues of mistrust and misunderstanding. Therefore, it is imperative that the

therapist invite and even encourage clients to voice concerns related to aspects of psychotherapeutic treatment of depression that may be considered culturally unacceptable. These may include confiding in a therapist of a different race or gender, revealing sensitive information in a professional treatment context (rather than one that is community-based), or other concerns. As clients may be reluctant to broach these topics, the therapist should "pull for the negatives" about race, culture, or gender.

Structure of the Engagement Session

The engagement session is semi-structured, with five phases: *Eliciting the Story*; *Providing Feedback and Psychoeducation*; *Exploring the History of Distress, Coping, and Treatment, and Hopes for Treatment*; *Problem Solving Practical, Psychological, and Cultural Treatment Barriers*; and *Eliciting Commitment or Leaving the Door Open*. We describe each phase and provide an annotated transcript with a prototypical client.

Eliciting the Story

The goals of the initial phase are to ensure that the client feels understood and to elicit talk about the importance of change. The therapist begins by inquiring how the client has been feeling and what things have been like for her lately. If she responds by talking solely about how she feels, the therapist also asks about her situation: "You've been feeling so hopeless lately. . . . What has been going on in your life that might be affecting you?" Similarly, if she responds by talking solely about the circumstances of her life, the therapist also asks about how she has been feeling: "You're stuck with all these bills and busy all the time. . . . Tell me about how you're being affected by the lousy situation you're in." The therapist listens for the client's perspective on how she is suffering, what she believes is contributing to her suffering, and how it interferes with her daily life, attending specifically to the social and interpersonal context.

In almost all cases, the client's "story" can be framed as a *dilemma*: a problem that is unsolvable in principle, because each potential solution would exact intolerable costs. This both reflects, and is a source of, feelings of hopelessness inherent to depression. A successful conclusion to this phase comprises a summary that both *crystallizes* the client's dilemma and highlights her wishes for help in escaping from it.

THERAPIST: Tell me how things have been going and how you've been feeling lately.

Beginning with an open-ended question to draw out the story.

CLIENT: My son Johnny is a terror. He is getting on my nerves so bad. I feel like I'm really going to hurt him. He's been getting into trouble at school. He won't let me alone at home. I don't know what to do.

The client focuses on how her troubled child is affecting her and conveys her sense of helplessness and distress.

THERAPIST: You're starting to worry about the way you feel around him—you might lash out and do something that you'd regret.

The therapist reflects meanings and feelings.

CLIENT: It's affecting my whole life. I'm irritable at work and snapping at my coworkers.

THERAPIST: It affects you when you're not with him, too. What else have you noticed about how you've been feeling and acting that's different from the way you usually feel or act?

Reflection

Asking for elaboration to elicit problem recognition, a contributor to increased importance of change.

CLIENT: I'm not enjoying my free time. I'm always angry. I don't want to talk to

The client describes symptoms of depression.

anyone. I'm never happy.

THERAPIST: It doesn't matter where you are or who you're with or what you're doing, you feel the same way . . . this angry, unhappy feeling, and it's really hard because you are trying to deal with Johnny, and no matter what you do, it doesn't seem to get any better.

Summary of the client's expressions of dissatisfaction with the status quo.

CLIENT: Yeah. Anything I try just doesn't work with him. It's getting worse and worse.

The client confirms that she feels understood.

THERAPIST: It's been incredibly frustrating for you.

Reflection of feeling.

CLIENT: I'm frustrated with everything.

THERAPIST: And this is a big change from the way things were before.

Looking back.

CLIENT: Yeah, it's just over the past year that he's gotten worse. His father left, and now he's living across the street with his girlfriend.

Focusing on the context of her child's problems, she describes sources of current distress.

THERAPIST: That's a difficult situation.

Supportive statement.

CLIENT: And before that things weren't too good between his father and me, and he saw a lot of that, but it's been worse since his father left. It seems like he's escalating. He's on the verge of being expelled. I've had conferences

with his teachers and his guidance counselor, and they make it seem like it's all my fault.

Is she afraid she will be blamed by this therapist and/or a future therapist as well?

THERAPIST: You're doing everything you can think of to get Johnny to come around, and not only is it not working, which is really hard for you, but you're feeling blamed by other people who you're looking to for help. (*Client nods*.) And you're really angry about this.

Affirmation and complex reflections; highlighting an aspect of her dilemma and identifying a possible barrier to engagement.

CLIENT: I am. Nobody seems to understand what is going on.

She's beginning to feel understood.

THERAPIST: You feel pretty much alone in all of this. (*Client nods*.) No one seems to be able to help, no one seems to really get it.

Reflecting meaning and feelings.

CLIENT: Even my mother blames me for the break-up. She thinks I should've stuck it out.

THERAPIST: How did you make that decision? What happened between you?

Drawing out more about her dilemma . . .

CLIENT: I couldn't take it anymore. He was going to kill me. I felt really bad because Johnny saw all of this. I would try to have him go upstairs, but he'd sneak down and sometimes he'd see his father beating on me.

. . . which she describes in terms of her situation and reasons for her actions.

THERAPIST: You felt like you had no

Empathizing with her choice in the face of her

choice. You *had* to leave. (*Client nods vigorously*.) Let me see if I'm understanding.

dilemma.

