

PRAGMATIC CASE STUDY ANALYSES OF MOTIVATIONAL INTERVIEWING WITH
DEPRESSED LATINOS

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ABSTRACT

Relatively little research has been conducted on improving adherence to treatment for Latino patients. Given the changing demands in the field of Latino mental health and the difficulties of treatment engagement and treatment retention with Latinos, finding effective mental health interventions is of utmost importance. The following study analyzes Motivational Interviewing (MI) techniques that have been used with depressed Latinos in an effort to increase their adherence to antidepressant medication and improve symptoms of depression. The analysis consists of a series of pragmatic case studies, which are intended to capture the contextual factors that contribute to either the success or failure of the MI intervention in facilitating medication compliance and that contribute to the manner in which psychological interventions can be adapted to special populations. The MI intervention involved two sessions delivered within a two-week time period and one booster session delivered approximately two months later. Throughout their participation in the study, participants were monitored with regard to their level of depression, motivation to adhere to their antidepressive medication treatment, and actual compliance in taking their antidepressant medication. In total, three subjects from the research study's database were selected for case study analysis: one who was found to have a positive outcome, one who was found to have a negative outcome, and one who was found to have mixed results with the MI intervention. The results suggest that while Motivational Interviewing has the potential to work as a treatment-enhancing intervention, its success in producing behavioral change largely depends on how well the techniques are adjusted to the individual's stage of change.

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CHAPTER I

Case Context and Method

Major depressive disorder has become a significant public health problem. The National Comorbidity Survey Replication reports that its lifetime prevalence has reached 16.2% and 6.6% in a 12-month period (Kessler et al., 2003). The National Institute of Mental Health (NIMH) indicated that more than 14.8 million Americans experience some form of depression in a given year and that depression is the leading cause of disability for people ages 15-44 (NIMH, 2008). Keller and Boland (1998) estimate that by 2010, depression will be the most costly of all illnesses worldwide.

While the effects of depression are wide-reaching, Latinos, have been identified as a particularly vulnerable population. They too carry high lifetime prevalence rates, with figures reaching as high as 14.8% for native-born Latinos, 5.2% for immigrant populations, 10.2% for urban populations and 6.3% for rural populations (Vega et al., 1998). Latinos face increased risk to mental health problems due to factors like alienation and isolation from their country of origin, acculturative stress, changes in lifestyle or environments, altered social support, fear of deportation, trauma due to immigration experience, discrimination, socioeconomic pressures, and increased likelihood to reside in communities with multiple risk factors for mental health problems (Miranda et al., 2003). Major depressive disorder, for Latinos, often co-occurs with other mental and physical problems like alcohol and substance use, domestic violence, anxiety, diabetes, and HIV infections (Rios-Ellis, 2005). Unfortunately, Latinos have difficulty

treating depression as they tend to underutilize services, have limited access to culturally and linguistically appropriate treatment, and have high drop out rates in mental health care (Atdjian & Vega, 2005; Rios-Ellis, 2005).

When it comes to the general treatment of depression, the American Psychological Association's Division 12 (Society of Clinical Psychology) has proclaimed several approaches as "empirically supported" including, behavior therapy, cognitive therapy and interpersonal therapy (Chambless et al., 1998). Despite the empirical support that these treatments have received, medication is the initial and most frequently prescribed form of treatment for unipolar depression in the United States (Antonuccio et al., 1995; Olfson, Marcus, & Druss, et al., 2002). Some treatment protocols, like the one issued by the American Psychiatric Association (1993), suggest that antidepressants are the only treatment for severe depression.

Difficulty with treatment engagement and non-compliance with pharmacotherapy has been found to be a major problem in the treatment of depression amongst inner city Latinos. With regard to treatment engagement, depressed patients struggle with various obstacles including "time and hassle" factors, lack of mental health insurance benefits or resources to pay for care, lack of access to transportation, inability to find appropriate childcare, worry or embarrassment about the illness or the treatment, previous negative experiences with mental health services, and mismatches between treatment offered and that desired (Swartz, H. A. et al., 2007). If they are successful in engaging in treatment, adherence to their prescribed medication can often present as an additional battle. In a clinic serving the mental health needs of monolingual Latinos of New York City, compliance with psychotropic medication was found to be less than twenty percent

(Opler, L. et al., 2004). Some of the reasons that led to poor compliance included lack of understanding as to why the medication was need and/or switched, lack of understanding of the medication's side effects, too disorganized to take the medication, distrust of the medical professional, shame and stigma, and cultural differences in conceptualization of the illness (Opler, L et al., 2004).

Fortunately, Motivational Interviewing (MI) has been effective in addressing difficulties with engagement and adherence to treatment. Originally developed by William Miller (1983), MI is a client-centered approach aimed to help people work through ambivalence and commit to change. The MI style is unique in that it is supportive and empathic, yet also directive (Miller & Rollnick, 2002). MI is brief in nature, can be delivered in one or two sessions, can be integrated into other therapeutic interventions, or serve as its own freestanding intervention.

A meta-analysis conducted by Hettema et al. (2005), found a .72 effect size with regard to Motivational Interviewing techniques applied to treatment compliance. A large percentage of the sample population for the 5 studies that were reviewed in this meta-analysis was either African American or Latino. This suggests that MI has the potential to be a particularly effective technique in improving treatment compliance with ethnic minorities. Hettema's meta-analysis also found that the effects of MI appeared to persist or increase over time when added to an active treatment, had a rapid impact within controlled trials, and had enduring effects when used as a prelude to treatment.

Other studies have also made a case for the integration of MI techniques for engaging depressed patients in psychotherapy and improving treatment participation. Swartz et al., (2007), argue that MI allows for an exploration and resolution of ambivalence which

ultimately facilitates treatment entry and adherence. It addresses both the patient-specific impediments to an alliance (i.e., ambivalence) as well as the clinician-specific barriers to treatment (bias).

While there seems to be a strong rationale for using MI to engage depressed patients in treatment and to improve compliance with treatment, relatively little research has been devoted to determining the effectiveness of MI in improving adherence to antidepressant medication amongst depressed Latinos. Alejandro Interian, Ph.D. at the University of Medicine and Dentistry of New Jersey, is currently investigating this via a randomized controlled trial. While the results of this study will yield information on the efficacy of the MI amongst depressed Latinos, little will be known about the mechanisms of change and the factors that lead to positive or negative outcomes with the intervention. As such, three cases have been selected for a pragmatic case study to capture the contextual factors that contribute to either the success or failure of the treatment.

The Rationale for Selecting These Particular Clients

To qualify for the larger randomized controlled trial, participants were required to meet DSM -IV criteria for either Major Depressive Disorder or Dysthymic Disorder within the last year. Participants were allowed to have co-morbid conditions, like anxiety or psychosis. However, those who had co-morbid substance abuse, alcohol abuse, or manic episodes within the last year were excluded. Additionally, those who were pregnant were excluded from the study.

The cases of “Lupe,” “Maria,” and “Ana,” were chosen for analysis because, respectively, they represented good examples of a positive outcome, negative outcome, and mixed outcome for the application of motivational interviewing to increase or sustain

adherence to antidepressant medication. These cases were distinctive for several reasons. First, each subject demonstrated noteworthy change with regard to level of depression [as measured by depression scores on the Beck Depression Inventory- II (BDI; Beck et al., 1996)] while participating in the research study (see Table 1 and Figure 1). Specifically, Lupe's scores very significantly subsided, Maria's scores at first substantially decreased and then to some extent increased, and Ana's scores did not significantly change.

In addition, each case's level of adherence to the antidepressant medication was noteworthy (see Table 3 and Figure 2). Lupe's scores were high at the beginning of the study and remained high, Maria's adherence scores fluctuated and lacked sustainability, and Ana's adherence scores started high and diminished towards the end. Finally, each case was selected for analysis because there was availability of rich qualitative information, and with the consensus of the research team, it was determined that these cases would facilitate an exploration of moderating variables that affected treatment outcomes as well as provide a good basis for comparison to other cases with different outcomes.

The Methodological Strategies Employed for Enhancing the Rigor of the Study

Several steps were taken to enhance the rigor of the treatment and preserve its validity. First, all participants in the study were randomly assigned to either the control group or to the intervention group. Random assignment allowed for the researcher to preserve internal validity as it controlled for variables like income, gender, level of acculturation, severity of depression, previous discontinuations of antidepressant medication, additional health problems, etc. In addition, the study employed standardized and reliable measures to determine extent of psychopathology, measure

severity of depression, measure change in attitudes toward antidepressant medication, and measure level of adherence. These measures included the Beck Depression Inventory-II (Beck, 1996), Attitudes towards Antidepressant Medication (Lin, Von Korff, & Ludman, 2003), Rating of Medication Influences (ROMI) (Weiden et al., 1997), and the Structured Clinical Interview for DSM- IV (SCID, First, Spitzer, Gibbon & Williams, 2005). Data on adherence to antidepressant medication was collected via use of a MEMS bottle (an electronic bottle which records each time the bottle is opened). Finally, the research assistants conducting the pre, post, and follow-up assessments were blind to participant's condition (either treatment or control). This minimized the amount of bias that could have occurred during the assessments.

The rigor of the study was also enhanced through the type and extent of training and supervision that the MI clinicians received. To start, the clinicians who delivered the Motivational Interviewing intervention were either advanced doctoral students or licensed psychologists. Each clinician attended a multi-day, off-site, MI training delivered by a Motivational Interviewing Network of Trainers (MINT) trainer (a trainer who has participated in Dr. Miller and Dr. Rollnick's training of trainers workshop). In addition, each clinician read Dr. Miller and Rollnick's book *Motivational Interviewing* (2002) to familiarize herself with the principles of MI, watched several video tapes of clinicians performing MI, and engaged in many role-plays to prepare for the MI sessions. While delivering the intervention, the doctoral students received face-to-face supervision with a licensed psychologist trained in motivational interviewing before and after each motivational interviewing session. All MI sessions were audio-recorded, which were then evaluated by a licensed psychologist and an MI consultant. They were rated with

the Motivational Interviewing Treatment Integrity scales (MITI), a measure of fidelity to the motivational interviewing approach (see Table 5). In addition, the clinicians received written feedback from the MI consultant as to how to improve on MI technique.

The Clinical Setting in Which the Case Took Place

The original research study was designed to recruit 60 Latino participants, ages 18 to 65. Participants were mostly monolingual Spanish speakers. A small minority of participants were English speaking or bilingual. Most of the participants were immigrants who came from disadvantaged backgrounds and who faced multiple psychosocial stressors. Typical stressors included unemployment, limited financial resources, history of abuse, neglect, or domestic violence, separation from family of origin and extended support network, lack of immigration documentation, and co-morbid psychiatric and medical illnesses.

Participants were recruited from a local community mental health clinic and were primarily referred by their psychiatrist or mental health clinician. A small minority of participants were self-referred via fliers that were posted around the clinic. Prior to participating in the research study, the participants were required to sign a consent form that was approved by the IRB of the University of Medicine and Dentistry of New Jersey.

Sources of Data Available Concerning the Client

Data for the study was gathered by bilingual (Spanish/English) research assistants and therapists. In addition, all questionnaires were available in English and Spanish. Data on adherence to antidepressant medication was collected via use of MEMS bottle (an electronic bottle which records each time the bottle is opened). Participants also completed several self-reported assessment measures including the Beck Depression

Inventory-II (Beck, 1996), a questionnaire about Attitudes towards Antidepressant Medication (Lin, Von Korff, & Ludman, 2003), Rating of Medication Influences (ROMI) (Weiden et al., 1997), and a self-reported medication-taking scale, and the Importance, Confidence, Readiness (ICR) ruler by Miller and Rollnick (2002). Motivational Interviewing Treatment Integrity scales (MITI) were used as a measure of fidelity to the motivational interviewing approach. Additional qualitative data was gathered from audio recordings of the narratives provided in the overview section, mood module, psychotic module, alcohol and substance use module of the Structured Clinical Interview for DSM-IV (SCID, First, Spitzer, Gibbon & Williams, 2005), as well as audio recordings of three motivational interviewing sessions.

In addition, the researcher conducted an exit interview with the participant. The purpose of the exit interview was to obtain a detailed, phenomenological “picture” of what it was like for the subject to participate in the study and to learn what kind of impact the treatment had on the participant’s life. Finally, since the researcher was drawn into intensive contact with the each associated case, data was also gathered from her role as a participant observer.

Confidentiality

To ensure confidentiality, names, nationality, and other specific identifying information have been changed. Nonetheless, the clinical reality of these cases has been preserved.

CHAPTER II

The Clients

Lupe, a Client with a Positive Outcome

At the time of the study, Lupe was a 46 year-old, married, monolingual Spanish-speaking Ecuadorian female with two children aged 13 and 23. She had graduated high school and immigrated to the United States at age 34. Lupe's first experience of depression occurred in her adolescence, at the age of 15, when she was raped. Shortly after this trauma, she attempted to burn herself by pouring alcohol on her body, but was found unharmed by her sister. Lupe's depression went untreated, and twenty years later, at the age of 35, Lupe's depression emerged again after emigrating from Ecuador to the United States. At intake into the study, Lupe met DSM-IV diagnostic criteria for a Major Depressive Episode with sub-threshold psychotic features (i.e., hearing her name being called, hearing doors open, hearing people talk when nobody is there).

Maria, a Client with a Negative Outcome

At the time of the study, Maria was a 30 year-old, monolingual Spanish-speaking Venezuelan female with a high school education. She had immigrated to the United States two and a half months prior to becoming a participant in the study. She was recently married and came to the United States to be with her husband, who was American. However, upon arriving in the United States, she learned that her husband had been having an affair and that he fathered another child. At the time of the study, Maria was living with friends and was unemployed. Maria met DSM-IV criteria for a Major

Depressive Disorder, Recurrent with Psychotic features. Her depressive symptoms had been persisting for about 2 months and amounted to intense sadness, feeling like a failure, loss of interest in activities that she used to find pleasurable, feelings of guilt, blame, and uselessness, low self-esteem, suicidal ideation, low energy and fatigue, inability to make decisions, and changes in her sleep and appetite.

Ana, a Client with a Mixed Outcome

At the time of the study, Ana was a 27 year-old, monolingual Spanish speaking Guatemalan female who was living with her partner and their two children, ages 5 and 3. She had achieved a fifth grade education before being pulled out of school so that she could work and contribute to the expenses of her family of origin. She had immigrated to the United States 8 years prior to her participation in the study. At intake, Ana met criteria for a diagnosis of chronic Major Depressive Disorder, complained of feeling depressed most of the day almost every day, wanting to be left alone to cry, loss of interest in spending time with her children, notable changes in sleep and appetite (i.e., gaining about a pound a week), low energy, psychomotor retardation, feelings of guilt and worthlessness, trouble concentrating, and suicidal ideation (i.e., thinking about walking into traffic with her children).

