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Motivational Pharmacotherapy: Combining Motivational Interviewing and Antidepressant Therapy to Improve Treatment Adherence

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Abstract

Treatment non-adherence in psycho-pharmacotherapy remains a significant challenge to the effective clinical management of psychiatric disorders, especially among underserved racial/ethnic groups. This article introduces Motivational Pharmacotherapy, an approach that integrates Motivational Interviewing into psycho-pharmacotherapy sessions in order to increase treatment adherence. We describe what aspects of Motivational Interviewing were incorporated into Motivational Pharmacotherapy and how we tailored the intervention to the clinical and cultural characteristics of monolingual Spanish-speaking immigrants with Major Depressive Disorder. Transcriptions of the interactions between psychiatrists and patients help illustrate this approach. In our experience, Motivational Pharmacotherapy differs substantially from standard pharmacotherapy in how it recasts clinicians and patients as equal experts, prioritizes patients' motivation to engage in treatment rather than clinicians' multiple inquiries about symptoms, encourages patients' self-efficacy to overcome barriers, and attends to the momentum of patients' language about commitment to change. We also found that Motivational Pharmacotherapy can be feasibly incorporated into medication treatment, can be tailored to patients' culture and disorder, and may help increase adherence to psycho-pharmacotherapy.

Treatment non-adherence represents a major challenge in the pharmacotherapy of depression. Elevated rates of medication non-adherence (median >50% at various treatment durations) and treatment discontinuation (e.g., 30% after one month) in Major Depressive Disorder greatly impact care (Lingam & Scott, 2002; Velligan et al, 2010). These rates are typically highest among underserved racial/ethnic groups (Schraufnagel, Wagner, Miranda, & Roy-Byrne, 2006).

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Non-adherence presents a major target for intervention in psycho-pharmacotherapy because psychiatric medications are frequently effective when taken properly (Rush, et al., 2006). Conversely, irregular antidepressant adherence and early discontinuation are associated with increased recurrence and multiple adverse outcomes (Geddes et al, 2003; Lingam & Scott, 2002).

A major barrier to implementing adherence interventions is that simple interventions are minimally effective and more effective interventions are not simple. Standard psychoeducation improves adherence only slightly or transiently (Zygmunt, Olfson, Boyer, & Mechanic, 2002). More complex approaches, such as adjunctive case management or intensive behavioral interventions, are more effective but require investment in ancillary staff, time, and cost, which can limit their implementability (Haynes, Ackloo, Sahota, McDonald, & Yao, 2008; Zygmunt et al, 2002). Moreover, these interventions have rarely been tested with underserved racial/ethnic populations, raising questions about their cross-cultural effectiveness. The need for sustainable, culturally validated, and cost-effective approaches to enhancing adherence in psycho-pharmacotherapy remains acute.

One potentially cost-effective approach to improving adherence is to rethink the way that psycho-pharmacotherapy itself is conducted. This article describes a novel approach to improving treatment adherence, called Motivational Pharmacotherapy, which combines the tasks of antidepressant therapy with Motivational Interviewing, a counseling approach that has been effective in enhancing treatment adherence in multiple health conditions, even during brief medical visits (Hettema, Steele, & Miller, 2005; Rubak, Sandboek, Lauritzen, & Christensen, 2005). We describe how Motivational Interviewing approaches were incorporated into Motivational Pharmacotherapy and how we tailored the intervention to the clinical and the cultural characteristics of the treatment population. Clinical transcriptions are presented from an ongoing randomized clinical trial comparing Motivational Pharmacotherapy to standard pharmacotherapy for Major Depressive Disorder. The study was approved by the Institutional Review Board of the New York State Psychiatric Institute.

Overview of Motivational Interviewing

Motivational Interviewing is an empathic, non-confrontational counseling approach in which the clinician guides rather than pushes a patient towards change, sidestepping resistance, and actively working with the patient's strengths to build self-efficacy towards the desired outcome (Miller & Rollnick, 2002). It strategically uses the basic tools of standard counseling and psychotherapy (i.e., open-ended questions, affirmations, reflections, and summaries) to evoke and reinforce *change talk* (language from patients that argues against the status quo or for behavior change) and *commitment language* (statements from patients about their intention to implement a behavior change). In Motivational Interviewing, the clinician interacts with the patient in a manner that facilitates change talk and avoids interacting in ways that hinder it, which includes confronting patients, giving advice, or raising concerns about patients' actions without obtaining their permission beforehand (Moyers, Martin, Houck, Christopher, & Tonigan, 2009). Underlying these clinical skills is the spirit of Motivational Interviewing which is empathic and highly respectful of the expertise and wisdom that patients have about themselves and their

autonomy to make their own decisions (Miller and Moyers, 2006). Without this underlying mindset, attempts to evoke change talk can be perceived as manipulative by patients, and may result in heightened guardedness and resistance to behavior change.