You've been dealing with these problems for a while now, but things were getting worse. So you decided you had to get away before something horrible happened, and you made that decision for yourself but also for Johnny, because you were worried about what he was seeing and how that was affecting him. You're trying to do the best thing you know how to do, make the best decision you can, and the result has been that things have seemed to get worse.

Transitional summary, including understanding of her view of how she came to be in her current problematic situation…

. . . affirmation of her good intentions and efforts . . .

CLIENT: That's right!

THERAPIST: Instead of feeling or acting better, Johnny seems to be acting worse, and you don't know how to get through to him or how to help him or what to do for him. It's like you took this incredibly difficult step, and things have just gone downhill.

. . . crystallizing her dilemma…

CLIENT: No matter what I do, I can't win.

THERAPIST: And now you don't know where to turn, you don't know what to do, and you're worried about what you might be capable

. . . and reflecting her fears about what will happen if she doesn't get help.

of if things don't get better.

CLIENT: Yeah, I'm afraid I'm going to lose control or at work I'm going to lose my job. *Implicit recognition of the need for change.*

THERAPIST: And that's really scary, because the bottom could really drop out.

CLIENT: Yeah. And I don't know how to get out of this by myself. *First approach to talk in favor of treatment (engagement talk).*

Providing Feedback and Psychoeducation

The goal of this phase is to offer the client a different perspective on her current difficulties. The therapist reframes the problems as comprising a recognizable medical condition for which effective treatment is available rather than a hopeless situation or a failure of will or ability. This is not intended to minimize the importance of the contextual factors but rather to suggest that alleviating the mood disorder will allow the client to cope with these factors more effectively.

The client is given individualized feedback on her current condition. Examples of assessment tools include standardized self-assessments of depressive symptoms such as the Quick Inventory of Depressive Symptoms (Rush, et al., 2003) or the 9-item Client Health Questionnaire (Kroenke, Spitzer, & Williams, 2001). The therapist then elicits what the client already knows about depression, offers (with permission) psychoeducation tailored to the client's individual concerns and current knowledge, and then elicits her reaction. The elicit/provide/elicit format helps to ensure that the client is open to what the therapist has to say and reduces the likelihood of discord, which often emerges when people are given education they're not interested in. It also communicates respect for her views and acknowledges that it will be her interpretation of this information that will ultimately determine what she does with it.

The psychoeducation offered by the therapist includes the ideas that depression is a "no-fault" illness and thus that the depressed person is not to blame for the troubles she is having; that depression negatively affects people's ability to solve interpersonal problems or manage difficult situations; that depression can be effectively treated; and that when depression is treated successfully, people often begin to see alternative solutions to what had seemed like unsolvable life problems. Should the client object to diagnostic language, express uncertainty as to whether she is really "depressed" (rather than, for example, "stressed out" or "overwhelmed"), or feel reluctant to acknowledge that she needs "treatment," the therapist accepts the status quo side of the client's ambivalence and responds nondefensively. Inquiring about the client's perspective and emphasizing its legitimacy, the therapist at the same time looks for opportunities to connect troubles the client describes—painful feelings, problematic thinking patterns, difficulty functioning—to the therapist's ability to help: "As you see it, stress is very different from depression, and you're sure that you're stressed rather than depressed. You've also told me that your new situation has been a big source of stress. Would a therapy that could help you find and use some better ways of managing the situation be something you'd find worthwhile?"

THERAPIST: I'd like to review the depression questionnaire we gave you to let you know what we make of your responses and see what your thoughts are. Is that OK? *Introduction of feedback.* *Asking permission.*

CLIENT: Yes, it sounds good.

THERAPIST: Let me know if anything I say doesn't sound right to you because I really want to know that, as well as anything that does *Inviting her to be active in the discussion to promote collaboration.*

make sense to you. This is the Client Health Questionnaire. It asks about markers that we use to tell us if somebody is depressed or not, and of the seven markers you agreed with five. For example, you said you had noticed some changes in your sleep. Tell me what you've noticed about how your sleep has changed.

Characterizing the source of feedback, explaining how the assessment was arrived at, providing feedback.

Asking for elaboration.

CLIENT: I'm waking up a lot in the middle of the night. I'll have a nightmare about something that I'm worried about, and when it wakes me up, I stay awake.

THERAPIST: So, it's harder to stay asleep, and it's harder to get back to sleep. You also said your appetite is not as good.

Clarifying symptoms.

CLIENT: I've been living on junk food. I eat, but not regular meals like I usually do.

THERAPIST: Changes in sleep and appetite are two physical changes we often see when people are depressed. Depression affects people's bodies as well as their thoughts and feelings. You've also been feeling much less interested in things, you don't have the energy you usually have, and you've had some thoughts

Offering information, in terms of the model of depression.

of wanting to die. Tell me about that.

CLIENT: Well, Johnny really acts out, and I don't have anybody to talk to. I feel like the reason I am living now is to take care of him, and then when he acts out it makes me feel like there is nothing really worth living for.

THERAPIST: You're exhausted all the time trying to deal with this, and you can't sleep well or eat right and that's taking a toll also. So, you sometimes reach this point where you want to give up, like there's no point in going on.

Collecting summary.

CLIENT: Yeah, why should I do it for him if he's going to treat me like that?

THERAPIST: So, there is an angry part, too. Like, "The hell with you . . . if you're going to act this way, I don't even want to be here."

Reflection of feeling.