CHAPTER III

Guiding Conception with Research and Clinical Experience

The therapeutic model employed in this case was an adaptation of Motivational Interviewing (MI). Miller and Rollnick (2002) define motivational interviewing as a client-centered, evidence-based, directive method for enhancing intrinsic motivation to change behavior by exploring and resolving ambivalence. Building from Prochaska & DiClemente's (1984) transtheoretical model, MI rests on an assumption that ambivalence is normal; all clients are viewed as having reasons for *and* against wanting a particular behavior change. In addition, motivation for behavior change is not a dichotomous or linear process. It is a dynamic process in which individuals fluctuate through various stages of readiness for change (i.e., pre-contemplation, contemplation, preparation, action, and maintenance).

MI was originally developed within the field of addictions (Miller & Rollnick, 2002). It proved successful in helping clients move beyond their ambivalence and change their patterns of substance use. Since then, MI has been applied to a variety of clinical problems with favorable results. While the efficacy of MI in its pure form has not been extensively studied, adaptations of MI, which retain its core principles, have received significant empirical support. Noonan and Moyers (as cited in Miller & Rollnick, 2002) reviewed 11 clinical trials of adaptations of MI with problem drinkers and drug abusers and were able to find that nine of the studies supported the efficacy of MI for addictive behaviors. Similarly, Dunn, DeRoo and Rivera (as cited in Miller & Rollnick, 2002)

reviewed 29 randomized trials that incorporated MI interventions to affect substance abuse behavior, diet and exercise, HIV risk reduction, and smoking. They were able to find that 60% of the studies had at least one significant effect size for the adaptation of motivational interview. Furthermore, the effect sizes did not appear to decrease over time. Finally, as previously mentioned, when applied to improving treatment compliance, MI was noted to have a .72 effect size (Hettema et al., 2005). While MI demonstrated some effect across different problem areas, it continues to have the strongest effect with substance abusers. Nonetheless, these clinical findings suggest that MI carries great potential for successful adaptation to new domains like adherence to antidepressant medication and with different ethnic groups, such as Latinos.

Guiding Principles of Motivational Interviewing

Collaboration, respect for the autonomy of the individual, and compassion are all important factors that contribute to the “spirit” of Motivational Interviewing. Motivational Interviewing recognizes that the resources of change reside within the individual and strives to create a counseling atmosphere where clients are apt to express their intrinsic motivation for change and be the ones to generate the solutions. Miller and Rollnick (2002) argue that what people say about change predict subsequent behavior. Therefore, the ultimate goal of Motivational Interviewing is to elicit change talk so that the client can move closer to achieving his or her personal goals.

In general, Motivational Interviewing rests on four basic principles: 1. expressing empathy, 2. developing discrepancy, 3. rolling with resistance, and 4. supporting self-efficacy. The first principle, *empathy*, involves relating to the clients’ experiences from the client’s perspective, in contrast to relating to their experience from outside their

perspective (judgment). Empathy can be achieved by respecting and understanding the client's position. Once empathy is established and communicated, it is believed that the client will open up to the possibility of change. Miller and Rollnick (2002) advise that counseling in a reflective and supportive manner decreases resistance allowing for an increase in change talk. The second principle, *developing discrepancy*, refers to the belief that motivation for change emerges when clients' feel dissonance between their current behavior and their goals, beliefs, or values. The third principle, *rolling with resistance*, offers a way of avoiding the arguing or confrontation that can result when one considers change. If one were to get resistant in the face of potential behavior change, Motivational Interviewing interventions would aim to reduce the resistance, not by confronting it, but by shifting the focus, reframing the issue, agreeing with the client in a way that changes the direction of the conversation, or emphasizing personal choice and control. Finally, the fourth principle, *supporting self-efficacy*, refers to the confidence that is needed for a client to make a change. Self-efficacy can be supported through an honest belief that the client is capable of behavioral change if he/she chooses and commits to do so. For specific motivational techniques that were used throughout the sessions refer to Appendix A.

Nuts and Bolts of Each Session

Figure 3 presents a time line of the study, including the T1 assessment session at entry; the two MI interviews one and two weeks later, respectively; the second T2 assessment session at 2 weeks after the second MI session; the MI Booster Session and at three months; and the final T3 assessment and Exit Interview session at 5-6 months into the study. Throughout the course of the study, participants continued to receive their

“treatment as usual,” which for all participants included medication management. Some participants were also in concurrent individual therapy, with variation in the frequency and modality of the individual therapy.

The MI intervention was delivered through two phases, the motivational enhancement phase (session 1) and the commitment strengthening phase (sessions 2 and 3). In the motivational enhancement phase (session 1), the primary focus was on enhancing the client’s motivation, getting the client to argue for change, and helping shift his/her decisional balance towards change. During this phase of treatment, there was very little discussion on specific action; rather the emphasis was on helping the client resolve his/her ambivalence. The clinician was instructed to meet the client at his/her stage of change and gradually work towards eliciting and reinforcing change talk.

General tasks accomplished in Session 1 included: informing the client of what was going to be done in the session and providing him/her with the opportunity to choose how to proceed (agenda setting), understanding the participants’ depression, establishing the importance of solving the problem (i.e., improving depressive symptoms), determining the source of motivation for the client by understanding his/her values and goals, assessing motivation for use of antidepressant medication (by using the Importance/Confidence/Readiness Scale), exploring reasons for and against adherence by means of a decisional balance, collecting data on use of antidepressant medication (scanning MEMs container), providing feedback (i.e., reinforcement for days that medication was taken or exploration of reasons for days medication was not taken), and eliciting a preference to meet for a second MI session (see table 6).

The work of strengthening commitment to improve adherence for antidepressant medication occurred once the client was ready to take action (typically in session 2). If the client was not ready to change, however, the MI clinician was instructed to remain in Phase 1, continue to meet the him/her at his/her stage of change, and work towards helping the client develop more reasons for change. If the client was ready to take action, session 2 proceeded towards strengthening the client's commitment. In this case, session 2 focused on exchanging antidepressant information by 1. informally listening for/assessing antidepressant knowledge, 2. reinforcing what participants already knew, and 3. imparting information if necessary. Additional tasks included exploring experiences of non-adherence and relating those experiences to client's current plan (use of ICR ruler), framing adherence to medication as one way of achieving the client's goal, reflecting the other ways the client manages depression (i.e., attending therapy, accessing support network, positive thinking, exercise, behavioral activation, etc), eliciting self-efficacy for adherence, anticipating barriers to adherence and providing the client with a menu of options for addressing those barriers so that he/she can maintain the desired level of adherence, arriving at an adherence plan, and eliciting the client's commitment toward the plan (see table 7).

Finally, clients were offered a booster session (Session 3) which provided the opportunity for them to continue to strengthen their commitment, review progress toward their adherence plan, support follow-through with change, and problem solve any barriers to adherence that may have developed in the interim. If/when the client chose not to commit to taking the medication, the booster session shifted to reviewing his/her decision not to do so, considerations for taking medication in the future, providing information on

relapse as a result of premature discontinuation, and exploring other ways of progressing toward achieving his/her goals.

Adaptations of Motivational Interviewing for a Latino Population

There are a number of reasons which make MI an appealing intervention to use with ethnic minority populations, particularly Latinos. To start, its short term nature makes it a viable intervention for a population which experiences difficulty in accessing and engaging in treatment. In addition, MI can be considered appealing for Latinos because its use of empathy has the potential to reduce the stigma that many Latinos face. Finally, the treatment is tailored to one's individual needs, allowing for greater understanding and the potential for stronger alliances.

One way that the principal investigator of the randomized control trial adapted MI to the Latino population was by conducting a series of focus groups prior to the study. These focus groups allowed participants to share their experience with antidepressant medication and their experience with mental health services.

Cultural Values.

Through the focus group discussions, a series of important cultural values emerged that were helpful in informing the MI clinician about common sources of motivation. For example, several members of the focus group spoke about the importance of *trabajando* (working hard), *luchando* (fighting, forging ahead, surviving difficult times), and *aprovechando* (taking advantage of what is available). These values captured a theme of striving to improve the difficult circumstances encountered through migration stressors and poverty. Not only did

these values evoke pride for the participants, they also reflected the difficulties of their social reality. *Poner de su parte* (putting forth effort), was another important value that reflected an internal sense of responsibility for treating depression. Ways in which this sense of responsibility translated to action included seeking doctor's help, making appointments, exercising, utilizing social support, and engaging in pleasurable activities. Finally, *familismo* (familism), emphasized family relationships over other social relationships or individual needs, as an important cultural consideration. This served to orient the clinician to the family as either a source of psychosocial stress, support, and/or motivation. While one should not assume that each Latino ascribes to the same set of values, these common themes provided a culturally constant language that could be used during the MI sessions.

Outreach Efforts.

Since treatment retention rates can be low among Latino patients with depression (Miranda, Nakamura, & Bernal, 2003), the clinicians, in a MI spirited way, engaged in considerable outreach efforts. Contrary to the way treatment "as usual" is delivered, the adaptation of MI to the Latino population included multiple phone contact attempts, the use of confirmation phone calls, and reminder appointment letters. The MI clinicians encouraged the participants to be actively engaged in their treatment by empowering them to make their own decision about taking the medication. This was compatible with the cultural expectation of *personalismo*, where relationships with providers are personalized and involve trust (*confianza*).

Dichos (Sayings or Proverbs).

One final adaptation of MI for the Latino population was through the use of *dichos* (sayings or proverbs). *Dichos* were found to be consistent with the spirit of MI and effective in bridging the gap between the language of MI theory and the language of Latino culture. It has been noted that Latinos have an affinity towards *dichos*, and utilize them in times of turmoil to express their feelings and attitudes (Cobos, 1985). *Dichos* were recommended to be used with careful clinical judgment, only if it complemented the discussion, was well-timed, and effectively communicated the therapeutic concept. For example, the value of persevering forward (“luchando”) in the face of hardship, could be expressed in *dichos* like: *Camaron que se duerme, se lo lleva la corriente* (“The shrimp that falls asleep gets taken by the tide”) or *Grano a grano, la gallina llena el buche* (“Grain by grain, the chicken gets a mouthful) or *Para nadar hay que tirarse en el agua* (“To swim, one must jump in the water”).

CHAPTER IV

Assessment of the Client's Problems, Goals, Strengths and History

As part of the research study, clients participated in a standardized assessment process which was meant to screen for eligibility to participate in the study, evaluate the severity of the depressive symptoms, assess level of motivation to take antidepressant medication, and uncover the client's attitudes about taking antidepressant medication. Much of the information was gathered through the use of semi-structured interviews and self-reported assessment measures like the Beck Depression Inventory-II (Beck, 1996), a questionnaire about Attitudes towards Antidepressant Medication (Lin, Von Korff, & Ludman, 2003), Rating of Medication Influences (ROMI) (Weiden et al., 1997), a self-reported medication-taking scale, and the Importance, Confidence, Readiness (ICR) ruler (see Table 8) by Miller and Rollnick (2002). In addition, each client participated in follow-up assessments one month into the study ("T2" after two sessions of motivational interviewing) and then four to six months into the study ("T3" after receiving a booster motivational interviewing session). All the same self-reported assessment measures were repeated in the follow up assessments as a way of comparing and contrasting the client's change in depressive symptoms, motivation to adhere to the medication, and attitudes toward taking the medication. The time frame for the administration of the standardized assessment procedures is presented in Figure 3.

*Lupe**Background.*

Lupe was a 46 year-old, monolingual Spanish-speaking Ecuadorian female who immigrated to the United States at the age of 34. Lupe was married and had two children, ages 13 and 23. She was a high school graduate and had a degree in nursing. While living in Ecuador, Lupe practiced nursing for four years. When Lupe moved to the United States, she worked in a window factory for a few years, a pen factory for 6 months, and also part-time as a babysitter for six years. At the time of the first intake appointment for the research study, Lupe had been unemployed for 3 years. She and her husband depended on the \$1,200 they receive a month from his disability benefits.

History.

Lupe's first experienced depression in her adolescence, at the age of 15, when she was raped. Shortly after this trauma, she attempted to burn herself by pouring alcohol on her body, but she was found unharmed by her sister. Her depression went untreated for twenty years, and at the age of 35, it emerged again when she immigrated from Ecuador to the United States. Lupe's immigration triggered her depression because she left behind resources like her support system and family at a time in which she was trying to parent young children. She found herself facing new stressors and only had the support of her husband, someone whom she described as a possessive and abusive. She recalled him calling her "crazy," "Bipolar," telling her that she was worthless, and keeping her closed off to others.

Shortly after arriving in the United States, Lupe attempted suicide for the second time by putting acid on her hands and wrists. After this event, she was treated with

antidepressants (Zoloft). However, her depression worsened two years later when Lupe and her husband underwent a series of medical issues and surgeries. Her anxiety increased and she withdrew from others. It was at this time that she presented to the outpatient mental health center where she was officially diagnosed with depression and prescribed Lexapro. She continued with her course of medication for a few months but discontinued it once her insurance company stopped covering it. For the next five years, Lupe continued to battle depression with and without treatment. In January 2008, when the symptoms were no longer bearable, Lupe returned to the outpatient community mental health center and was referred to the research study.

At the time of intake for the randomized control trial, Lupe complained of feeling very depressed, tired, and sad. She had become increasingly aggressive, it was difficult for her to take care of herself (she would go two to three days without bathing), and she had lost pleasure in activities she had previously enjoyed (like babysitting children, regularly attending church, and having a sexual relationship with her husband). She had experienced changes in appetite (including significant weight gain of more than 100 lbs), changes in sleep, was unable to get out of bed for days at a time, cried all day in front of others, had difficulty staying focused, was forgetful and indecisive, and was feeling worthless, "like garbage." In fact, four weeks prior to her initial appointment, she experienced suicidal ideation which consisted of "wanting to die," thoughts of cutting her veins, and the desire to "get rid of everything." For Lupe, her suicidal ideation usually occurred in the context of fights with her husband or when she felt "low." Additionally, Lupe was having auditory hallucinations, including hearing her name being called, doors being opened, and voices in the absence of people. She worried that she was "going

crazy.” Aside from feeling anxious and depressed, Lupe complained of several health problems, including gastric pain, constipation, chest pain, liver problems, headaches, and arthritis. Lupe was diagnosed with Major Depressive Disorder and treated with 40 mg of Citalopram by her psychiatrist prior to being referred to the research study.

Status at Intake.

Lupe met DSM-IV diagnostic criteria for a Major Depressive Episode with sub-threshold psychotic features. She did not meet criteria for mania or alcohol/substance abuse disorders and thus qualified to participate in the study. On the Beck Depression Inventory- II (1996), a self-report assessment which measures different depressive symptoms, Lupe endorsed having the most difficulty with self-blame, appetite (I feel like eating all the time), irritability, feeling like a failure, difficulty with decision making, and lack of interest. Her sub-threshold psychotic features consisted of hearing her name being called, hearing doors open, hearing people talk when nobody is there.

