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Motivational Interviewing:
Overcoming Disparities in Pharmacotherapy Engagement

Roberto Lewis-Fernández, MD[a,b,*]; Angela A. Coombs, MD[a,b]; Iván C. Balán, PhD[a,b]; and Alejandro Interian, PhD[c]

Racial and ethnic disparities in mental health care remain pervasive in the United States.[1] Health care disparities are differences in care that are not due to clinical need, appropriateness, or genuine care preferences.[1] Disparities occur in all aspects of care but are especially evident in treatment engagement, a multistep sequence that includes treatment initiation, participation, adherence, and retention. This complex process requires patients' acceptance of the need for mental health treatment, the ability to access and remain in care, good alliance and communication between patients and clinicians, and shared treatment goals.[2]

All racial/ethnic groups, including non-Latino whites, have limited engagement with mental health treatment. However, underserved racial/ethnic groups, including African-Americans and Latinos, show lower engagement than non-Latino whites in relation to acceptability of mental health care, care initiation, continuity of care, visit participation, medication adherence, and retention.[3–7] The 2000 Medical Expenditure Panel Survey, a national household probability sample of 1,347 depressed US adults, showed that, relative to non-Latino whites, the odds of initiating antidepressants among African-Americans and Latinos were 0.47 (95% CI, 0.30–0.73) and 0.47 (95% CI, 0.31–0.73), respectively, after adjusting for age and type of insurance.[5]

Unequal care is a major contributor to engagement disparities. Depressed African-Americans and Latinos are less likely than non-Latino whites to have access to care, be identified as depressed by their clinicians, engage in participatory communication during treatment, have sessions of equal duration, and receive guideline-concordant care in terms of dose, duration, or number of visits.[8–13] Clearly, implementing programmatic initiatives and specific interventions to overcome the many barriers to equitable care facing our health care system is an urgent need.

These barriers exist at the organizational, provider, and patient levels.[14] Some affect all racial/ethnic groups and/or represent general structural limitations of the health care system. But, at every level, additional barriers exist that limit engagement specifically among racial/ethnic minorities; these obstacles must also be addressed to overcome engagement disparities. Examples of these barriers include lack of appropriate language services and limited workforce diversity (organization); explicit and implicit biases and mismatched communication styles (provider); and higher stigma and mistrust, alternative views of illness and treatment, and lower acceptability of certain forms of care, such as psychiatric medications (patient).

To overcome these barriers, engagement-focused strategies and interventions have been developed at all levels, based on cultural/structural competence approaches. Two such interventions at the provider level that focus on patients' ambivalence about engaging in psychopharmacotherapy are Motivational Pharmacotherapy (MPT)[15,16] and Motivational Enhancement Therapy for Antidepressants (META).[17]

MPT and META apply motivational interviewing (MI) to help patients resolve ambivalence and problem-solve treatment barriers. MI is a highly collaborative interaction approach based on 4 processes: *engaging* the patient, *focusing* on desired behavior change, *evoking* and reinforcing "change talk"—a person's own stated reasons for wanting to change—and *planning* steps to achieve this goal.[18] MPT and META differ somewhat in their intervention structure. MPT integrates MI directly into the procedures followed by the prescriber to make all interactions MI-consistent while retaining the standard frequency and duration of psychopharmacotherapy sessions. In contrast, META adds 3 adjunctive MI sessions by a psychotherapist to the psychopharmacologic procedures, which are conducted in the usual way by the prescriber. Both approaches galvanize patients' internal motivation to feel better by systematically fostering change talk and minimizing explorations of "sustain talk"—reasons for nonadherence. Both utilize an empathic (ie, understanding the other's internal perspective)[18] and nonconfrontational approach to "sustain talk," sidestepping treatment resistance. With the aim of evoking motivation and self-efficacy for treatment and recovery, the clinician and patient collaborate with mutual expertise to arrive at treatment decisions: patients are the experts on their medication reactions, and clinicians are the experts on the medication itself.

MPT and META were developed for low-income, largely Spanish language–dominant Latino immigrants with major depressive disorder. In this population, ambivalence is heightened due to illness constructions inconsistent with antidepressant therapy and elevated concerns that medications are harmful or addictive.[19] Both interventions pursue cultural congruence with the values, attitudes, and illness representations common in many Latino individuals while personalizing care to each patient and not operating based on stereotypes. Cultural adaptations in MPT include using the patient's own illness terms, providing lists of concerns about antidepressants derived from qualitative data with Latino populations, and conducting confidence-building exercises tailored to low-income migrants, such as describing their efforts to arrive in the United States.[15] Examples of cultural adaptations in META include reframing antidepressant treatment to be more congruent with cultural values related to coping (eg, *poniendo de su parte* [doing one's part]) and use of *dichos* (sayings) to reinforce discussion.