CLIENT: Exactly. Isn't that terrible to feel that way toward your son?

THERAPIST: When people have these kinds of problems with sleeping, appetite, energy, interest, and feeling like giving up, we say they have depression. So, from our perspective it looks like you are depressed and

With implicit permission to provide information, reframing her mood and behavioral changes, and her self-blame, in terms of the medical model of depression.

that's why you're feeling and acting in ways that aren't normal for you. What are your thoughts about that?

Eliciting her reaction.

CLIENT: I don't think I'd be depressed if it wasn't for everything going on in my life.

A little defensiveness (discord) arises.

THERAPIST: It's having a big impact on how you feel and how you're doing.

Defusing discord via reflection.

CLIENT: Yeah, if Johnny wasn't acting out, if his father wasn't living across the street with his girlfriend, if I wasn't trying to scrape to get by, I don't think I would feel this way.

THERAPIST: That makes sense. People in stressful situations are more vulnerable to becoming depressed and feeling the way you've been feeling. I think that is very consistent with the way we see things. Do you have any other thoughts about that? (*Client shakes her head, looking uncertain*.) You're sure?

Reframing in line with the model of depression.

Eliciting her reaction.

Checking for unspoken disagreement.

CLIENT: So, is depression something inside me? Is it like a disease?

THERAPIST: You're wondering what I mean by "depression." When you hear the word "depression," what is your understanding?

Eliciting the client's understanding, and the concern she's hinting at.

CLIENT: Just feeling sad. Like when my friend broke up with her boyfriend, she was down and she said she was feeling depressed.

THERAPIST: People can use the word "depression" to talk about times when they feel kind of down or sad, that will probably pass on their own. It sounds like that's how you're thinking about it. Our understanding is that depression is a medical illness that people can suffer from but, fortunately, also something that's treatable and that we know how to help people with. (*Client looks thoughtful*.) We also think that once someone is depressed, stressful situations are more difficult to deal with. So, each affects the other. The stress and difficulties can trigger a depression. Then, once you're depressed, the difficulties are harder to deal with. You don't have the same energy and focus to handle the stressful situations in your life. Does that sound like what's been happening?

Providing psychoeducation . . .

. . . and offering hope.

Eliciting her reaction to the psychoeducation.

CLIENT: So, what you're saying is that the way I'm feeling is because of everything going on, and once I feel this way it is going to make

Is she suspicious that the therapist is implying that her complaints are exaggerated?

everything seem like it is worse than it really is?

THERAPIST: Not that it seems worse than it really is, but probably more *hopeless* than it is. I believe your situation is very difficult and that it feels really bad to you. We find that when someone is depressed it becomes very hard to see any kind of solution to difficult situations. Everything looks sort of bleak. As people become less depressed, it doesn't make the situation get better right away, but they're more able to see ways to improve the situation and to use the things that they know how to do to deal with difficult situations. Does that make sense?

Being careful not to minimize the difficulty of her situation . . .

. . . and reframing in terms of the model of depression, which offers hope.

CLIENT: Yes. I could definitely use some help dealing with some of the things that are going on. Because I can't fix them myself.

Engagement talk—the discord seems defused.

THERAPIST: The good news is that if we can provide that help for you, you will probably start to feel a little more like you can deal with the situation, and that's actually going to help the depression as well. How does that sound?

Conveying optimism.

CLIENT: Good. That would be good.

This phase, in which the therapist shifts focus from the client's perspective to a professional one, is one place where racial, cultural, or gender-related barriers may arise. Understanding the client's cultural context and allowing the client to educate the therapist about unique elements of her background and identity are crucial. However, it is often very difficult for individuals of different backgrounds to frankly discuss issues of mistrust and misunderstanding. Therefore, the therapist should invite and even encourage clients to voice concerns related to aspects of the psychiatric view of depression and its treatment that may be considered culturally unacceptable. These concerns may include reluctance to confide in a therapist of a different race or gender or to reveal sensitive information in a professional treatment context.

For example, a white therapist talking with an African American client:

THERAPIST: I noticed that you got quiet when I said that this questionnaire shows that you're depressed. Could I ask what you were thinking just then? *Drawing out unspoken discord.*

CLIENT: Nothing important (*looks away*).

THERAPIST: I don't want to put any pressure on you to tell me anything you'd rather keep to yourself. Would it be all right if I asked you one more question? (*Client nods*.) *Emphasizing personal choice and control.* *Asking permission.*

Sometimes when I've talked with African American clients, they've told me they had doubts about these kinds of questionnaires. I was wondering if you might feel that way, too. *Pulling for the negatives.*

CLIENT: I think they made those questionnaires by asking white folks a bunch of questions, and that doesn't necessarily mean it's the same for us.

Cultural barrier.

THERAPIST: The questions we asked might not really apply to you.

Amplified reflection.

CLIENT: Well, some of those are true for me, but that doesn't necessarily mean I have an illness. No offense, but that's what white people have always done to black people—called them sick just because their lives are hard.

Articulation of the client's concern.

THERAPIST: I really appreciate your being so honest with me. And the last thing I'd want would be for you to feel like I'm putting some label on you that doesn't fit. Putting aside the questionnaire, how would you describe the way you've been feeling lately?

Affirmation.

Defusing discord.

Eliciting the client's perspective.

CLIENT: I don't mind the word "depressed." I just don't think those questionnaires are the last word on how I feel.