Lupe’s stated goal for taking antidepressant medication was “so that it can try to help me a little bit with my depression.” Nonetheless, she faced the decision to take the medication (Citalopram 10mg) with great ambivalence. On the one hand, she felt as though it was very important to take and rated it a 10/10 on the importance scale. On the other hand, she had relatively low confidence in her ability to take the medication (4/10 on the confidence scale) and noted that she was not quite ready to take the medication (4/10 on the readiness scale). Most of Lupe’s ambivalence was attributed to concerns over weight gain, side effects, boredom with having to take so much medication, and feeling as though it was not very effective. In fact, Lupe reported that she was taking her

medication inconsistently, at times stopping when she felt better as well as stopping when she felt worse.

The initial assessment also revealed specific attitudes and concerns that Lupe had about the medication. She wondered whether she really needed the medication and felt as though antidepressant medication was not the answer to one's problems in life. She was concerned that it could be dangerous and that she could become addicted to the medication. The most influential reason for her to take the medication was that her doctor, therapist and family believed that she needed it.

Though Lupe had a significant history for depression, she also remembered periods of her life when she had adequate emotional and occupational functioning. During these periods, Lupe described herself as independent, someone who laughed all the time and sang songs at church. Lupe's main goal was to treat her depressive symptoms and return to the type of person she remembered being. Aside from mental health problems, Lupe reported a history of medical problems, including gastric pain, obesity, constipation, asthma, chest pain, liver problems, headaches, and arthritis. For these medical problems, Lupe took an additional four medications daily.

Maria

Background.

Maria was a 30 year-old, monolingual Spanish-speaking Venezuelan female who had immigrated to the United States two and a half months prior to becoming a participant in the study. She was recently married and came to the United States to be with her husband, who was American. However, upon arriving in the United States, she learned that her husband had been having an affair and that he fathered another child.

History.

While Maria's depression was not officially diagnosed until a few months prior to her participation in the research study, it appeared that her depression dated back to her adolescence. Maria disclosed that she first felt depressive symptoms at age 14 when she broke up with a boyfriend. Shortly after this event, she attempted suicide by drinking from a bottle of bleach. She received 2-3 sessions of treatment in her home country of Venezuela. A few years later, at the age of 17, she again felt distressed by "another woman who treated her poorly and said bad things about her." She attempted suicide for the second time by overdosing on Tylenol.

Learning that her husband of three years was carrying on an affair with someone in the United States, and that he had fathered another child, precipitated Maria's current depressive episode. Maria explained that she had married an American citizen and had maintained a long distance relationship with him with the intention of eventually immigrating to the United States to live with him. About two years into the relationship, Maria noticed that her husband started changing. He was ignoring her phone calls, was distant, less affectionate, and not providing as much financial support. She became suspicious that he was having an affair and began having nightmares. Around the time her visa was going to expire, she decided to come to the California (unbeknownst to her husband) to confirm or disconfirm her suspicion. Shortly after, she discovered his infidelity. According to Maria, all of her illusions about a future with him were destroyed; she was heartbroken and humiliated.

Since she had nowhere to turn, she stayed with her husband and his mistress for two weeks in their home until she could gather enough money to return to Venezuela. This

experience was incredibly difficult for Maria as she witnessed the way her husband doted on his mistress and their child, while he ignored her needs and pain. In addition, he was hurtful toward Maria, telling her that he no longer loved her, and that she “never knew how to make love anyway.” Maria felt alone, sad, and angry. She was hopeless about her future and wondered whether she would ever forget what he had done to her, be able to heal from this experience, and be able trust again.

Eventually, her husband made arrangements for Maria to stay with friends of his in Illinois. Maria’s depression worsened while she was staying with her husband’s friends. She began feeling suicidal and ended up being psychiatrically hospitalized. Even while hospitalized, she attempted to reach out to her husband, hoping that he would respond to her distress. Her outreach efforts failed as he hung up the telephone when she called. She asked him to pay for her antidepressant medications, but he refused. After being discharged from the hospital, Maria moved to New Jersey to be with another set of friends. She continued to be depressed, unable to eat and unable to attend to her activities of daily living (i.e., bathing and dressing). She was hospitalized for a second time, and upon her discharge, was connected with outpatient treatment at the community mental health center where the research study was taking place. The psychiatrist diagnosed her with Major Depressive Disorder and prescribed Lexapro (10 mg) and Abilify (15 mg).

Status at Intake.

At the time of the study, Maria was living with friends and was unemployed. She had a high school education and had worked as a seamstress for eight years, earning about \$1,300 to \$1,400 Venezuelan pesos per week.

Maria met DSM-IV criteria for a Major Depressive Disorder, Recurrent with Psychotic features. Her depressive symptoms had been persisting for about 2 months and amounted to intense sadness, feeling like a failure, loss of interest in activities that she used to find pleasurable, feelings of guilt, blame, and uselessness, low self-esteem, suicidal ideation, low energy and fatigue, inability to make decisions, and changes in her sleep and appetite. As for psychotic features, Maria endorsed auditory hallucinations (voices telling her to kill herself) and visual hallucinations (black spots that appeared when she was sad and having suicidal ideation). She stated that she got special messages or premonitions from God telling her why her husband was not calling her and that he was being unfaithful. She also endorsed some homicidal ideation (“bad thoughts of killing someone or choking someone”), but denied intent and plan. Maria noted that these psychotic symptoms only occurred in the last two months in context of her depression. She also disclosed a past history of suicide attempts, including once when she was 14 years old when she drank bleach and once when she was 17 years old when she overdosed on medication. Maria did not meet criteria for current mania or for alcohol/substance abuse.

At the time of her first appointment with the research study, Maria had been given a prescription for Lexapro (10 mg) and Abilify (15mg). She had a history of two prior discontinuations, the most recent having been due to bad side effects after 2 days of taking the Lexapro. She presented with ambivalence about whether or not to take antidepressant medication. On the Importance-Confidence-Readiness Scale (Miller & Rollnick, 2002), she rated the importance of taking antidepressants as a 10/10. She had

moderate confidence in her ability to take the medication (8/10), but was slightly less ready to take the medication (7/10).

Her main reason to take the antidepressant was to help her sleep. She was also somewhat motivated by having the doctor tell her that she needed to take the medication and by a fear of being re-hospitalized. However, she had serious concerns about the kinds of effects that the medication could have on her body. She had already experienced some side effects like nausea, dizziness, and stomach pain. In addition, she was concerned about whether or not the medication would cause lasting damage and whether she could become addicted to it. She had little faith that the medication would help her feel better and actually felt as though the medication would interfere in her ability to reach certain goals. She also lacked support from her family; they did not want her to be on medications. Finally, Maria faced additional obstacles to obtaining the medication including lack of insurance and limited income.

Maria's ambivalence about taking antidepressant medication was evident in her adherence behavior. At the time of the first evaluation, she admitted that in the last month, she tended to forget the medication, at times was not careful in taking the medication, discontinued when she began feeling better and also discontinued when feeling worse.

Ana

Background.

Ana was a 27 year-old, monolingual Spanish speaking Guatemalan female who had immigrated to the United States 8 years prior to her participation in the study. She lived with her partner, their two children (ages 5 and 3), her sister, and brother-in-law in a two-

bedroom apartment. Ana had a 5th grade education. She was pulled out of school so that she could work and contribute to the expenses of her family of origin. After immigrating to the United States she worked in a factory for about one year. At the time of the research study, she was unemployed and carrying for her children full time.

History.

Ana reported first experiencing depression during her young adolescence, at about the age of 11 or 12, when she became the victim of incest by her father. In addition, two other men sexually abused Ana during her adolescence. Ana remembered always “being sad,” lonely, and crying. She had intrusive nightmares and attempted suicide by overdosing on medication. Ana’s abuse lasted until she left home; however her depression persisted much beyond that time. She continued to fear men, especially when they were drunk. She also had chronic passive suicidal and homicidal ideation. In fact, when pregnant with her son, she considered ending her life by jumping off a bridge.

Ana was referred to the community mental health center after expressing suicidal ideation and thoughts of hurting her children while at a general medical check up at a community health clinic. Her only previous exposure to treatment had been two years prior when she saw a psychiatrist on two occasions. She did not take any medication at that time. By the time of the first interview with the study (T1), she had been re-engaged in treatment with a psychiatrist for 3-4 months and was taking Lexapro and Seroquel. Ana had no history of psychiatric hospitalizations.

Status at Intake.

Based on her history and current presentation, it appeared as though Ana met criteria for a diagnosis of chronic Major Depressive Disorder and Post Traumatic Stress

Disorder. At the time of the initial interview, she complained of feeling depressed most of the day almost every day, wanting to be left alone to cry, loss of interest in spending time with her children, notable changes in sleep and appetite (i.e., gaining about a pound a week), low energy, psychomotor retardation, feelings of guilt and worthlessness, trouble concentrating, and suicidal ideation (i.e., thinking about walking into traffic with her children). The depression had become so debilitating that she was having difficulty taking care of household chores and taking her children to school. In addition, her depressive episode appeared to have some mood-congruent psychotic features including auditory hallucinations and paranoid ideation. A Bipolar presentation was ruled-out as Ana did not endorse any manic or hypomanic symptoms. Finally, while she did not meet criteria alcohol or substance abuse at the time of the study, Ana admitted that she drank heavily from the age of 15-17 to numb the psychic pain of the sexual abuse.

At the time of the study, Ana had been taking 10 mg of Lexapro and 25 mg of Seroquel daily. Her primary motivation to take antidepressants was because she “did not want to remember the past” and wanted to feel better. She was influenced to take the medication by her relationships with her doctor and therapist, the desire to prevent depressive symptoms from coming back, and the belief that taking the medication would help her achieve certain goals or aspirations of her life. On the importance and confidence scales, Ana provided ratings of 10/10, stating that the medication and therapy were helping her feel better and reducing the amount of nightmares she was having. Nonetheless, she identified a few obstacles to taking the medication: difficulty remembering to take it every day, not having enough money or insurance to pay for the treatment (she depended on free samples to get the medication), and some concern about

becoming addicted. For these reasons, she provided a rating of 5/10 on her readiness to take the medication.

Most of Ana's attitudes toward the medication were positive. She strongly believed that antidepressant medication was an appropriate type of treatment for depression and that it could help her with her problems. She also believed that the medication could prevent symptoms in the future. Unlike other patients in the study, Ana did not face any resistance from her family for taking the medication nor did she believe that it would interfere with her ability to work. She was also willing to take it on a long-term basis and noted that in the 30 days prior to the study, she had been taking the medication whether she was feeling better or feeling worse.

Quantitative Data for the Three Clients

Quantitative data for the three clients at three points throughout the study on the BDI measure of depression and on adherence to medication can be found in Tables 1 and 3 and Figures 1 and 2, respectively.

CHAPTER V

Formulation and Intervention Plan

General Formulation across the Three Clients

All three participants met symptom criteria for Major Depressive Disorder at the time of the first assessment. While none of the participants had manic symptoms or co-morbid substance or alcohol abuse disorders, each one had other co-morbid psychiatric symptoms like those associated with Post Traumatic Stress Disorder (PTSD) or mood-congruent psychosis. The depressive symptoms were long-standing for each participant, with symptoms dating back as early as childhood or adolescence. In addition, each participant faced significant psycho-social stressors including immigration, acculturation, language difficulties, financial strain and limited support network. The stressors combined with the depressive symptoms resulted in considerable difficulty with occupational and social functioning for each participant.

Goals for the participants generally included “feeling better” and returning to a previous state of adaptive functioning. Nonetheless, they all had struggled with ambivalent feelings about the role of antidepressant medication as part of their treatment. The source of the ambivalence often ranged from unpleasant side-effects to lack of resources or information about the medication to fear of becoming addicted or dependent on the medication.

Specific Aspects of the Formulation for Each Client

Lupe.

Lupe's main motivation to treat her depression and adhere to her antidepressant medication was to feel more energetic and to be able to engage in life goals. She wanted to return to the person that she used to be, which for Lupe meant gaining independence, working, socializing more, and becoming a role-model to her children. The main barriers that had prevented her from treating her depression were lack of insurance, limited financial resources, and concern about medication side-effects (particularly weight gain). In addition, Lupe had recently faced psycho-social stressors including her son getting married and relocating to another state as well as her husband undergoing open-heart surgery.

Maria.

At the time of the study, Maria's depression was most influenced by a recent betrayal from her husband. Since she was acutely distressed, she was most motivated to move past the event. This included reducing her depressive symptoms (i.e., anhedonia, rumination, hopelessness, and suicidal ideation), gaining employment, and establishing a sense of independence. Maria's long-term goals included marrying, having children, and traveling. Her ability to "move forward" was guided by values like religion, faith, and a strong belief in taking care of herself. However, she too faced obstacles to treatment, such as lack of insurance and financial resources, sensitivity to medication side-effects like nausea, sleepiness, stomach pain, and lack of social support. In addition, her depressed mood, in and of itself, presented as an obstacle to treatment.

Ana.

Ana's presentation was complicated by co-morbid PTSD. She had been the victim of childhood incest at the hands of her father as well as repeated sexual abuse by other men. As a result, her depression was characterized by intrusive nightmares, flashbacks, and chronic suicidal and homicidal ideation. Her main goal was to leave her past behind her and move forward by cultivating her identity as a mother, a spouse, and an independent woman. She was motivated to have symptom-free days. Ana's main barrier to adhering to the antidepressant medication was forgetfulness and confusion over whether or not she had taken the medication on a given day. She was also significantly socially isolated and experienced shame and stigma over her mental illness. Nonetheless, at the time of the research study, Ana was participating in concurrent intensive individual psychotherapy, from which she derived a great deal of support and insight.

Intervention Plan

Motivational Interviewing was chosen as the treatment modality because it has shown to be effective in increasing engagement and adherence to treatment (Hettema et al., (2005). It was applied to the Latino population because its short term nature made it a viable intervention for a population which experiences difficulty in accessing and engaging in treatment. In addition, its use of empathy had the potential to reduce the stigma, a cultural barrier that many Latinos face when first encountering mental health treatment.

The treatment plan included three sessions of Motivational Interviewing intended to help participants work through their ambivalence about their antidepressant medication. The primary focus of the first session, which was delivered one week after the initial

assessment, was to enhance motivation for adherence to antidepressant medication (see table 6 for components of the first session). The primary focus of the second session, which occurred the week after session 1, was to strengthen the participant's commitment to adhere to her antidepressant medication (see table 7 for components of the second session). The goal of the third MI session, which occurred two to three months later, was to problem-solve barriers to adherence and consolidate gains. Additional treatment goals were tailored to each individual case, but often included aligning "treatment as usual" to the participant's values, reducing depressive symptoms, resolving suicidal ideation, improving ability to achieve goal related tasks (i.e., employment), reducing anxiety, and addressing loss, grief or a history of traumatic experiences.