Due to their MI base, MPT and META differ considerably from usual pharmacotherapy. We illustrate with some prototypical

[a]Department of Psychiatry, Columbia College of Physicians & Surgeons, New York, New York
[b]New York State Psychiatric Institute, New York, New York
[c]VA New Jersey Healthcare System, Lyons, New Jersey
*Corresponding author: Roberto Lewis-Fernández, MD, New York State Psychiatric Institute, Unit 69, 1051 Riverside Dr, New York, NY 10032 (roberto.lewis@nyspi.columbia.edu).

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exchanges, summarized from hundreds of examples. A typical non-MI pharmacotherapy session might go like this:

Patient: I have now been taking these medications for almost 10 days and I still don't feel any different.
Clinician: Sure, remember that these medications typically take a few weeks until they begin to work. Don't worry, keep taking them, and they should start working soon [*directing*].

Usual psychoeducation prioritizes prescriptive information-giving by the "expert" clinician without systematic engagement of the patient's emotional reactions to the treatment or its effect on symptoms. This approach risks evoking and deepening "sustain talk." MPT and META, conversely, follow the MI-consistent approach of prioritizing the patient's feelings through empathic reflection:

Patient: I have now been taking these medications for almost 10 days and I still don't feel any different.
Clinician: You're not happy about this. You've gone through the trouble of meeting with us, filling your prescription, and taking your medication and you really want to feel better [*empathy; reflection to evoke change talk*].
Patient: Yes, I definitely want to feel better. I hate feeling like this [*change talk*].
Clinician: This depression you are going through is really making a difference in your life [*empathy, developing discrepancy*].
Patient: I know, I've had enough, I'm ready for a change [*change talk*].

The MI-consistent approach enables the clinician to roll with the patient's resistance and minimize ambivalence about the medication. The example illustrates how this may lead to further reflection that heightens the discrepancy between the depression and the desired emotional state. Developing discrepancy is an MI technique to reinforce the person's awareness of the need to improve the situation. Change talk builds motivation to change and enables the planning component of MI, in which the focus shifts to exploring what patients need to do to bring the change about, such as by taking the medication regularly.

MPT and META follow an MI-consistent approach even when providing psychoeducation, called "Elicit-Provide-Elicit." First, the clinician *elicits* from the patient what the patient already knows about antidepressants. Then, after obtaining the patient's permission, the clinician *provides* more information. Last, the clinician *elicits* a response from the patient to assess how the information was received. Thus, in the example just presented, the clinician may choose to follow up the discrepancy-producing reflection by providing psychoeducation:

Clinician: What have you heard about how long it takes for an antidepressant to start helping? [*elicit*]
Patient: Well, when my sister took them, it took a little while.
Clinician: Yes, usually, we find that antidepressants start helping after about 3 to 4 weeks [*provide*]. What do you make of this, that they begin helping at about 3 to 4 weeks? [*elicit*]

Both MPT and META have shown initial efficacy. The pilot open trial of MPT (N = 50) focused on retention at 12 weeks, revealing low levels of discontinuation compared to historical controls at the same clinic (20% vs 36%–46%) among a traditionally underserved and resource-limited population.[16] Responder and remitter rates were 82% and 68%, respectively. The average session duration was 36.7 minutes for the initial visit and 24.3 minutes for follow-up visits. These data on session length illustrate that MPT sessions do not have to be longer than a typical pharmacotherapy session, which averaged 32–38 minutes in the United States in 1989–2006.[20] Results from a larger, randomized controlled trial (RCT) are being analyzed.

The pilot RCT of META (N = 50) assessed medication adherence using electronic monitoring. It revealed that META participants had significantly higher antidepressant adherence than usual care recipients at 5 weeks (72% vs 42%) and at 5 months (60% vs 34%). In adjusted analyses, META participants were significantly more likely to show symptom remission.[17]

In conclusion, MPT and META are promising manualized engagement interventions that combine MI and pharmacotherapy to overcome health care disparities. By paying close attention to the affective content of every exchange and to the goal of retaining the patient in care, the clinician helps evoke and strengthen the patient's own motivation to improve. Although initially developed for Latinos, MPT and META may be beneficial for many patient groups through simple tailoring procedures for a patient's culture and disorder(s). Other culturally and structurally competent engagement interventions are being tested at the patient, provider, organizational, and community levels.[21–23] Their initial successes provide the field with multiple tools to help overcome the persistent disparities due to race/ethnicity and other social stratifications that characterize our health care system.

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