The discord is diminishing.

THERAPIST: I couldn't agree more. Your perspective on what you're going through is definitely what matters the most.

Joining with the client.

Exploring the History of Distress, Coping, and Treatment, and Hopes for Treatment

The therapist's goals in this phase include understanding the client's current difficulties in the context of her relevant history; uncovering potential barriers to engagement related to negative experiences with or beliefs about treatment; understanding her past and present coping efforts and affirming the strengths she has called on in doing so; and eliciting talk about the possibility of positive change (i.e., hope).

The therapist begins by asking whether the client has previously felt the way she feels now. Discussion of the client's experience with depression is followed by questions about how she coped with these feelings (if she has been depressed previously) as well as about what she has tried recently to help herself feel better and manage her situation. The therapist looks for opportunities to affirm the client for her efforts and to support self-efficacy as well as to understand the kinds of interventions she is likely to find plausible or desirable.

If the topic has not come up already, the therapist then asks about the client's perceptions of treatment. These may derive from personal or vicarious (e.g., children's or other family members') experience, or from media portrayals. It is crucial to elicit discussion of both positives and negatives—the former, because they constitute engagement talk, and the latter, because they potentially constitute the most potent sources of ambivalence or barriers to engagement. The therapist employs empathic reflection to communicate nonjudgmental understanding of negative feelings and/or beliefs about treatment, strategies such as shifting focus and emphasizing personal choice and control if such negativity generalizes to the current therapist or treatment, and reframing to emphasize the potential for the proposed treatment to be more helpful.

Finally, the therapist asks about the client's hopes and fears for treatment now. Encouraging the client to describe what she does and does not want from the treatment and from the therapist

is both an unusual thing to do and, we believe, among the elements of the session that have the most powerful engagement effect. Looking ahead—"What would you like to be different at the end of this treatment?" or "If this treatment were to work exactly the way you hope, what would your life be like two months from now?"—can further evoke hope that things can be better and that treatment could play an important role in the improvement.

During this discussion, the therapist looks for opportunities to help the client see how the treatment on offer can provide what she is looking for. This typically involves briefly describing the treatment's basic principles and noting consistencies between the treatment approach and the client's wishes. We have found IPT to be a good match for the women with whom we work; the idea that depression is linked to transitions, disputes, or losses in our interpersonal world seems to make intuitive sense to them and almost always fits with the focus of the discussion. Similarly, the stance of the IPT therapist—warm, active, encouraging, moving flexibly between more and less directive interventions—has great appeal. The effectiveness of the engagement session is tied in part to the acceptability of the treatment in which clients are being asked to engage.

THERAPIST: Were there times in the past when you've felt like you're feeling now?

Asking for history of depression.

CLIENT: When my dad passed. It only lasted about a month and gradually it got better. This time it seems to be getting worse.

Recognition that the current problem is different and could require professional help.

THERAPIST: You expect to have difficult periods in your life and then things get back to normal. But it's not getting back to normal.

Highlighting this recognition through reflection.

CLIENT: Yeah, usually I am able to kind

of get myself back up.

THERAPIST: How have you done that? *Asking about past success in coping.*

CLIENT: Well, Johnny's father was there for me. Johnny wasn't as bad when he was around. And when my dad was around, if I felt this way I could talk to him. Then after my dad passed I could talk to my mom. Now it just seems like I'm taking care of Johnny all by myself, and no one really cares or understands. They can't understand what's going on. *Identifying interpersonal contributors to current depressive episode.*

THERAPIST: You feel like you don't have anyone to turn to when you're feeling down and when you need someone to understand you or offer a little support. That's the big difference between now and before—you don't have anyone to turn to who could help. *Reflection of meaning . . . . . and a subtle reframe.*

CLIENT: I hadn't thought about it that way. I don't have anyone now who I can talk to.

THERAPIST: And you miss that, and you're really feeling the need for it now. *OK—but it would be better to elicit this from the client.*

CLIENT: I've got to do something. I just can't go on feeling like this anymore. *Preparatory engagement talk.*

THERAPIST: Have you ever been able to *Asking about previous treatment experience.*

talk to someone outside the family or friends?

CLIENT: I used to talk to Johnny's pediatrician. She understood the problems he was having. But she seemed to understand me, too. We talked about how hard it was for me to deal with him. I always felt better after that.

Describing what she wants from a "helper" by recalling positive experiences of being helped.

THERAPIST: What was it about her that made you feel understood?

Asking for elaboration.

CLIENT: Even though the focus was on Johnny, she would take time to ask how I was dealing with things and listen to me. I feel like I'm taking care of everyone else all the time, and she was interested in how I was feeling.

Positive talk about help from a professional.

THERAPIST: You didn't have to worry about taking care of her. You could let her take care of you a little bit, be concerned about you.

Reflection of meaning.

CLIENT: Yeah. I mean, she wasn't family, so she never really talked about her problems.

THERAPIST: She listened, she seemed to understand, and she wanted to help. She seemed to care about you and wanted to help you feel better and deal with Johnny better.

Interim (collecting) summary.