Via the MI session, the participants had the opportunity to explore the reasons for and against taking the medication in the presence of an empathic clinician who could amplify their experience and guide them toward creating a plan of action that was aligned with their goals and values. The reflective and supportive stance of the clinician allowed the participants to begin to relinquish their resistance while, at the same time, increase their "change talk" and the potential for adaptive behavioral change. As participants got closer to resolving their ambivalence, they were more likely to become behaviorally activated toward taking their medication. This ultimately resulted in a reduction of symptoms, a greater sense of agency in one's treatment, and positive reinforcement which served to strengthen to behavioral change.

CHAPTER VI

Course of Motivational Interviewing Intervention

Lupe

First Session.

It is not surprising that Lupe was responsive to motivational interviewing. To start, Lupe immediately fostered a strong working alliance with the treatment team. Even prior to meeting with the MI clinician, it appeared as though Lupe carried positive expectations into the experience. The research assistant had made extensive outreach efforts to recruit and engage Lupe in the study, which made her feel as though someone cared about her. This in turn, became a motivating factor for improving her adherence to her treatment. In her own words, Lupe stated:

Pues me sentí un poquito mejor porque ella (research assistant) me dio animo. Yo siento que es bien, bueno, yo siento que estas terapias son buenas, ayudan bastante...

Well I feel a little better because she (research assistant) gave me strength and I feel that it is good, I feel like these therapies are good, they help a lot...

Not only was the strong therapeutic alliance evident from Lupe's statements, but a careful review of the transcript from the first session also revealed that Lupe and the clinician were well attuned to each other. In fact, they were finishing each other's sentences. This type of attunement demonstrates that MI was well at work. The following excerpt is from the first two minutes of the session:

Lupe: ...pero por lo menos me siento, mucho menos (mal) de lo que estaba antes, amm, pues me da un poquito de animo en el día pa'trabajar, con, con unas (medicinas) que me mando para dormir, duermo mejor, y, y así, no te voy a decir que me siento alegre alegre, pero estoy comenzando a tomarla

MI Clinician: Poquito a poquito

Lupe: Poquito a poquito... porque por lo menos antes estaba bien triste, ahora me siento un poquito mas contenta...

Lupe: ... but at least I am feeling less worse than before, amm, I have a little bit more energy to work during the day with some of the medicines that the doctor gave me to sleep. I'm not going to say that I feel happy happy, but I'm starting to take them

MI Clinician: Little by little

Lupe: Little by little...at least before I was sad, but now, I am a little bit happier.

In addition to building a strong working alliance to the treatment providers, Lupe seemed to present to the initial session with a high level or “readiness” for change. Lupe easily recognized that depression “changed her as a person” and was eager to return to the type of person she had been “before.” By inventorying what her experience was like while depressed, the MI clinician learned that Lupe cried all the time, was aggressive with others yet passive in getting her needs met, contemplated suicide, full of self-doubt, and kept isolated. This state greatly contrasted to the type of person she remembered being, one who was independent, laughed all the time, sang songs at church, was able to care for children, and who “knew how to do more than just household chores.” Contrasting these distinct states created dissonance for Lupe, which served to fuel her motivation to return her to a “healthier” self.

The clinician also spent much of the first session guiding Lupe in talking about and identifying her values so that they could be woven into the MI and produce more meaningful interventions. Lupe’s values included being able to work, independence, belief in God, and being a strong example for her children. Once these values were identified, the clinician linked them to her goals: returning to her former self, obtaining her driver’s license so that she could achieve independence, gaining employment so that

she could be in charge of her own finances, and practicing assertiveness with others, particularly with her husband.

One of the most striking aspects of the first session with Lupe was the extent to which she was engaging in “change talk,” a phase of MI which usually takes time to develop.

Lupe stated,

Saber que yo puedo, si yo siempre he podido. ¿Porque no ahora? Caí en este trato, pero yo pienso que voy a salir.

Know that I can, if I have always been able to. Why not now? I fell into this, but I think that I'll get out.

In addition to engaging in change talk, she spoke with confidence and a sense of self-efficacy. She began remembering instances where she succeeded, people who believed in her, and moments in which reducing her depressive symptoms had given her good results. Ultimately, she was fueling her motivation to keep her depressive symptoms at bay and “work” her treatment for the sake of her future, her children, and her family.

The first session concluded with an analysis of the role that medication had on her symptoms. Lupe was able to identify that the medication helped her feel more lively, and it reactivated her desire to engage in activities that she found pleasurable, like going to church and grooming herself. Lupe also acknowledged that medication was just one part of her overall treatment. In essence, it reduced her symptoms just enough to allow her to do the things that she wanted to do, leading to a surge in positive reinforcement and an improved sense of self. Lupe rated medication with high importance, and talking about its importance prompted her to remember her routine of taking it every morning. In addition, she asserted great confidence that she could take it as prescribed. She cited that the only barrier to taking the medication would be if her insurance changed, in which

case, she would ask for the medication to be changed. When Lupe received feedback from the MEMs monitor, she was able to praise herself for doing a good job. Taken together, her ability to identify the components that helped her “fight” the depression, coupled with her high ratings of importance and confidence toward taking her medication, served to fuel her motivation and adherence to treatment.

Second Session.

At the time of the second session, Lupe continued relishing in self-confidence and motivation to rid herself of the depression. The MI clinician managed to deepen Lupe’s motivation by linking it to religion, culture, and eventually her own self-efficacy (i.e., her belief that through her own effort she could take care of herself and evolve into the person she would like to become). Lupe began the session by immediately launching into her progress toward becoming healthy, which in this case, included returning to being an active member of the church. This prompted a discussion about the role of God and prayer (one of Lupe’s values) in helping her *seguir adelante* (move forward).

To sustain Lupe’s gains, the MI clinician also added Lupe’s efforts or *poniendo de su parte* as a critical factor from which her motivation was rooted. He noted that much of her success was due to the decisions she had made and the effort she had put forth in seeking help, albeit an uncomfortable process. Lupe confessed that at one point in her treatment, even though she was taking the medication, she was being inconsistent, and she “didn’t care about returning to the doctor.” She recognized that these types of decisions prevented her from moving forward. The clinician highlighted her positive efforts through a MI technique called “reflection with a twist,” and stated,

Uno diría bueno, el medicamento ayudo pero, usted, usted fue la que tuvo que salir a buscar el medicamento.

One would say the medication helped, but you, you were the one who had to go out and look for the medication.

This type of internal attribution helped build Lupe's confidence and sense of self-efficacy.

During this session, the MI clinician also touched on culture by incorporating the use of *dichos*, ultimately making the interventions more meaningful for Lupe. The two *dichos* that he introduced are "*A quien madruga, Dios le ayuda*" (God helps he who rises to the occasion) and "*Grano a grano, la gallina llena el buche*" (Grain by grain, the hen fills up her mouth). Lupe's efforts, her "can do" attitude, and her belief in God were infused in a way that was culturally and religiously consonant. She responded positively to the use of *dichos* and even added one of her own "*Todo lo puede Cristo como lo fortalece*" (All that Christ can, he strengthens). This demonstrated that the clinician and the patient were well attuned to each other; they were moving at the same pace and in the same direction.

Aside from reinforcing Lupe's gains, the second MI session focused on identifying the work that was "left to be done" and Lupe's concerns about experiencing a relapse of depression. Again, Lupe's was in an action-oriented stage of change, where she was ready to problem solve and full of change talk. Lupe made assertions like, "My attitude toward life is changing," and "I'm doing the things I have to do, and I am feeling differently." She recognized that if she were to relapse, it would probably be temporary, and it would not mean that she would lose all the gains she had made. She articulated a relapse prevention plan that included continuing with her medication until she regained

enough strength. Lupe also stipulated a plan to seek out psychological treatment if she were to experience worsening depressive symptoms. Lupe addressed her experiences of discontinuing medication prematurely in the past and acknowledged that it quickly led to an increase in depression. Finally, she included the need to have support from her family, be connected to treatment providers, and feel close to her “home country” as part of her relapse prevention plan. Lupe and the MI clinician determined that her move to Miami would serve as a protective factor as she would have the support from her son and be immersed in the Latino culture. This type of discussion worked to solidify her motivation by empowering her to handle any backslides or relapses.

The topic of premature discontinuation of medication was given special attention in the second session, especially because Lupe felt some ambivalence about this topic. On the one hand, she wanted to have a trial period of not using medication to see what would happen. On the other hand, she was afraid that discontinuing prematurely would lead to a surge in symptoms, and she did not want to return to that state of suffering. Ultimately, she recognized the “danger” that could occur from stopping her medication, stating that it was a risk she did not want to take. Furthermore, she reconfirmed a willingness to “put forth her part,” which in this case meant taking her medication as indicated or for at least six months after her symptoms remitted.

The MI clinician continued to engage in motivational interviewing by anticipating potential barriers that would keep Lupe from taking her medication. They began by addressing previous barriers, which in Lupe’s case, included not having medical insurance to pay for the medication. Instead of offering Lupe solutions to these problems, the clinician built her sense of self-efficacy by eliciting what information she

knew about programs that help for people who lack prescription coverage. She remembered hearing about a discount program at Wal-Mart and was able to ask the clinician more questions about how the program works. She walk away feeling more confident and more informed about how to manage this type of barrier, should it present itself in the future. Furthermore, she was prompted to think about how she could find a psychiatrist and a psychologist once she moved. This way, she could ensure continuation of care and work towards preventing a relapse of depressive symptoms.

Another potential barrier that Lupe identified was the anticipated adjustment to moving to Miami. After all, it was Lupe's move to the United States that triggered her depressive episode. Nonetheless, Lupe was able to problem solve this barrier by recognizing that she was resilient and had experience adapting to new environments. She was excited to be surrounded by more family and cultural comforts. The move to Miami signified a return to feeling connected to others, something that for Lupe had the potential to improve her quality of life.

Lupe also revealed her concerns about side effects from the medication, in particular, weight gain. The MI clinician noted the ambivalence around not wanting to gain weight (she was already 300 lbs) but also not wanting to relapse into a deeper depression. Instead of advising Lupe, he solicited her thoughts on the issue. She was able to come up with sensible solutions (exercise, eliminating sweets, and reducing caloric intake) to alleviate her concerns about weight gain without having to discontinue the medication. Together they also explored the option of asking the doctor to adjust her medication should the weight gain continue.

The second session concluded by scanning Lupe's MEM's bottle. Again, she received the feedback that she was taking the medication with 93.5% adherence. This compares to the mean of the treatment group of 75.8% (see Table 4). She confirmed the importance and confidence which she placed on taking the medication as a 10/10, stating that she "will continue to fight to have the medication no matter where she is."

Unfortunately, due to Lupe moving out of state, she was unable to participate in the third MI booster session.

Maria

First Session.

In her motivational interviewing sessions, Maria presented with some difficulty in forming a rapid therapeutic alliance. While she was very cooperative with the clinician, she appeared somewhat indifferent, deferential, slower than Lupe to warm up, and frequently offered one-word responses to the clinician's questions. The clinician attempted to engage Maria in brief chit-chat at the beginning of the MI session as a way of building rapport. In addition, the clinician attempted to empower Maria to take the lead in the session by offering her a menu of options and asking her how she would like to proceed with the session. Despite these interventions, Maria depended on the clinician to guide the session.

Maria was most open when talking about the events that led to her recent bout of depression. After all, she was consumed with very strong emotion since she had recently discovered that her husband had been unfaithful and had fathered someone else's child. Maria spent much of the first part of the session providing the details and the chronology of the affair. She explained that while they were in a long distance relationship, he would

visit her frequently and tell her that he wanted her to come to the United States so that they could buy a house, have children, and build a future together. She noted that he treated her well throughout the course of their relationship; he was attentive and generously sent her money. Maria then described how she became suspicious of her husband once she noticed his behavior changing. According to Maria, he started calling her less, stopped sending her money, and responded evasively to the idea of her coming to the United States once her visa was expiring. She shared her reaction to learning about the betrayal and the feelings of humiliation, sense of worthlessness, disappointment, and hopelessness that followed.

Throughout Maria's account of the affair, the MI clinician asked clarifying questions and validated her experience by providing reflective statements and being empathic. The use of complex reflections, which are meant to validate and amplify the patient's experience, proved to be fruitful in broadening the scope of the discussion. Maria realized that beyond being affected by her husband's betrayal, she was questioning whether she would ever be able to heal from this event and learn to love and trust again.

Maria: Y pienso que esto como que nunca lo voy a olvidar. Me va costar. Lo que me paso, lo que el me hizo. Porque yo creía en el plenamente. Lo mas lejos que yo tuviera es lo que el llevo hacer.

Clinician: Entonces tienes ese temor de que ha sido como, una herida tan, tan grave y tan onda que, nunca vas a sanar.

Maria: Pienso eso. ¿Como voy a estar? Con ese dolor y pensando, en todo lo que el me hizo. Porque yo confiaba en el y de la manera en que el me trataba. Pienso que si el, que decía que me quería mucho, me hizo eso, que no me hará otra persona que no me quiera.

Maria: And I think that I may never forget this. It will be very hard. What happened to me, what he did to me. I unequivocally believed in him. It was the furthest thing I thought, he managed to do.

Clinician: Then you have this fear that you will never heal from a pain that has been so great and so deep.

Maria: I think that. How will I be? With that hurt and those thoughts, all that he did to me. Because I trusted him and the way that he treated me. I think that if he told me he loved me a lot and he did this to me, what would someone else do who does not love me?

To shift from talking about Maria's distress from the betrayal, the MI clinician asked Maria how she was doing now that she was living in a different part of the country, away from her husband, and receiving the support of friends. Maria acknowledged feeling less lonely. She also reported that he was better able to attend to her activities of daily living and that she was comforted by being surrounded by people who responded to her needs. In addition, she identified an important goal (being able to have enough money to live independently) and an important value (her faith in God). With regard to her belief in God, Maria admitted that upon learning about her husband's affair, she lost all her faith and began to question whether this was a punishment from God. Nevertheless, she expressed an interest in recuperating her faith so that she could "return to be the person she used to be." Upon further questioning, the MI clinician learned that Maria aspired to once again feel happiness and optimism, to no longer be apathetic, and to return to attending church and practicing prayer. To elicit additional values and goals from Maria, the MI clinician asked an effective, yet provocative question: "How would your life be different, if you were not depressed like you are now?" Maria noted that ideally, she would be working, studying English, spending time with her husband and cooking.

Once identified, the MI clinician was able to build on Maria's values and goals to leverage her motivation for improving her depression and adherence to her treatment. In particular, the MI clinician linked Maria's faith in God to her willingness to seek treatment and begin the process of helping herself. Maria expanding this concept by stating that God had not forgotten about her. Instead, he "found people to help her,"

including the friends with whom she was currently living with. The MI clinician validated Maria for being able to accept the help that had been offered to her, despite feeling badly. This allowed her to feel more empowered and permitted for internal attributions of success. The ability for the MI clinician to shift attributions from being external to internal adherence supports the MI principle of building self-efficacy.