Cultural and clinical considerations in Motivational Pharmacotherapy

In developing Motivational Pharmacotherapy we considered three important issues. First, the intervention had to be feasible within the duration of a typical pharmacotherapy session. Second, it had to be culturally congruent, particularly by incorporating values, illness representations, and attitudes toward medications that are relevant to Latinos (e.g., we wanted to make sure that Latino patients would accept a more collaborative approach to treatment). And third, because depression can decrease energy and motivation, we sought to facilitate the active participation of patients during the session through the use of structured materials such as values card sorts and lists of common obstacles to treatment adherence and retention. Table 1 presents the outline of the Motivational Pharmacotherapy sessions. The complete treatment manual is available at www.nyspi.org/culturalcompetence.

Key Differences of Motivational Pharmacotherapy

The first contribution of Motivational Interviewing to pharmacotherapy is a strong focus on enhancing patients' motivation to overcome their depression through antidepressant therapy, and on encouraging confidence in their ability to overcome treatment barriers. In standard pharmacotherapy sessions, the emphasis is mostly placed on symptoms, side effects, and adherence to dosing, with a curious lack of emphasis on how to guide the patient to achieve the desired change (i.e., take the medicine), which is usually conducted in a simple, didactic, exhortative manner. By contrast, in Motivational Pharmacotherapy the psychiatrist is more attuned to the stream of change talk from the patient in order to gauge and influence the momentum of the session and spends time managing the patient's motivation, obstacles to adherence, and strategies to enhance it. This means the psychiatrist has to trust that open-ended queries about the patient's condition will identify important symptoms, side effects, and concerns, which may occasionally necessitate more detailed assessment. At first, this may raise concerns about missing basic information. Yet, it is important to balance this concern with the realization that by over-focusing on symptom elicitation the patient may be lost to early termination. In effect, Motivational Pharmacotherapy does not consist of *adding* a series of Motivational Interviewing techniques to what occurs in the standard pharmacotherapy sessions; instead, Motivational Pharmacotherapy requires that the pharmacotherapist *limit* some of his/her typical activities and replace them with interactions that are more consistent with Motivational Interviewing.

Second, Motivational Pharmacotherapy emphasizes the use of basic counseling skills during the pharmacotherapy encounter. This reshapes the interaction from one aimed primarily at assessing and prescribing to one centered on understanding the patient's treatment experience and responding accordingly. This approach fosters improved communication and engagement and allows the clinician to clarify any barriers to adherence and patient's strengths that can be used to overcome them. The focus on understanding the patient helps

to build therapeutic alliance, which is an important, but often overlooked, component of effective pharmacotherapy (Weiss, Gaston, Propst, Wisebord & Zicherman, 1997).

Third, Motivational Pharmacotherapy recasts the patient-clinician relationship as one of equal experts, who explore together what course to follow. Whereas clinicians are experts in antidepressant therapy, patients are experts in their treatment expectations, previous subjective experiences with medications, barriers to treatment, and capacities to overcome these barriers. Within the Motivational Interviewing framework, patients' expertise is even more crucial to the success of the therapy, since the decision whether to adhere with treatment to effect change rests ultimately with them. This means the clinician fully engages the patient as an active co-decision-maker. The following example illustrates how changes in treatment are discussed with the patient:

> **Psychiatrist:** So, you have been at 75mg these two weeks. We have various alternatives and I would like to discuss them with you to see what you think. One idea is to keep the medication at 75mg another two weeks, see how things go, and see if your headaches decrease. The other is that we can reduce the medicine to 50mg, and the other alternative is that we raise the medication a bit to 100mg. Remember that I am the expert in medications but you are the expert in your body and you are the one who is feeling these things. You decide if you are willing to tolerate more or less of what you are feeling. What are your ideas about this?

Respect for a patient's autonomy also includes considering a decision to discontinue treatment. Table 2 depicts a session addressing this issue. Note how the psychiatrist uses a Motivational Interviewing approach (i.e., counseling skills, respecting autonomy, equality in the treatment relationship, focus on building motivation to continue) to pace with the patient, not pushing but guiding him to take the medication home just in case, and how the patient's statements about feeling better on the medication are selectively reflected. Not feeling pushed, the patient has no need to defend his position, thereby avoiding a right vs. wrong dynamic. Thus, when the patient notices the return of depressive symptoms, he is more willing to re-start the medication. Motivational Pharmacotherapy is therefore consistent with recommendations for personalization and shared decision-making in clinical care (Patel & Bakken, 2009), and with interventions aimed at empowering the patient to be a more active partner in mental health treatment (Alegría, et al., 2008). These participatory approaches have been associated with greater patient satisfaction (Swanson, Bastani, Rubenstein, Meredith, & Ford, 2007) and improved outcomes (Alegría, et al., 2008; Clever, et al., 2006).

The development of Motivational Pharmacotherapy demonstrates how Motivational Interviewing can feasibly be embedded into psycho-pharmacotherapy in order to address ambivalence about medication adherence. In our experience, Motivational Pharmacotherapy results in a patient-clinician interaction that is more patient-centered, collaborative, and personalized than standard psycho-pharmacotherapy. Motivational Pharmacotherapy was also amenable to cultural tailoring for first-generation Latinos, as suggested by the worldwide use of Motivational Interviewing and its effectiveness across diverse cultures and social groups (Hettema et al., 2005).