CLIENT: She would help me deal with

Johnny and tell me what to do with the problems he was having, not like I was a bad mom, but just suggestions.	*Key point about what she wants and doesn't want from a helper.*
THERAPIST: That was a very positive experience. Were there times when you had less positive experiences with doctors or therapists?	*A specific reflection could have highlighted the key point about not feeling blamed.*
CLIENT: That's the only time I ever talked to anyone outside of friends or family. I always felt like I could handle it myself. My girlfriend went to see someone, and they put her on this medicine, and then she wasn't herself. I'd rather feel like myself than be on the medication and change like she did. I tried to talk to my doctor once, and he wanted to put me on medicine.	*Revealing a barrier: negative treatment expectations.*
THERAPIST: And that was not something you felt comfortable with at all.	*Reflection of meaning.*
CLIENT: Yeah, he gave me a prescription, but I didn't have it filled.	*She will not follow a course of treatment just because a professional tells her to.*
THERAPIST: It was scary for you to see the change in your friend. (*Client nods*.) There are two kinds of help you've seen people get. One is medication, which you are not comfortable with. It wasn't helpful when your	*Reflection of feeling.* *Linking summary and reframe.*

doctor gave you medication, because you didn't feel it was right for you. On the other hand, having somebody to talk to, who understands you and seems to care and want to help—somebody you don't have to worry about taking care of—that feels like it could be a helpful thing. At least that was a helpful thing before.

CLIENT: Yes, a very helpful thing. *Preparatory engagement talk.*

THERAPIST: What we offer is called "interpersonal therapy." It's a talking therapy that focuses on relationship problems to help relieve depression. The therapist will be in your corner, listening to you and helping you figure out what you can do to make things better. *Introducing the treatment.*

CLIENT: That sounds good. Those are the kinds of problems I have. *Preparatory engagement talk.*

THERAPIST: Looking down the road months from now, if the therapy works and is helpful for you, how will things be different? *Looking ahead.*

CLIENT: What I would really like to be different is the situation with Johnny, but I don't see how that could change because it takes everything I have to keep my cool at work and *Expressing her wish but also her pessimism—i.e., her ambivalence.*

get through the day and take care of him.

THERAPIST: A change with Johnny is one thing that you would really like, yet you can't quite see how that would happen.

Double-sided reflection.

CLIENT: Maybe if I could get a break or have a little time for myself I wouldn't be so short with him and I could try some of the things his therapist suggests. I spend my whole day working, and then I have to come home in the evenings and take care of everything there and fight with Johnny, and I never get a break.

Thinking about possible steps toward change and the barriers to taking them.

THERAPIST: If things could go well with the therapy, one change would be that you would somehow find a way to get some help with Johnny so that you could have a break to focus more on yourself and take care of yourself instead of just taking care of everyone else.

Highlighting a source of hope through reflection.

CLIENT: And I would like to have the energy to do that. I can barely drag myself out of bed to go to work and take care of Johnny.

Reason for change.

THERAPIST: The way you're feeling it doesn't seem like there's any way you could do this, but if things went well and you had the

Reframing in terms of the model of depression, from pessimism to hope.

energy again, you could figure out how to get some additional help or handle situations with Johnny more constructively or get a break to take care of yourself. Those would be some really positive changes.

CLIENT: Yeah. It would be really great if therapy could help with that.

Envisioning change through engagement.

Addressing Practical, Psychological, and Cultural Treatment Barriers

As the focus of the session shifts from evoking to planning (building and strengthening commitment to treatment), the therapist's goal moves to drawing out, exploring, and problem-solving remaining barriers to engagement. Practical reasons why it will be hard to come for treatment are usually the first ones offered; they are safe—socially appropriate and not too revealing. The therapist takes these at face value and works to resolve them; if they are the only barriers, that will soon become apparent, and if there are other concerns, these will emerge once the practical barriers are addressed.

Underlying psychological barriers include disagreement with the diagnosis of depression, desire for a different kind of treatment, negative mental health treatment experiences, discomfort with self-disclosure, or generally negative relationship expectations (e.g., anticipation of being controlled, neglected, or exploited). In particular, many mothers express feelings of guilt about taking care of their own needs rather than thinking only of their family members. Culturally-related concerns may include doubts as to whether someone of a different race, gender, ethnicity, religion, age, sexual orientation, or social status can really understand their lives or anticipation of being judged negatively for their differences. Alternatively, some clients from small minority

communities may fear recognition and stigmatization by another member of the same community and prefer a therapist from a different ethnic or religious background.

In some cases the client will not spontaneously offer any barriers; she may even initially deny that any exist. This may be true, but to ensure that important barriers are not going unspoken the therapist should suggest some. For example: "Some people have told me that, even though they wanted to come for therapy, it might be hard to find the time or money. Others have worried about what it would be like, or felt guilty about taking time for themselves instead of putting all their effort into taking care of their families, or had other concerns. It wouldn't be unusual if you had some doubts like these . . ." Trying to elicit the direct expression of these potential unspoken barriers, remaining non-defensive and open to clients' worries, and placing the client in the role of teacher can often defuse such concerns.

THERAPIST: What could make it hard for you to come for treatment? *Open question to elicit barriers.*

CLIENT: I don't have much energy, and that makes it hard to do anything. *A psychological barrier.*

THERAPIST: No energy to get here. *Reflection of meaning.*

CLIENT: It takes all the energy I have to take care of Johnny and make it to work. I had trouble coming here today.