Maria and the MI clinician then explored the effect that the antidepressant medication had on her overall treatment. Maria acknowledged that she responded poorly to the first course of antidepressant treatment. She discontinued it after a few weeks because she felt nauseous, stomach pain, dizziness, increased anxiety, and could not sleep well. Nonetheless, Maria was willing to talk to the psychiatrist about these side effects and try a different class of antidepressant, one that so far, produced less side-effects and helped her feel “a little bit better.”

As a way of expanding the discussion on side-effects and providing some psycho-education, the MI clinician elicited the information that Maria already knew about medication and then asked permission to provide additional information. The MI clinician was able to inform Maria that the side-effects from the antidepressant medication typically last for 3-4 weeks, until one’s body can begin to acclimate to the medication. She also provided psycho-education on the best way to take the medication and the effects that it can have on one’s mood and state of mind.

Having received more information on antidepressants, the MI session then proceeded by expanding on Maria’s ambivalence about the medications. Together, the clinician and patient explored her reasons for having decided to try another course of medication despite having had such a negative experience with the original medication, Lexapro.

Maria admitted that she “hit rock-bottom” during her period of non-compliance, experiencing extreme sadness and inability to sleep. The clinician again reflected Maria’s desire to “feel better” and her wish to “return to the person she used to be” as the motivating factors that helped her decide to take a chance on a new course of medication.

Since an obvious barrier for Maria’s adherence to the treatment was negative side-effects, the MI clinician explored what would happen if Maria began to re-experience side-effects while on the new course of medication. At this point, Maria’s ambivalence was most evident as she responded that she did not know whether she would discontinue the medication or continue to take it. The MI clinician reminded Maria that in addition to choosing between stopping or continuing the medication, she could also talk with her doctor and explore another change in medication, as she had done before.

Aside from dealing with the side effects of the medication, Maria expressed concern about becoming dependent on the antidepressant. The MI clinician dealt with this concern in a similar manner, first by asking her what she knew about this issue and then by providing additional information to clear up misconceptions. This modeled for Maria the importance of acquiring accurate information in order to empower herself, resolve ambivalence and move towards her goals.

The session concluded with Maria’s ratings of the importance she places on taking the medication (7/10), her confidence in taking the medication (3.5/10), and her readiness to take the medication (7/10). Maria explained that her relatively high rating on the importance and readiness scales was being driven by her wish to “feel better.” Her low rating with regard to her confidence in taking the medication was largely attributed to her

doubts about the side-effects. Nevertheless, Maria acknowledged that if she were to begin to see positive effects of the medication, it would increase her confidence.

Interestingly, following the “importance/confidence/readiness” conversation, Maria did not respond with the expected surge in motivation or increase in change talk. Instead, her depression appeared to worsen as she returned to talking about her lost dreams, her loss of faith, and questioning how God could let her suffer to the extent that she had. This forced the MI clinician to rebuild Maria’s motivation by validating her pain and reminding her of the action she had taken to move past her depression, including calling 911 when she felt suicidal and coming to the various therapy sessions. However, Maria did not respond positively to the clinician’s interventions. She was consumed by her depression and began to express suicidal ideation (“I wish God would come find me and take me”). This led the MI clinician to conduct a thorough risk assessment. While Maria was deemed safe enough to leave the clinic, the risk assessment revealed additional obstacles to Maria’s treatment including lack of money and insurance.

Second Session.

The second MI session began with Maria reporting improved mood, improved compliance with the medication, a resurgence of prayer and faith, and no side effects from the new class of antidepressant (Cymbalta). She credited God, the medications, and her MI sessions for helping her “feel better” and begin to regain the confidence she needed to pursue her goals. In fact, Maria noted that during the course of the week, she was able to go out to eat with friends and search for employment.

The MI clinician effectively reflected the apparent contrast in Maria's presentation from the previous week and inquired how she was able to produce such a dramatic turnaround:

Veo la diferencia, en que me esta diciendo que 'me siento mejor, estoy tomando mi medicamento como debe ser, no me esta sentando tan mal, y busque trabajo y encontré uno.' Eso es tremendo... y eso, lo hizo usted, nadie se lo hizo, pero usted mismita. ¿De donde saco esas fuerzas?

I see the difference in what you are telling me... that you feel better, are taking your medication like you should, not feeling so bad, and that you looked for a job and found one. That is tremendous... and that, you did by yourself, nobody but you. Where did you get the strength?

This led to a dialogue on Maria's sources of motivation (i.e., her friends and God) and her goals (helping herself, helping her mother, achieving independence, feeling comfortable). While Maria continued to feel the pain of her recent betrayal, she and the MI clinician were able to observe that the pain did overpower her or keep her from moving toward her goals. Furthermore, Maria noted that the busier she was, the less time she could spend ruminating over her husband. Throughout the session, the clinician specifically focused on Maria's personal strength and the steps she had independently taken to move forward (e.g., following up with her charity care applications, obtaining employment, taking her medication). Interestingly, instead of feeling empowered, it appeared as though Maria was uncomfortable with this level of validation. She responded by minimizing her achievement, stating that she still had periods in which she was suffering, and attributed any success to an external source (God helping her feel better). She also began to question "Why me?" and wonder whether she deserved this type of punishment.

As in the case of Lupe, the MI clinician incorporated the use of *dichos* as a way of addressing Maria's faith and level of self-blame. The clinician asked Maria if she had heard of the *dicho* "*Dios aprieta pero no ahorca*" (God squeezes but does not choke). In part, this *dicho* stimulated hope within Maria as she remembered that there is "always a way out of a situation." Unfortunately, Maria did not completely respond to this intervention. She was resistant and pushed against the clinician's efforts to expand her hope. She questioned whether this *dicho* really applied to her since she had already lost her faith. The clinician and Maria remained stuck in the resistance by arguing about the extent to which she had or had not lost her faith.

As a result of much resistance, the MI clinician was unable to move toward the expected tasks of a typical session 2, like strengthening commitment to improve adherence for antidepressant medication. Instead, she returned to many session 1 type objectives, such as understanding Maria's course of depression, solidifying her source of motivation, and assessing the role that antidepressant medication played in her overall treatment. The clinician asked provocative questions like: "Why did you decide to turn to God again if you had lost your faith?" or "Where do you see yourself in the future (e.g., in a week or in a month)?" and "What are your good days like?" These questions were useful in drawing out Maria's values, goals, and sources of motivation.

Of interest, Maria noted in the second MI session that her new course of medication was helping her and not producing any negative side-effects. Nevertheless, she continued to be concerned about becoming dependent on the medication and the long-term effects that it could have on her body. As in session 1, it became clear to the clinician that Maria had many questions about the medication. While the clinician continued to offer some

information and clear up misconceptions, she also worked toward empowering Maria to take a greater interest in learning about the medication and share her doubts or questions directly with the psychiatrist. In addition, the clinician attempted to anticipate additional barriers (i.e., getting medication despite not having insurance or enough money) and offered Maria alternative options, like obtaining samples from the psychiatrist, accessing low fee pharmacy programs, and continuing with the application for charity care.

Maria rated an 8/10 for all the scales on the ICR (importance, confidence and readiness to take the medication). She attributed the increase in her ratings (as compared to Session 1) to having had a positive response on the new course of medication (Cymbalta). After all, she reported feeling more relaxed, thinking less about the betrayal that precipitated her depression, and sleeping better. She also had the experience of taking the medication for one week consistently without having negative side-effects. In fact, Maria noted that the lack of side-effects made it feel as though she were not even taking medication. Given these relatively high ratings, the MI clinician took advantage of the opportunity to point out to Maria that despite her concerns, she was motivated enough to give the medication another and attempt to feel better and “return to the person she used to be.” The MEMs readings served to reinforce Maria’s success in taking the medication as it demonstrated that Maria had taken her medication everyday since switching to Cymbalta.

After the MEMs reading, the clinician explored with Maria whether she would be willing to make a commitment to taking the medication for an extended period of time (i.e., three to six months). This induced a resurgence of ambivalence for Maria. She returned to talking about her concerns of becoming dependent on the medication and

predicted that in three to six months, she would be “sick and tired” of taking the antidepressant. It appeared that Maria was not yet at the appropriate “stage of change” for that level of commitment or change talk.

Since Maria presented with suicidal ideation during the first MI session, the second MI session concluded with a brief risk assessment. Maria confirmed that she was experiencing less suicidal ideation and that she would be willing to call emergency numbers if needed. The MI clinician reinforced Maria’s strengths and reflected her desire to live as evidenced by wanting to take care of her body by not over-medicating it. Maria expressed her genuine appreciation to the MI clinician for her concern. The MI clinician self-disclosed that she had been worried about Maria over the course of the week, and Maria acknowledged that it made her feel better knowing that others cared about her. Of note, this last interchange was probably the strongest marker of alliance between the clinician and patient.

Endpoint Assessment.

Maria returned to the research study a week later to meet with the research assistant for her endpoint assessment (T2). While completing the Beck Depression Inventory-II, Maria disclosed that she continued having thoughts of killing herself. She had a vague plan and was unable to contract for safety. The research assistant referred Maria for a psychiatric evaluation, and she ended up being hospitalized in an inpatient psychiatric unit for two weeks. This marked her third hospitalization in less than 6 months.

Booster Session.

Two months after her second MI session, which was a week after her release from the hospital, Maria was invited to meet with the MI clinician for a booster MI session. She

stated that she was doing well, continuing her work in a factory job, and continuing to follow up with her psychiatrist. She also informed the MI clinician of her recent inpatient hospitalization and admitted that, at the time, she had been feeling increasingly upset, ruminating about her husband's betrayal and having strong suicidal ideation.

Nevertheless, she noted that since her release, her suicidal ideation had mitigated and she was able to keep her goals in sight (i.e., working, taking care of herself, and helping her mother). In fact, staying busy with work was serving Maria well as it kept her distracted for thinking about her husband's betrayal. The MI clinician took advantage of this opportunity to reflect that Maria was taking active steps toward helping herself feel better. In addition, she emphasized that her ability to follow up with her psychiatric appointments clearly demonstrated an investment in her treatment.

The role of the medication as part of her treatment was revisited in the booster session. Maria indicated that, while in the hospital, her medication dose of Cymbalta had been increased. She stated that it was "too strong" and complained of feeling "out of it." Despite this side effect, the MEMs reading revealed that she had been taking the medication almost regularly since being released from the hospital (she forgot to take it 1 day). Her desire to feel better served as her source of motivation despite having doubts about the medication. In fact, Maria revealed that she had learned to manage the side-effect by taking the medication at night. That way, if she felt nauseous or dizzy, it would not interfere with her daytime activities. The MI clinician affirmed Maria for figuring out a way of navigating obstacles to treatment.

For the booster session, Maria rated the importance of taking medication as an 8/10 and her confidence and readiness as a 7/10. She attributed the high ratings to the

recognition that medication was helping her feel better, that she was more active, and that she was less suicidal. However, her ratings fell short of a 10/10 because she still acknowledged that her mood cycled and she continued to have days which she felt sad, hopeless, and apathetic. During these days, she wondered whether there was any hope in taking the medication. The MI clinician accurately reflected that despite feeling depressed and unmotivated, Maria was somehow able to find the strength to take the medication, which in turn, helped her regain energy and feel less depressed. When asked to reflect on this process, Maria once again credited her faith in God as helping her have the strength to “get things done.”

Since this was the last MI session with Maria, the MI clinician attempted to get a sense of Maria’s long-term commitment to the antidepressant and anticipate any outstanding barriers to treatment. Maria indicated that she was willing to continue taking the medication until her body could acclimate and she would no longer feel the side-effects. The MI clinician validated Maria’s concerns about side-effects and becoming addicted to the medication. Similar to how she had done in the first session, she also provided information on these topics and elicited Maria’s reaction. Maria appeared to respond positively, and the MI clinician encouraged her to follow up with her psychiatrist should she have more questions. She still, however, had clear ambivalence about the medication. Maria admitted that she preferred to go back to the lower dose of Cymbalta since it caused the least amount of side effects, but noted that it made little impact on her depressive symptoms. The session ended with a summary statement of Maria’s plan: continuing to take the medication, observe whether or not the side effects decrease, and continue consulting with the psychiatrist.

Ana

First Session.

The MI experience for Ana started in a similar fashion as the cases presented above (i.e., with brief chit chat to break the ice followed by agenda setting). However, Ana's case was different in that she was assigned to an MI clinician who had also conducted her initial intake for the clinic a few months prior. As a result, the alliance was quickly established. One could also argue that Ana's case was different because she presented in an action-oriented stage of change. She started the session by excitedly updating the clinician on how she had been doing since her intake. She noted that when she originally came for help, she was depressed, isolated, feeling worthless, guilty, and victimized, and having recurrent thoughts of ending her life and the life of her children. She recognized that she was not treating her children well, noting that because of her experience of being sexually abused by her father, she feared that her son would somehow violate her daughter. As a result, she pushed her son aside and would often hit him or yell at him. He was scared to talk to her or even approach her. However, by the time of the first MI session, Ana was no longer feeling or behaving this way. For the last two weeks, she had been happy, not ruminating about her problems, having fewer nightmares, feeling less frightened, no longer turning to suicide as an answer, and confiding in others.

Of particular importance was how Ana's relationship and interactions with her son had improved. A few weeks prior to the MI session, she had approached her son and told him not to be scared of her. She apologized for having made the mistake of yelling and hitting him and reassured him that it would not happen again. She offered herself as someone he could go to if he needed something. Her relationship with her children had

changed so drastically that they were engaging in activities together, including dancing around the house (something that had never happened before). In addition, Ana's relationship with her partner was changing. She was no longer thinking of leaving the house or rejecting her partner's touch. Ana was surprising herself and those around her with her positive behavioral changes and renewed confidence.

Ana expressed gratitude for having been referred to the clinic, noting that at first she was ambivalent about accepting treatment, but was now thankful because she was feeling better. She indicated that the way she was welcomed by the clinic was especially meaningful because in the past, she had been rejected from services for her inability to speak English. She was grateful that she had found a place where she felt supported.

Ana mostly credited her success to the therapy she was receiving at the clinic. She indicated that her individual therapist taught her that what had happened to her as a child (sexual abuse at the hands of her father) was not her fault. Therapy also provided an outlet for her to talk about her problems, especially because her family and those at home were unaware of the extent to which Ana was suffering. She was learning how to manage psychosomatic symptoms and traumatic flashbacks by naming it as something "psychological." Ana's individual therapist also helped her learn how to show affection to her son. In turn, her son spent more time with her and expressed his love to her. This led Ana to feel more competent as a parent. Ana was particularly excited that she had been "symptom free" for weeks at a time, instead of just a few days. She was motivated to remain this way as her primary goals were to "*seguir adelante*" (move forward), feel worthwhile, no longer feel afraid, enjoy her children, and gain employment.

Pursuing Ana's goals (e.g., employment) was not an easy task, especially because her PTSD produced a higher sensitivity for re-traumatization. For example, Ana noted that she was afraid to go back to work because she remembered being frightened when she once found a male in the woman's bathroom at the factory where she was working. Following this incident, she did not return to work. Nonetheless, since feeling better and more motivated to "*seguir adelante*," Ana was able to think of other means of employment. She was considering jobs that placed her less at risk, like cooking and baking. In fact, her main motivation to gain employment was so that she could have enough money to take her children out McDonalds or Burger King, something she knew would make them happy.