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Table 1
Outline of Motivational Pharmacotherapy sessions

1. Welcome patient to session
   - **a.** Affirm patient's commitment to getting better
   - **b.** Explain structure for session

2. Discuss patient's state/symptoms
   - **a.** Assess symptoms/side effects primarily using open-ended questions and reflections
   - **b.** Improvements in state are reflected and explored to elicit more change talk

3. Assess treatment adherence
   - **a.** Focus on adherence successes to build self-efficacy
   - **b.** Collaboratively identify ways of overcoming obstacles to adherence

4a*. Elicit change talk and commitment language about overcoming depression and starting antidepressant therapy (early sessions)
   - **a.** Goals and values card sort (Week 0)
   - **b.** Confidence ruler/Story of overcoming obstacles (Week 1)

4b*. Elicit and resolve obstacles to treatment (mid-treatment)
   - **a.** Obstacles to adherence bubble sheet (Week 4)
   - **b.** Thoughts about early termination from treatment (Week 8)

5. Review medication dosage and treatment plan
   - **a.** Collaboratively reach decisions about treatment

*Only conducted during the enhanced sessions on weeks 0, 1, 4, and 8.

Table 2
Addressing premature termination collaboratively

After increasing sertraline from 25mg to 50mg a patient returns 4 weeks later reporting numerous side effects. On his own, he had first reduced the dosage to 25mg but then discontinued the medication, thinking that he had sustained sufficient improvement, and that his body was now rejecting the medication. During the session he informs the psychiatrist of his actions. The psychiatrist explores the patient's decision and empathically reflects the patient's experience, then reaffirms the patient's autonomy in deciding to take medication and moves to establish a plan with the patient:

C: So, what would your plan be, what would be the next step?

P: You are the doctor, so you decide… and we had decided that I would take the medication for the next 9 months, but since I had to stop the medication --not because I wanted to but because my body was rejecting it-- I would like to continue with the treatment for the 9 months and see how my body is doing without the medication during these three months. I don't know if you would be in agreement with that.

C: So continuing to come, but evaluating the need for the medication; not necessarily taking it, but evaluating how you continue without it and seeing if there is a need for change.

P: If you want to, you can even give me the medications, though I wouldn't take it. And if there is a problem, I would have it there…

C: To take.

P: Yes to take if anything happens. But more than anything I would like you to do an evaluation these three months to see what my reaction is to not taking the medication.

C: What you propose is interesting, I understand that it's like an extended evaluation, like continuing to evaluate you without necessarily taking the pill, depending on what happens. I think it's fine. It's a process during which we evaluate jointly what needs to be done.

P: You are the specialist here and you are the one that knows much more about these things.

C: I think this is fine in principle, let me tell you what I am thinking and we can talk about it, okay? What you are proposing is that we can evaluate your situation without you necessarily taking the pill. Nobody would be forcing you to take something that your body is telling you that, at this specific time, it shouldn't take…the advantage is that we can continue to evaluate you without you having to take the medicine, and that might be the most advantageous thing for you, since your body is sending you a message.

P: Because in reality, I would like you to continue treating me in this manner and see what happens.

C: Yes, I think that is perfectly fine. The concern that I have, and it's a concern that we can talk about and don't have to reach a decision about today, is that there is a risk that the depression might return more quickly if you take the medication for less time. That is, you have been taking the medication for a few months, and that is good, you have that treatment in your body, no one can take that from you and it might be sufficient to protect you.

P: If it were for me…I am supposed to take the medication longer and if it were possible, I would do so, but in reality, maybe it sounds illogical, but really it's my body that is rejecting the medication.

C: No, I hear that, that is very clear. How about if we do the following, because I like your plan? We are in agreement about you staying in treatment for 9 months, evaluating you and seeing you. During the visits we would see how you are doing, and based on that decide if it's worth trying to start the medication again or not. And we continue another month with that decision… we'll decide on a month-to-month basis. I can even give you some medication in case you decide you want to take some so you have them available, if not, no. Like you suggested, having them there just in case.

P: Yes, I actually brought back the pills I didn't take so I can take those back with me. I don't like to take medication unless I have to and right now, I don't need them.

C: And really, you are telling me that you are feeling really well right now…

P: Yes, I feel well, like I told you earlier, it's like I feel strong, positive, so I don't think I will need the medication right now, but as you say, maybe in the future I might relapse.

C: Well, but I think it is fine for us to continue talking about it and without any pressure that you should do one thing or another, we can do whatever we think will work.

P: No, I really want to keep coming here and I am hoping that my decision to stop taking the medication will not change anything in the treatment.

C: I agree, the idea is to continue with the treatment. Perfect. Let's do that.

Although this vignette was edited for clarity and brevity, the psychiatrist's exploration of the patient's experience and his ambivalence about the medication did not lengthen the session substantially (the whole session lasted 19:58 minutes). The patient returned for his session on week 24 reporting that he began taking the antidepressant again after depressive symptoms reemerged. He continued to take the medication and completed all 36 weeks of treatment.

C = Clinician, P = Patient