THERAPIST: It takes energy to get help so that you can have more energy. *Acknowledging the apparent paradox.*

CLIENT: If I could see someone on Monday, I could probably come. That's my

afternoon off, and Johnny has his therapy that day. The rest of the week I have to be at work and take care of Johnny.

A potential practical barrier.

THERAPIST: The last thing we want to do is to put one more thing on you that's going to make your life more difficult. I'm certain we'll be able to work out the schedule so that you can come on your afternoon off. It sounds like that would clear one potential hurdle out of the way. That doesn't necessarily solve the energy problem, though. When you imagine yourself coming to the next session, what kinds of thoughts go through your mind?

Reflection of meaning.

Problem solving the practical barrier first . . .

. . . then returning to the psychological barrier, asking for specifics.

CLIENT: I know it will be hard to get here—I'll just want to go home and shut myself in my room. If I come, someone might try to tell me how to feel better, but I don't know if it's going to work. They might try to tell me that I should do this and that to feel better, but it's hard for me to do anything right now.

"Low energy" is revealed to be related to concerns about what the therapist will expect of her and how much control the therapist will seek to exert.

THERAPIST: You are imagining yourself getting ready to come in, and part of you will be wondering, "How is this going to go?"

Reflection—a bit general.

CLIENT: I may not be able to do what they're going to tell me to do. If I didn't have the energy to do those things and someone didn't understand that, then it wouldn't help.

Trying again to get the therapist to understand her concerns.

THERAPIST: I'm *sure* it wouldn't help. It would be very important for your therapist to understand how hard it is for you right now to get yourself to do the things you need to do, and not have unrealistic expectations. If you felt the therapist was going to be critical and give you things to do that you couldn't handle, it would be very discouraging for you.

Joining, empathizing, and subtly reframing.

Implying the counterfactual: "If this were to happen it would feel bad . . . (but it won't happen here)."

CLIENT: Yeah, or things I didn't want to do, like "Take this pill."

An underlying concern.

THERAPIST: You're wondering if the therapist might tell you to do things that didn't feel right to you.

Still too general for the client to feel understood.

CLIENT: I want to make sure that they would understand certain things about my life. I need them to not be telling me things about work or Johnny or his father that I can't do.

She really wants this therapist to understand, concretely.

THERAPIST: What would not be helpful would be for someone to say, "Just tell your

The therapist "gets it."

boss you need time off, and tell your son's father that he has to help you"—things like that.

CLIENT: Because that would just make things worse—create problems at work and more arguments with Johnny and his dad.

THERAPIST: Right. You're in this delicate situation. The therapist needs to understand and respect that. I'm wondering if you have any thoughts about how you could make sure the therapist understands?

Eliciting her ideas for solving the problem.

CLIENT: I guess I need someone who will listen to me. Someone who understands my situation. My mom doesn't even understand. She doesn't know what it's like to have no one who is really there just for you, to listen to you.

The client says what she wants from therapy, but not how to get it.

THERAPIST: So, imagine a therapist who is first going to sit down and listen to you and try to understand your situation, not offer advice or suggestions right away, but take the time to understand how difficult things are for you and the delicate situation you're in. If you knew you were coming to see a therapist like that, would that make it easier to make it here?

The therapist implicitly offers her what she is asking for . . .

. . . and then asks if this resolves the barrier.

CLIENT: Yeah, because I don't know how to get the energy to come to see someone if it isn't going to help. My situation is difficult. I'm not just making a big deal out of nothing.

Indirectly expressing recurring concern about being blamed or criticized.

THERAPIST: It's a bad situation and a delicate one. You feel like you're right at the edge and if you're not careful you could fall off.

Validates her perspective . . . but could have spoken to her anxious anticipation of being blamed.

CLIENT: Yeah, and I've got to do something to keep from doing that because I have to take care of Johnny.

Preparatory engagement talk.

THERAPIST: I'm hearing both things: it does feel important get help with this, to find something that is going to help you feel better; and, if there is something that you really believe is going to help you feel better, you'll probably be able to find the energy you need to get there.

Reframing summary, with the implication that "energy" is a metaphor for willingness or motivation.

CLIENT: I have to, because Johnny is difficult enough to handle when I am feeling good, and I'm afraid of what I might do.

Engagement talk.

THERAPIST: And what would take your energy away would be feeling like you were coming to someone who doesn't get your situation and understand how difficult it is.

Using her language.

CLIENT: Like that doctor who tried to give me pills. *A potent potential barrier to engagement.*

THERAPIST: You probably didn't feel like going back to see him at all.

CLIENT: No, I haven't gone back to him.

THERAPIST: What else can you think of that might keep you from coming in? *Asking for more barriers.*

CLIENT: Nothing, really.

THERAPIST: Some mothers we've worked with have identified some things that make it difficult for them to come in. Would it be all right if I mention these things just to see if they apply to you? (*Client nods*.) *Asking permission to explore other possible barriers.*

One thing that sometimes comes up is concern about whether a therapist *can* understand you, because of differences between you and the therapist or between the therapist's life and your life. Has that thought crossed your mind at all? *Probing for cultural barriers (which the client has not raised spontaneously).*

CLIENT: No. I just need somebody who will listen. As long as they are willing to listen, I think they could understand.

THERAPIST: It's not so important who the therapist is, their background, if they're a *Reflecting meaning . . .*

man or woman, white or black, rich or poor. What matters is how interested and willing they are to hear you and understand your situation and not impose their ideas on you.