Since Ana appeared to be in an action-oriented stage and ready for change, the MI clinician advanced the session in the direction of increasing change and commitment talk.

The MI clinician stated:

¿Y como podemos continuar con los avances y lo que ha ganado? ¿Como puede continuar con todo lo que ha progresado?

How can we continue with the advances and that which you have gained? How can you continue with all the progress you have made?

This type of question allowed Ana to identify and consolidate all the factors which helped her achieve her goals, including: her work with her therapist, her work with her psychiatrist, her participation in the research study, and taking the antidepressant medication. Ana noted that the medication had been specifically helpful in reducing her rumination of her traumatic past. It also decreased the frequency and intensity of her intrusive nightmares. Since Ana mostly made external attributions of her success, the MI

clinician attempted to reinforce internal attributions, like her efforts in taking advantage of the treatment that was being offered to her.

Despite all of her gains, Ana noted that she still had moments where she struggled with PTSD symptoms, especially on the days when she came to her individual therapy sessions and spoke about her past. In fact, during the MI session, Ana indicated that as she was speaking about her sexual abuse, she felt her body getting warm, as if it (the abuse) was happening to her again. These moments made Ana concerned her happiness would disappear. After all, in the past, she had only been symptom free for 1-2 days before her nightmares and negative thoughts returned. The MI clinician normalized this experience for Ana and reinforced that she was beginning to learn the “tools” that could help protect her from experiencing a resurgence of depressive symptoms.

During the first MI session, Ana’s MEMs scans revealed that she was taking her medication with 100% adherence. This reflected Ana’s dedication and motivation to take advantage of her treatment and achieve her goal to “*seguir adelante*” (move forward). She noted that her health and happiness had a direct impact on her family’s well-being. Her motivation to adhere to her treatment was also reinforced by believing that she was becoming a good fit as a mother and that nobody else could love her kids in the same way she did.

On the importance and confidence rating scales, Ana rated herself a 10/10. She confirmed her commitment to take the medication, stating that she always carries the pills because they “help me.” In addition, she noted that her confidence had been reinforced by individual therapy sessions since they were contributing to all the improvements in her life (i.e., eating and sleeping better, getting along better with her husband, providing for

her children, enjoying life, dancing, wanting to work, and improving her ability to tolerate past trauma). As for readiness to take the medication, Ana rated herself an 8/10 citing that one of her barriers to readiness was forgetfulness. Nonetheless, she was able to offer up strategies to remember to take the medication, including pairing it with mealtime. Though Ana's adherence at the time of the first MI session was 100%, she continued to be a good candidate for Motivational Interviewing as it would help determine whether she could sustain this level of adherence over a long period of time. After all, research shows that adherence to antidepressant medication significantly decreases after the first 30 days, especially amongst socio-economically disadvantaged Latinos (Olfson et al., 2006).

While Ana felt rather confident about the antidepressant medication, she presented with more ambivalence about the sleeping pills that the psychiatrist had prescribed to her. On the one hand, the sleeping pills helped her escape the intrusive thoughts she often experience once she laid down for bed. On the other hand, they caused excessive drowsiness leaving her too tired to attend to her children the next day. As a way of negotiating this ambivalence, she decided to take the sleeping pills only when necessary.

The other area of concern for Ana was her fear of relapsing into a depressive state. She worried that her suicidal ideation would return, and at the same time, she would lose sight of the importance of her children. Despite the apprehension of a setback, Ana remembered that she had resources to help her, including phone numbers to emergency hotlines as well as the continued support of her individual therapist.

Second Session.

Lo and behold, by the time of the second MI session, Ana was experiencing a relapse of symptoms. Her intrusive nightmares had returned, and she was having visions of her children being sexually abused. She was feeling desperate, tired, unmotivated, overeating, and ruminating about the past. With the return of her nightmares came her suicidal ideation, where she lost sight of all those who loved her and only thought about death. According to Ana, the depressive and PTSD symptoms resurfaced one week prior to the second MI session, with the most intense symptoms occurring the day before. In fact, she reported that if she had been left alone the day before, she might have attempted suicide. She felt grateful for the opportunity to talk to her individual therapist and the MI clinician in back to back sessions the next day. This, however, was not without ambivalence. On the one hand, Ana recognized that she gained strength from talking with someone about her problems. On the other hand, she felt embarrassed that she continued to struggle with the same problems and ashamed that “strangers” (the treatment team) cared more about her than her own family.

The MI clinician attempted to explore with Ana the factors that kept her from harming herself. Ana stated that thinking about her individual therapist helped her feel better as she remembered that there was someone who worried about her and took an interest in her. She also felt strongly connected to the clinic, noting that it was a place that had helped her heal, a place that she trusted, and where she felt like she was treated well. She also noted that being around others, distracting herself with cleaning the house, and evoking her religious beliefs helped keep her safe. The MI clinician validated Ana for having put together, albeit unconsciously, several behavioral strategies which helped

her feel better. In addition, the MI clinician took advantage of the opportunity to remind Ana of some of the strategies that she used to combat her negative thinking, which she had mentioned during session 1, including reminding herself that “this was psychological.” This served to boost Ana’s sense of self-efficacy as well as reinforce her own ability to successfully manage her symptoms and self-soothe. In addition, the MI clinician reminded Ana of all her recent achievements (dancing with her son, improved communication with her partner), the personal strength she had gained, and the progress she had made towards her future goals (working). Despite having experienced this setback, Ana was resolved to “*seguir adelante.*” She was motivated to return to her symptom-free days.

Aside from trying to strengthen Ana’s ego, the MI clinician also spent some time validating Ana’s experience. The truth of the matter was that she was struggling with very intrusive and disturbing nightmares. She was scared that she had lost her grip on recovery and worried that the symptoms would “overtake her.” Since Ana’s symptoms were so intense, the MI clinician provided Ana with psycho-education about the general course of a Major Depressive Episode and reminded her that the symptoms would eventually pass.

Despite the clinician’s efforts to move Ana past her depressive symptoms, she was very much trapped in a negative self state, wondering how she could possibly rid her mind of her intrusive thoughts. The MI clinician attempted to dislodge Ana from this state by having her compare her current experience of intrusive thoughts to previous experiences. This approach proved successful as she recognized that, at present, she was

a “stronger person,” with more confidence and resources to help her manage her symptoms.

Nonetheless, feeling isolated, as though nobody cared about her, was a theme that resurfaced for Ana throughout the session. She was reluctant to turn to others for support because she (1) did not want to make them feel bad, (2) was afraid of not being believed if she were to disclose her history of sexual abuse, and (3) feared that she would be ridiculed or called “crazy.” While she was extremely grateful for the support of her individual therapist and the community mental health center, she was ashamed that she did not have people in her life to which she could turn to for help. Ultimately, Ana was willing to push past the shame and embrace the sense of safety and trust that she felt from the clinic.

Ana indicated that she had forgotten to take some of her medication during the last week. She noted that since her nightmares had returned, she found herself more forgetful and had experienced difficulty concentrating. The MEMS reading, however, revealed that she had nearly 100% adherence, only having missed 1 day. The MI clinician reinforced her level of compliance despite feeling forgetful. Nonetheless, Ana appeared to feel guilty that she had failed one day and was observed to be distraught by the confusion she experienced about whether or not she had taken the medication. She also disclosed fear that she was going to be reprimanded by the treatment team for having missed one day. This misconception was immediately cleared when the MI clinician stated,

Y aquí estamos, no para castigarla pero para apoyarla en la manera que podemos y ayudarla hacer el plan que, que funcione bien para usted.

We are not here to punish you, but instead to support you in any way we can and help you find a plan that works well for you.

Since Ana presented forgetfulness as a barrier to taking her antidepressant medication, the MI clinician spent some time addressing how she could overcome this obstacle. With Ana's permission, the MI clinician first solicited Ana's ideas of how to solve this problem. When she was unable to produce any solutions, the MI clinician reminded Ana that, in the previous session, she had thought of pairing the medication with meals. Ana noted that this strategy no longer worked because her anxiety had increased, she craved food all the time, and had ceased to have formal mealtimes. She demonstrated renewed motivation to remember her medication, predicting that as she began to feel better, her concentration and memory would improve allowing her to take her medication as prescribed. Ana increased her change talk stating, "voy a tratar de seguir como yo estaba/ I am going to try to return to the way I was (less confused about having taken the medication)." The MI clinician reinforced Ana's dedication and desire to renew her commitment to taking the medication and took advantage of the opportunity to offer Ana concrete strategies on how to remember the medication, like using a calendar system, setting an alarm, or using a pill box. After presenting these options, the clinician and Ana evaluated each option and created a plan of action.

At the time of the second MI session, Ana rated the importance of taking the medication as high, stating that she very much wanted to continue with the medication in hopes of feeling better. She confirmed having complete confidence in returning the happiness she had felt in the previous week and noted that she was ready to move forward. This type of change talk transported Ana to a place where she felt optimistic about her future,

Si, esto lo voy a dejar, algo pasajero, que ahorita voy a salir y voy a ir. Me siento ya contenta.

Yes, I'm going to leave this behind, like something temporary; now I'm going to move forward. I'm feeling happier.

The MI clinician reflected that this type of positive attitude would not only help her reach her goals, but also protect her from future relapses. By the end of the second MI session, she was expressing her motivation to “*hechar ganas*” (put forth effort) and asserting her commitment to battle her depression, both for herself and in honor of the treatment team.

Booster Session.

Ana's presentation at the time of the last MI session, which was two months after the 2nd MI session, was very similar to how she appeared in the first MI session. She excitedly reported to the MI clinician that she had survived her depressive relapse and was doing well. She had learned to manage her nightmares, had released her feelings of guilt over her past sexual abuse, built trust in her individual therapist, and was “getting to know” what life was like in a state of happiness. She was pleased that she was no longer yelling or hitting her children, fighting with her husband, or constantly thinking about death. Over the course of those couple of months, Ana reported discovering a sense of inner confidence and self-worth, which led her to develop a stronger love for herself and her children. In addition, she was becoming more independent and practicing assertive behavior.

Of particular interest, Ana noted feeling younger and stronger. She acknowledged that while depressed, she was often in physical pain and felt “too old to pursue life.” However, her psychosomatic symptoms had nearly disappeared and she was now able to imagine the life that lay ahead of her. Furthermore, she had regained the energy to engage

with the world around her, including running, laughing, singing, and “jumping” around with her children.

She again credited having someone to talk to (her individual therapist) as one of the main factors in helping her achieve her gains. She had learned to trust her therapist and unburden herself of the heavy load she was carrying. In addition, she identified that the most important source of motivation to *seguir adelante* (move forward) was so that she could have a presence in the lives of her children. This was of particular significance because her children, which used to be a source of fear, had become a source of strength. Ana was so impressed with the changes that she had observed in herself that she commented,

Todo es diferente para mí. Todo ha cambiado. Si quiero cantar, canto. Si quiero bailar, bailo. Me llevo bien con mis niños. No les pego y no les grito.

Everything is different for me. Everything has changed. If I want to sing, I sing. If I want to dance, I dance. I get along with my kids. I don't hit them or yell at them.

In addition, others were noticing these positive changes. Some of her relatives were so impressed by her transformation that they began requesting referrals to therapy, even though they had previously disavowed it as something just for “crazy” people.

While in the past, she had only experienced happiness for short periods of time (i.e., a day, two days, a week at most), she was now feeling confident that the “good times” were going to last. The MI clinician reflected Ana's personal strength, her willingness to “*poner de su parte*” (put forth effort), her ability to build a trusting alliance with her individual therapist, and her dedication to practicing what she had been learning in treatment as factors that helped her survive her relapse and get back on track toward her goals. Ana added that the feedback and attention that she had received, including a letter

from the MI clinician and several phone calls from her individual therapist, also contributed to her success. In addition to lifting her spirits, these outreach efforts reminded her that she was not alone. In fact, Ana disclosed that one of the reasons she kept from harming herself was because she did not want to disappoint her service providers.

As Ana began to gain more strength, she was able to reflect on her history of abuse and start to consider addressing her emotions in a more meaningful way. For example, Ana began to contemplate having a conversation with her mother about her experience of being sexually abused by her father. She also thought that perhaps, in the far future, she may be able to confront her father. This was a delicate matter for Ana. On the one hand, she was feeling ready to unload some of her anger and have some of her questions answered. On the other hand, she was concerned that revisiting her past would trigger strong emotions and a resurgence of depressive symptoms. Ana was resolved to “take things one step at time” and approach this matter slowly and strategically.

Ana’s progress was also unfolding in her dream life. While she continued to have occasional nightmares, Ana was no longer running away from them or waking up in tears and wanting to end her life. Her dreams continued to include themes of death, guilt, shame, ridicule and being unappreciated. She saw the people that harmed her in her nightmares, but this time, she was able to see herself getting help in the dreams. The more she took interest in understanding the meaning of her dreams, the more activated she became in addressing her pain. Ultimately, this led her to a deeper layer of healing.

The MI session concluded by once again checking in with Ana about the role of medication in her overall treatment and consolidating her adherence to the medication.

Ana confirmed that both the medication and her individual therapy had equally helped her in achieving her goals. The MI clinician and Ana discussed the barrier to adherence that she had identified in previous sessions (i.e., forgetfulness or confusion of whether or not she had taken the pill). Ana reported that she continued to struggle with this issue, especially when feeling very depressed. She noted that the use of calendar was not too effective, and the MI clinician was able to spend part of the session brainstorming new ways to overcome this obstacle (i.e., using a pill box or an alarm). Ana was given the opportunity to evaluate the different options and take ownership over a strategy that best suited her lifestyle.

On the ICR scale, Ana rated the importance of taking the medication as 10/10. She maintained 100% confidence (rating of 10/10) in her ability to adhere to her treatment, noting that her confidence had increased over time. She had gotten a “taste” of the positive effects of the medication and what it felt like to feel better, stating “I feeling like a new person, as if nothing had happened.” This strengthened her commitment to continue to her adherence to the medication. As for her readiness to adhere to her medication, both she and the MI clinician agreed that she was already putting it into practice.

Even though Ana expressed commitment to taking the antidepressant medication, her behavior reflected some level of continued ambivalence. At the end of the session, she disclosed that she was about to run out of medication and was considering going without it for 4-5 days until her next appointment with the psychiatrist. Then again, she expressed concern about what could happen if she were to discontinue the medication and was afraid of a resurgence of symptoms. She continued to require a significant

amount of support in resolving this ambivalence and figuring out ways in which she could get her needs met (i.e., obtain a prescription from her psychiatrist so that she did not need to go without medication).

CHAPTER VII

Therapy Monitoring and Use of Feedback Information

Symptom Monitoring

There were several sources of symptom monitoring throughout the course of the study. Participants were mainly assessed at three points during the study (T1= first assessment, T2= after 2 sessions of MI, and T3= five month follow up; see appendix A). The primary measures that were administered during these assessment periods included the BDI-II, which evaluated the participant's level of depression and scanning of the MEMs bottle (a bottle with an electronic top that recorded each time it was opened), which measured adherence to the antidepressant medication. The possible scores on the BDI-II ranged from 0-63 with a cut off score of 14 indicating mild depression, 20 indicating moderate depression, and 29 indicating severe depression (Beck, 1996). Additional symptom monitoring was obtained via the patient's self-report during the Motivational Interviewing sessions and from the exit interview, where the participants were asked to provide a detailed "picture" of what it was like for them to participate in the study and what impact the treatment had on their life. Finally, since the researcher was drawn into intensive contact with each case, symptom monitoring was obtained from her role as a participant observer.

Feedback Delivery for the Patient

By participating in the study, subjects were able to obtain rich individualized feedback on their symptoms, the course of their depression, antidepressant medication

adherence, and on their overall treatment. To start, the use of the MEMs bottle provided participants direct feedback on their patterns of medication use. Following the scan of the bottle, participants were able to obtain further feedback from the clinician on issues of adherence. In addition, after the first MI session, participants received an informative brochure about depression in the mail along with a hand-written letter providing personalized feedback on the patient's experience with depression and goals for treatment.

Feedback Delivery for the Clinician

Clinicians in the study received on-going feedback via supervision by a doctoral level psychologist trained in MI as well as an off-site MI consultant. Supervision included audio- review and live role-plays. The MI consultant listened to transcripts of the session and coded the sessions according to the Motivational Interviewing Treatment Integrity scales (MITI). This allowed clinicians to gauge their level of fidelity to the intervention and improve their technique in areas like empathy/ understanding, "MI spirit," and use of open-ended questions and reflections. In addition, the consultant provided written feedback to the clinician after the first two sessions of MI with commentary on strengths, areas of improvement and potential homework assignments to practice the technique. Based on the on-going supervision, the clinicians were able to modify the intervention accordingly. For example, after receiving feedback, one clinician was increasingly about mindful of creating a collaborative environment with the patient, avoiding the role of "expert," watching her tone of voice so that her statements would not be perceived as questions but rather as reflective statements, and deepening her reflective statements to make them more meaningful while still conveying understanding.

CHAPTER VIII

Concluding Evaluation of the Therapy Process and Outcome

Lupe's Positive Outcome

It is clear that the Motivational Interviewing intervention in Lupe's case was a success as measured by her subjective report as well as the results of some of the final assessments. Lupe dramatically eradicated her depressive symptoms according to her BDI-II scores. When she began the study, she scored a 43 on the BDI, placing her in the severe range and higher than the treatment group mean which was 31.1 (see Table 1 and Table 2). By the time of the last assessment, 4 months later, her BDI score was 3, which not only significantly lower in comparison to her original score, but was also lower than the mean for the treatment group which was 18.0 (see Table 1 and Table 2). Lupe's final BDI score suggests that she ended the study with minimal to no depressive symptoms. In addition, Lupe was able to increase her percentage of adherence to the antidepressant medication from 80% (at T1, the beginning of the study) to 89% (at T3, the time of the last assessment period). This compares to a mean adherence percentage for the treatment group at T3 of 65.7% (see Table 3 and Table 4).

As for her subjective experience of the MI, by the time of the exit interview, Lupe was reporting that she had met her initial goal: returning to her old self. She was back to smiling, singing, and being active. In fact, her improved mood had impacted her family as she reported that her relationships were stronger and the home environment was more relaxed. Her relatives were grateful for these changes, and they validated her efforts at

getting better. This, in turn, fueled her motivation to continue her adherence to the medication. Lupe stated,

Yo voy a continuar a tomar la medicina, aunque me sienta mal (con efectos secundarios) o aumente de peso. Lo mas importante es que me sienta bien (emocionalmente).

I'm going to continue taking the medication, whether or not I feel bad (with side-effects) and whether or not it causes weight gain. The most important is that I feel better (emotionally).

Overall, Lupe credited her recuperation to her own efforts, therapy, medication, her treatment team, belief in God, and her family. With regard to the Motivational Interviewing sessions, Lupe reported that the ability to confide in someone else and feel as though that person really cared about her was the most therapeutic factor. She felt relief in being able to “unload.” In addition, she noted that the outreach efforts and sincere concern from the treatment team left her feeling as though “others cared about her.” This motivated her to help herself and take the first step of coming to the appointments. At the appointments, she was able to learn more about herself, clarify misconceptions about medication, and contrast the effects of her depression to the goals she had yet to achieve. Her pleasant experience at the appointments fueled her motivation to adhere to her treatment and to “stick with her plan” of taking the medication. Ultimately, this became an interacting chain, with each component reinforcing the next, resulting in Lupe’s improved mood and strong commitment to the medication.

Maria’s Negative Outcome

In the case of Maria, the MI process was less successful as compared to that of Lupe’s case. At the time of the final assessment, Maria continued to experience severe

depression as measured by her BDI-II scores, which was 33 points (see Table 1). She also had elevated levels of suicidal ideation throughout the study, and she required psychiatric during the middle of her participation in they study (at the time of the T2 assessment). In addition, there was no lasting effect of the MI sessions on improving her adherence to the antidepressant medication. Her adherence dropped from 78%, measured after her two MI sessions (which compares to the group mean for the treatment condition of 75%) to 37% at the end of the study (compared to the group mean for the treatment condition of 65.7%; see Table 3 and Table 4). In fact, Maria lost her medication bottle for several weeks, and it was not until she was called in for the exit interview that she found it (note that the time period where she reportedly lost the MEMs bottled was not included in the adherence data). Finally, the MI sessions did not produce any change in increasing Maria's confidence or readiness to take the medication; her ratings remained the same over the course of her participation in the study.

Interestingly, according to Maria's subjective experience, the MI sessions were "a good experience." She felt particularly comforted by knowing that the treatment team and the MI clinician were concerned about her. She referred to the MI clinician as "more than just a doctor," and was appreciative of how the clinician followed up with by calling and sending her letters. While she acknowledged that there were times when she continued to feel sad, she reported that, overall, she had improved as compared to when she first presented to the study. She cited God, the research study, her therapist and her psychiatrist as the factors which helped her get better.

Maria's main obstacles to adherence at the time of the exit interview were the side-effects she felt from the medication (nausea and stomach pain) and the stigma she

experienced over her mental illness. She reported that others did not understand her depression and would criticize her for being “too dramatic.” For that reason, she was reluctant to confide in others, ask for help, or let someone know when something was bothering her. Given the extent of Maria’s shame and social isolation, the opportunity to confide in the MI clinician and feel understood was likely one of the most important therapeutic factors.

One marker of progress for Maria was that by the end of the study she was starting to access more community resources. Maria acknowledged that her faith had been fundamental in helping her fight her depression. To that end, she decided that it would be helpful to seek support from the church. Increasing her participation in church had the potential to strengthen Maria’s spirit and expose her to a network of people that could be good sources of support.

Ana’s Mixed Outcome

Ana’s outcome with the MI sessions had mixed results. Objectively (i.e., as measured by BDI-II scores), Ana had minimal change in her level of depression throughout the course of the study. At the time of the final assessment, Ana continued with moderate levels of depression and had only decreased 3 points in comparison to her ratings from the first assessment (from a 26 to a 23; see Table 1). Interestingly, after 2 sessions of the MI intervention, her level of depression actually worsened into the severe range, to a score of 35 (see Table 1). Compared to the mean of the treatment group, Ana’s depression scores at the beginning of the study were below the mean and above the mean by the final assessment (see Table 2). In addition, her percentage of adherence to the medication decreased over the course of the study. She started off with 100%

adherence at the outset of the study. By the time of the exit interview, she was 78% adherent, suggesting that the MI intervention had little effect on sustaining her level of adherence over time. Nonetheless, Ana's adherence was above the group mean of 65.7% (see Table 3 and Table 4).

Ana's subjective experience of the MI sessions proved differently that her objective results. She expressed immense gratitude to the study, for it provided her the opportunity to "move forward," offered her someone to talk to, allowed her to build insight into her mental illness, and gave her the tools to manage her symptoms. As she gained internal strength, she noticed a reduction in the frequency and intensity of her symptoms, particularly suicidal ideation. She was able to shed her feelings of worthlessness and guilt and discovered new passions, interests, and values. Instead of feeling victimized and asking herself "Why me?," she began to view her previous experiences as opportunities to learn and grow. Most importantly, she credited the study for solidifying her identity as a competent mother and wife. Her transformation was so noticeable that by the time of the last assessment, the research assistant commented that she was "carrying herself with more confidence."

Ana reported that the most helpful component of the treatment "was the way that she was treated." She felt listened to and understood. Ana acknowledged that, at times, the questions that were asked of her were challenging and provoked emotion. However, she was grateful that the clinician took the time to process her reactions. She was also appreciative of the team's outreach efforts (calls and letters). It helped her feel motivated and made her realize that strangers were taking an interest in her. In fact, after receiving

a pamphlet from the research study with information about depression, she bought a book to learn more about the origin and course of her illness.

Cross Comparison of the Three Cases

The Participants' Readiness for Change.

Analysis of the three cases suggests in part that the success or failure of the MI intervention depended heavily on the participant's readiness for change and whether or not the clinician tailored the intervention appropriately. As mentioned earlier, the motivation to change a particular behavior is a dynamic process and people fluctuate through various stages of readiness including pre-contemplation, contemplation, preparation, action, and maintenance (Miller & Rollnick, 2002). One could argue that Lupe, the most successful case, responded well to the intervention because she moved quickly through the aforementioned stages of change. When she presented to the first session, she may have been in a contemplation stage. By the end of the intervention she was likely in the action phase. Maria, on the other hand, may have had less success because she entered the study at an earlier stage of change (i.e., pre-contemplation), and instead of progressing to other stages of change, she more or less vacillated between pre-contemplation and contemplation.

To that end, it would have been important for the MI clinician to respond appropriately to the participant's stage of change. For people who are in a pre-contemplation stage, it is important to listen carefully, roll with the resistance, offer information if necessary, instill hope, and provide the space for the individual to make his/her own decision (Miller & Rollnick, 2002). When reflecting on Maria's course of therapy, I would argue that the clinician did not consistently "meet" her at her stage of

change. On the one hand, the clinician appropriately responded to Maria's sense of disempowerment and her lack of information. On the other hand, the MI clinician hurried Maria through several key moments of the intervention, like building rapport (i.e., setting the agenda) and exploring her values and goals. For example, while the clinician appropriately elicited Maria's goals and values through the provocative question "How would your life be different without depression," she did not spend enough time working with Maria on elaborating the response and eventually developing a state of discrepancy. Instead, only moments later, the MI clinician proceeded to inquire about the role that medication had on her depression. In addition, Maria's resistance was not sufficiently validated, and she seemed rushed to engage in change and commitment talk prematurely. In fact, most of the change talk was actually being produced by the clinician instead of the participant. This made it difficult to determine whether Maria was genuinely feeling committed to change or simply being acquiescent.

Likewise, the outcome of Ana's case may have also been affected by inconsistent response to her stage of change. Reviewing her course of treatment revealed that a main concern for Ana was the fear of relapsing to depressive and PTSD symptoms. Relapse is a common concern in individuals undergoing change, and according to Miller & Rollnick (2002), clinicians should provide reassurance, help the participants make sense of the resurgence of the symptoms, and help them see the relapse as a learning opportunity rather than a crisis. However, in the case of Ana, the MI clinician seemed to hurry her to prematurely focus on issues related to the medication instead of spending more time validating and amplifying her fear of relapse.

Factors Associated with Medication Adherence and the Reduction of Depression.

In terms of adherence to antidepressant medication, while the rich case process data suggest that the MI intervention was helpful in increasing adherence, it is difficult to definitively determine whether it improved because of the influence of the MI intervention or if participants simply became more responsible in taking their medication because they were using a novel bottle and they were aware that their usage was being monitored. In order to answer this question, the results of the randomized control trial have to be analyzed to determine whether there was a statistically significant difference between the treatment group and the control group.

The changes in the BDI scores of depression were associated with the changes observed in the clinical process of the case studies, with Lupe clearly showing the most improvement in her depression both quantitatively and qualitatively. The clinical process data document how the MI intervention appeared to work in helping Lupe, as opposed to Maria and Ana, in overcoming and reducing her depression. On the other hand, the MI intervention is multifaceted, involving both common factors, such as having been listened to in a non-judgmental manner, feeling cared for by the treatment team, having the ability to confide in someone, and being able to receive information and clarify misconceptions; and specific techniques, like developing discrepancies, rolling with resistance, imparting information, providing feedback, facilitating change talk, supporting self-efficacy, and empathically meeting the client at his or her stage of change. More research is needed to either parse out the relative effects of the common and specific factors or to determine if they work inextricably as a whole.

Conclusion

While improving adherence to antidepressive medication is an important goal for depressed Latino patients, relatively little research has been conducted in this area. In this context, the present research analyzed in depth three case studies of a Motivational Interviewing (MI) intervention for increasing such adherence for such patients. The cases, which were drawn from the experimental condition of a randomized trial, were chosen to sample the variation in effectiveness of MI's capacity to increase medication adherence and to enhance some of the psychological factors—like increased self-efficacy—that can combat depression. The small number of patients and the holistic application of the MI intervention limit definitive conclusions about the effectiveness of MI in general and the relative contribution to effectiveness of specific components of the MI intervention. However, the rich clinical process data and clinical outcomes across the three clients, and the correlation between these qualitative data and the standardized quantitative measures employed, are consistent with the conclusion that the MI intervention has the capacity to be powerfully effective with some depressed Latino patients in increasing their medication compliance and facilitating the reduction of internal depressive factors in their lives. Moreover, cross-case comparison from the study strongly suggests factors that can facilitate or inhibit the effectiveness of the MI intervention within particular patients.