. . . though also reflecting her wish to be heard without being blamed would have added to the impact.

CLIENT: Yeah, Johnny's pediatrician. She didn't have a life like mine. We didn't really talk about her life. She would just listen to me.

THERAPIST: It didn't look like you had similar lives. But that didn't matter because she cared and was willing to listen.

CLIENT: Yeah, and I guess I didn't really think about the rest of it.

And, in a case of a white therapist talking with an African American client:

THERAPIST: You're hoping that therapy might be helpful, and at the same time I still have this feeling that you're a little unsure.

Double-sided reflection to evoke unspoken barriers.

CLIENT: Well, I don't know…

THERAPIST: You know (*smiling*), I could imagine that one thing that might make you hesitate could be the idea of talking to a white therapist like me.

Broaching the subject of racial difference.

CLIENT: (*Nervous laugh.*)

THERAPIST: It's sometimes hard to talk

Normalizing.

about these things, but I've had other African-American clients say to me that they're not sure a white therapist could understand what their life is like.

Pulling for negatives.

CLIENT: Well, the doctor who gave me the medication was white.

Barrier emerges.

THERAPIST: And he really didn't understand what you needed.

Reflection of meaning (continuing the paragraph).

CLIENT: Yeah.

THERAPIST: So it would be important to keep this concern on the table.

CLIENT: I'm not too worried about it. You seem ok to me.

Tentative engagement talk.

THERAPIST: You've had some bad experiences with a white doctor before, but you feel comfortable talking with me right now.

Double-sided reflection, emphasizing the engagement talk.

CLIENT: Yeah. Everybody here has been pretty nice, actually.

Stronger engagement talk.

THERAPIST: I'm glad to hear that. At the same time, we'd really want you to tell us when you feel we're missing something or just not getting you, no matter what the reason.

Making it safe for the client to raise future cultural barriers or concerns.

CLIENT: Sure, I could do that.

Mobilizing engagement talk.

Eliciting Commitment or Leaving the Door Open

The therapist's final goal is to elicit commitment to treatment. This begins with a recapitulation: the client's perceived dilemma and change talk; the strengths she has shown in coping with challenges; objective evidence of "no-fault" depression and expressed ambivalence about seeing herself as depressed or coming for treatment; what the client most wants from treatment and the therapist and anything she does not want; and identified barriers to treatment participation and potential solutions. After providing information about the next steps in the treatment process, the therapist asks a "key question"—"How does this sound to you? Is this what you want to do?"—and listens for the opportunity to highlight commitment talk.

Whether or not the client expresses commitment to treatment, the therapist seeks to end the session on a positive note: taking a positive and inviting stance regarding the client's ability to participate in and gain benefits from treatment should she choose to participate; normalizing occasional struggles with treatment attendance; and offering hope by affirming the client's participation, reiterating the view of depression as a treatable condition, and expressing the belief that the client has already taken a first step toward feeling and functioning better.

THERAPIST: [Summary of the client's story, dilemma, and strengths, expressed need for change, feedback on depression, perceived disadvantages and barriers for treatment, perceived positives of treatment, and resolution of ambivalence toward treatment engagement] Is that a fair summary?

Recapitulation.

CLIENT: Yeah, I think it is. (*Pause*)

I would be taking a chance, I guess. *Not quite a commitment.*

THERAPIST: How are you feeling about taking that chance right now? *Key question.*

CLIENT: I need to find a way to deal with some of the problems I'm having. If it gets any worse, I might do something I'd regret. It's at least worth trying therapy to see if it will help. *Strong preparatory engagement talk.* *Mobilizing (commitment) talk.*

THERAPIST: There's a part of you that feels "I'm taking a chance here," and at the same time it feels like not taking that chance might be even more risky for you. *Double-sided reflection, ending with a gentle reframe.*

CLIENT: Right. I can't afford not to do something, so it's worth taking a chance.

THERAPIST: Got it. I can schedule you an appointment. Is that what you want to do? *Asking for commitment to treatment . . .*

CLIENT: Yeah. I think it would be good. *. . . and getting it.*

THERAPIST: Great. I'd like to mention a couple of things before we end. If you can't keep the appointment, we'd like you to call to let us know so that we can reschedule. At the same time, we know that sometimes things come up at the last minute and you might not be *Recalling the practical barrier and its solution.*

able to call. We understand that when people's lives are as stressful as yours, these things can be unavoidable. I don't want you to feel like you can't call later to reschedule.

Emphasizing the nonpunitive stance.

CLIENT: That's good. I do have a very busy life and things change at the last minute.

She appreciates this stance.

THERAPIST: I guess this seems especially important, because there is every reason to think that we will be able to help you. We have had a lot of success in helping moms like you in the past. And as you said, our therapy tackles just the kinds of problems you're having. And you're already working hard to make things better. So, we don't want you to miss this chance. (*Client nods, smiles*.) Is there anything else you'd like to ask about before we stop?

Expressing optimism about treatment success.

Affirming her efforts.

Eliciting questions/reactions.

CLIENT: No. I think I've got it.

THERAPIST: I'm glad you came in today. It's not always easy talking with a stranger about such personal things. I appreciate your trust. I think this went well, and that's a good sign for what's to come.

Ending with affirmation and optimism.

PROBLEMS AND POTENTIAL SOLUTIONS

Semistructured Intervention

A challenge in conducting semistructured interventions is to find the balance between adhering to the structure too rigidly or too loosely. The outline we provide represents an "ideal" form of the engagement session, and the structure is intended to ensure that the therapist accomplishes a set of tasks designed to enhance commitment to treatment. At the same time, the session should be delivered flexibly to meet the specific needs of each client. If a particular area does not seem relevant to a given 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. Being flexible may also mean that, in rare cases, the therapist may determine that the need for a given client to tell her story and be heard is so great that the bulk of the session must be given over to simply listening empathically. Delivering the engagement session in a rigid or "cookbook" fashion is likely to undermine its purpose of meaningfully engaging the client being interviewed.

Intervention Duration

The engagement session takes 45–60 minutes to complete. Factors that drive the duration of the interview include client style (loquacious vs. taciturn), mood disorder symptoms (psychomotor agitation vs. retardation), the number of treatment barriers, and the extent of client ambivalence about treatment. If pressed for time, the therapist should focus primarily on those aspects of the session that seem most relevant for a given client. For example, a client may come for therapy already well educated about the nature of depression, making extended psychoeducation redundant; another may have had positive treatment experiences for another condition, yet may never have been depressed before, requiring more focus on understanding

depression than on ambivalence about treatment. It is also important to explain the intervention duration to clients so that they allot enough time in their schedules to complete the interview.

Engagement Session versus Psychotherapy

Although the engagement session may be therapeutic for the client, it is not intended as psychotherapy but as a "pretherapy" intervention. Therapists who are unaccustomed to starting this way may be tempted to revert to a more familiar initial agenda—for example, taking a thorough history, making a final diagnosis, and establishing a treatment plan. The rationale for conducting an engagement session is simple: clients who are ambivalent about treatment may be more likely to drop out; in such cases, history taking, diagnosis, and treatment planning are premature. Investing a session in engaging the client prior to initiating the formal treatment process has the potential to get the treatment started on a more solid footing.

The Suicidal, Psychotic, or Agitated Client

Good clinical judgment supersedes all protocols. If the therapist observes acute suicidal ideation, psychosis, uncontrollable agitation, or another critical condition, intervention should focus on making arrangements for the client's immediate safety and an appropriate level of care. Zerler (2008) and Britton (2015) provide guidance on MI-consistent approaches for engaging suicidal individuals.

When the Engagement Session Therapist Is Not the Psychotherapist

In some settings, the individual conducting the engagement session may not become the client's therapist. Although it is optimal to arrange for continuity of care, it may not always be practical. In these cases, the therapist conducting the interview should align him- or herself with the prospective therapist (e.g., "It will be very important for us both to keep in mind that you felt intimidated by your previous therapist") and emphasize that he or she will communicate the

important aspects of the session with the individual's consent. It goes without saying that ensuring such communication is essential.

When the Engagement Session Is Not the First Encounter with the Client

In some settings, the first encounter with the client must follow external guidelines promulgated by the facility or by regulatory agencies. In these cases, therapists who want to enhance engagement have two options. Therapists may choose to look for moments in the standard interview in which they can insert elements of the engagement session—for example, while inquiring about previous treatment episodes, the therapist could ask what the client did and did not find helpful in each of those experiences. Alternatively, the therapist may conduct the initial visit in the standard way and then initiate an engagement session at the follow-up meeting. In these cases, the client is likely to have already articulated key elements of her story, and the admitting diagnosis may have been discussed. Rather than repeating this material, the therapist can begin by summarizing what has already been discussed and then either ask for elaboration (if this seems likely to deepen the encounter) or move on to the next phase of the session.

Using the Engagement Session Prior to Other Forms of Treatment

Although developed as a prelude to IPT-B, the engagement session seems easily transferable to other contexts. Many of the issues the session is intended to address are found frequently in treatment of persons with anxiety, substance use, and other disorders. O'Mahen and colleagues (2013) successfully added an engagement session to a CBT intervention for depressed perinatal women and we think it likely that therapists can adapt the intervention for use prior to other treatment modalities as well. The goal of helping clients to see how the help they want can be provided by a given treatment extends to multiple treatment approaches.

CONCLUSIONS

The engagement session has shown considerable promise. At face value, the MI, ethnographic interviewing, and psychoeducational strategies work well together to address common barriers to treatment. Women who have completed the session have consistently expressed the sense that it had helped them to clarify their treatment needs and goals and facilitated their participation in treatment. We have also trained numerous therapists from a variety of disciplines in both research and community settings to conduct the intervention, with good results. The engagement session is worthy of further dissemination to determine the extent to which the addition of an MI-based integrative engagement intervention can help to address the pressing problem of limited treatment engagement and participation among depressed individuals.

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[1] This manual is an expanded version of the following chapter: Zuckoff, A., Swartz, H.A., & Grote, N.K. (2015). Motivational interviewing as a prelude to psychotherapy for depressed women. In H. Arkowitz, W.R. Miller, & S. Rollnick (Eds.), *Motivational interviewing in the treatment of psychological problems* (pp. 136-169). 2nd Edition. New York: Guilford Press.

[2] Understanding and ability to make skillful use of the strategies and techniques of motivational interviewing is necessary for providing the engagement session. For more information see Miller, W.R. & Rollnick, S. (2012). *Motivational interviewing: Helping people change.* 3rd Edition. New York: Guilford Press.