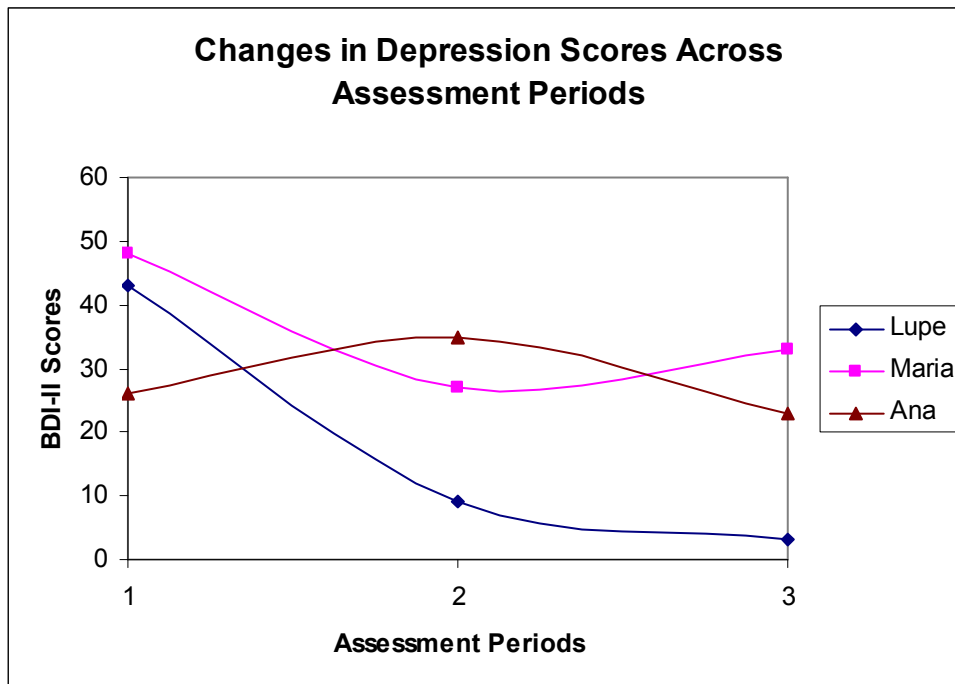


Figure 1. Changes in depression scores across assessment period.

Table 1
Depression Scores across Assessment Periods for All Three Cases

Time of Administration	Beck Depression Inventory-II Total Score for Lupe #	Beck Depression Inventory- II Total Score for Maria #	Beck Depression Inventory- II Total Score for Ana #
Prior to MI Intervention (T1)	43	48	26
Post MI Intervention (T2)	9**	27*	35
4 Month Follow Up to MI Intervention (T3)	3**	33*	23

0-13, minimal or no depression

14-19, mild depression

20-28, moderate depression

29-63, severe depression

Cut off scores from B Beck, A. T., Steer, R. A. & Brown, G. K. (1996). Manual for the Beck Depression Inventory-II. San Antonio, TX: Psychological Corporation.

* *Reliable improvement* on Jacobsen & Truax's (1991) Reliable Change Index, that is, (a) statistically significant change occurred between admission and the subsequent assessment, but (b) the participant did not achieve a move from the clinical to normal range on her scores.

***Reliable change* on Jacobsen & Truax's (1991) Reliable Change Index, that is, (a) statistically significant change occurred between admission and the subsequent assessment, and (b) the participant achieved a move from the clinical to normal range on her scores.

Table 2
Depression Means and Standard Deviations for Treatment Group across Assessment Periods

	BDI- T1	BDI- T2	BDI- T3
Mean	31.1	21.1	18.1
Standard Deviation	15.2	15.4	15.8
N	25	24	20
Minimum Score	1	0	0
Maximum Score	53	55	49

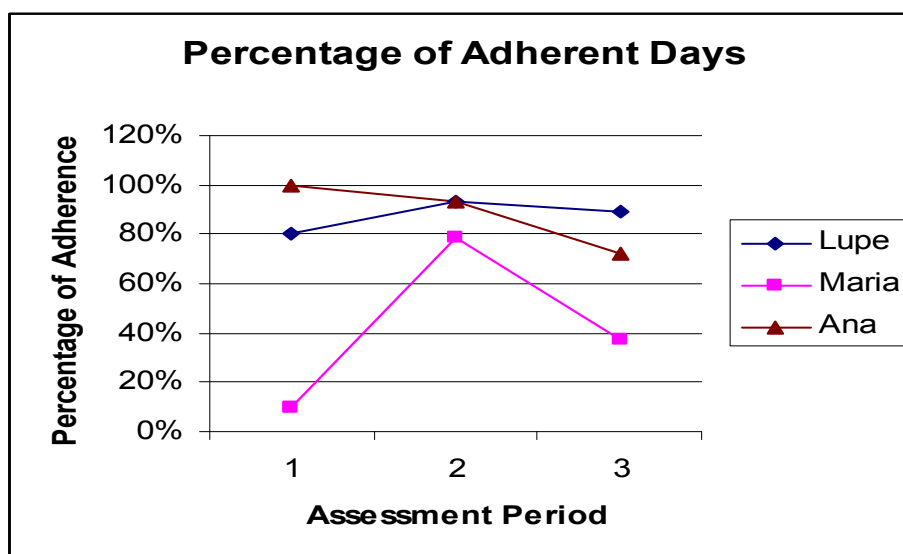


Figure 2. Percentage of adherent days for all three cases.

Table 3
Percentage of Adherent Days for All Three Cases

Time of Administration	Score for Lupe	Score for Maria	Score for Ana
First 10 Days	80%	10%	100%
Post MI Intervention (T2)	93.5%	78.8%	93.5%
4 Month Follow Up to MI Intervention (T3)	89%	37.1%	72%
Total Adherence	89.5%	49.1%	78.7%

Table 4
Group Means and Standard Deviations for Treatment Condition at T2, T3, and Total Adherence

	T2 Adherence	T3 Adherence	Total Adherence
Mean	75.8	65.7	69.6
Standard Deviation	32.3	30.5	29.29
N	25	23	23
Minimum Score	.00	.00	.01
Maximum Score	100.0	99.1	99.4

Table 5
Motivational Interviewing Treatment Integrity (MITI) Scales for Participants across MI Sessions

	MI 1	MI 2
Lupe	Empathy - 6 MI Spirit – 7 Commitment Statements -19	Empathy - 6 MI Spirit – 7 Commitment Statements - 10
Maria	Empathy- 7 MI Spirit – 6 Commitment Statements -0	Empathy - 7 MI Spirit -6 Commitment Statements –10
Ana	Empathy -3 MI Spirit -2 Commitment Statements - 14	Empathy -6 MI Spirit -7 Commitment Statements - 25

Empathy and MI Spirit ratings are on a Likert scale 1 (low) through 7 (high)

Table 6
Treatment Plan for MI Session 1: Motivational Enhancement Phase

Component	Purpose
Agenda Setting	To inform the client of what will be done during the session and provide him/her with the opportunity to choose how to proceed
Discussion focusing on establishing motivation to treat depression, through the use of open-ended questions, affirmations, reflective statements and summary statement (O.A.R.S)	Establish the importance to solve the problem
Elicit goals and values	Determine the source of motivation
Elicit motivation for antidepressant adherence	Explore the role of antidepressant medication as part of the treatment
Assessment of Importance/Confidence/Readiness of taking antidepressant medication	Assess motivation for antidepressant medication and elicit reasons for and against adherence
Discussion to increase motivation for treatment, of which antidepressants are an important part	Prepare for strengthening and commitment phase
Scan M.E.M.S Container	Collect data, reinforce adherent days and explore for days not taken

Table 7
Treatment Plan for MI session 2: Strengthening Commitment Phase

Component	Purpose
Agenda Setting	To inform the client of what will be done during the session and provide him/her with the opportunity to choose how to proceed
Open-ended questions, thoughts on the previous session	Assess where client is in the process of change
Informally listening for/assessing knowledge on antidepressant medication	Reinforce information that the client already knows and provide information only when needed
Assessment of Importance/Confidence/Readiness of taking antidepressant medication	Assess motivation for antidepressant medication and elicit reasons for and against adherence
Explore previous non-adherence	Relate previous experience to client's current plan
Anticipate Barriers	Provide client with a menu of options for maintaining his/her desired level of adherence
Scan M.E.M.S Container	Collect data, reinforce adherent days and explore for days not taken.
Reflect Adherence Plan and elicit client's commitment	Strengthen and solidify commitment for change

Table 8
Importance, Confidence, Readiness Ratings for Each Case throughout the Study

Time of Administration	Score for Lupe	Score for Maria	Score for Ana
Prior to MI Intervention (T1)	I-10 C-4 R-4	I-10 C-8 R-7	I-10 C-10 R-5
Post MI Intervention (T2)	I-10 C-10 R-10	I-10 C-7 R-8	I-10 C-10 R-10
4 Month Follow Up to MI Intervention (T3)	I-10 C-10 R-10	I-10 C-8 R-8	I-10 C-10 R-10

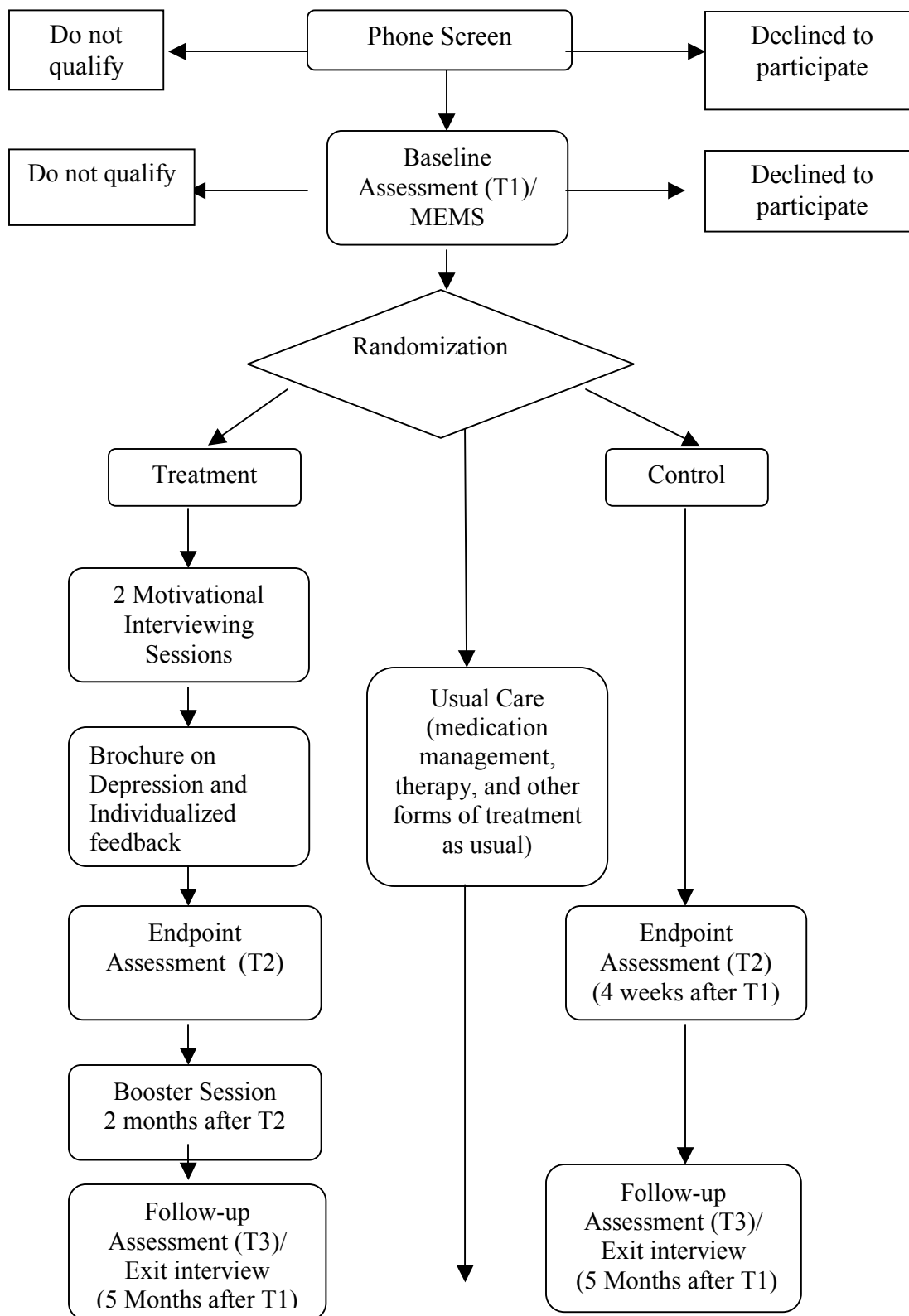


Figure 3. Participant's progression through the randomized controlled trial.

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APPENDIX A

Specific Motivational Interviewing Techniques

Miller and Rollnick (2002) introduced several specific techniques that can be used throughout the course of motivational interviewing to help people explore their ambivalence, build their motivations for change, and address potential barriers for change. These include the following:

Open ended questions not only allow for the clients to do most of the talking, but they also open the door for more exploratory work. They have the potential to invite clients to provide elaborative answers and elicit adherence talk. These types of questions contrast with closed-ended questions, whose answers are typically in the form of yes/no responses or concrete pieces of information.

Affirmations, both via compliments or statements of understanding and appreciation, facilitate rapport building and create a space for open exploration. The client's strengths and efforts are areas that should be affirmed. Affirmative statements can also be used when encountering barriers or resistance to change or to reinforce change talk. These statements should be used sporadically and genuinely

Reflective statements are considered one of the most important therapeutic skills of motivational interviewing. These statements facilitate rapport building and allow the clinician to make guess about what the client is trying to communicate, check in, and convey understanding. Rather than simply repeating what is said, they are meant to move the conversation forward. Reflective statements can range from *simple reflections* (an empathic acknowledgement of how the client feels toward change), *amplified reflection*, (essentially a simple reflection that is amplified to overstate the client's position. It is

intended to elicit a response from the client that corrects the therapist by highlight why the other side of the position, thereby changing the direction of conversation), *double sided reflections* (statements that reflect both sides of the ambivalence for change).

Summary statements should be included throughout a motivational interviewing session to tie points together, as well as emphasize the importance of certain issues. Summary statements also provide yet another opportunity for the counselor to indicate that he/she was listening and understands the client's perspective on antidepressant medications. Three forms of summary statements include *collecting summary statements* (involve collecting various aspects of what has been discussed and reflecting them to the client), *linking summary statements* (involves linking the variance and contradictions between what clients say during a different part of the interview or between sessions), *transitional summary statements* (these statements are used to shift the focus of the interview by either discussing different aspects of the problem or focusing on options for addressing the problem), *motivational summary* (similar to a collecting summary in that is presents the client with various aspect of what has been discussed, making sure to review both sides of the ambivalence. However, it is presented with an emphasis on shifting their ambivalence towards change).

Providing feedback within the spirit of motivational interviewing involves asking the client if he/ she is interested in receiving feedback, followed by inquiring what the client experiences after receiving this feedback (i.e., "What do you make of this information given your goal of?). This provides useful clinical information as the client can express his/her thoughts as he/she receives different pieces of feedback and the clinician can observe the feelings that emerge. The techniques described above, including open-ended

questions, reflective statements, affirmations, and summary statements can be used to proceed into 1.a discussion that elicits the client's ambivalence regarding change, whether it relates to issues of importance or confidence or 2.reinforce the client level of change especially if it is aligned with his or her values and goals.

Imparting information in a motivational interviewing style discourages lecturing, rationalizing, or persuasion with logic since it can be viewed as a form of confronting resistance. Instead, to impart information or give advice, the clinician should consider asking permission prior to providing the information, eliciting the client's response after providing the information, and exploring how the client will use the information. Imparting information should not be done early during the counseling process as it tends to run counter to the spirit of motivational interviewing. The exception, of course, is if the client directly asks the clinician for information.