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Transdiagnostic Motivational Enhancement Therapy to Reduce Treatment Attrition: Use in Emerging Adults

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Improving outcomes of youth with mental health (MH) needs as they transition into adulthood is of critical public health significance. Effective psychotherapy MH treatment is available, but can be effective only if the emerging adult (EA) attends long enough to benefit. Unfortunately, completion of psychotherapy among EAs is lower than for more mature adults (Edlund et al., 2002; Olfson, Marcus, Druss, & Pincus, 2002). To target the high attrition of EAs in MH treatment, investigators adapted a developmentally appropriate brief intervention aimed at reducing treatment attrition (TA) in psychotherapy and conducted a feasibility study of implementation. The intervention employs motivational interviewing strategies aimed at engaging and retaining EAs in outpatient MH treatment. Motivational enhancement therapy for treatment attrition, or MET-TA, takes only a few sessions at the outset of treatment as an adjunct to usual treatment. Importantly, it can be used for TA with psychotherapy for any MH condition; in other words, it is transdiagnostic. This article presents the first description of MET-TA, along with a case example that demonstrates important characteristics of the approach, and then briefly describes implementation feasibility based on a small pilot randomized controlled trial.

The Clinical Population and Mental Health Care

Older adolescents who are emerging into adulthood, also commonly referred to as *transition-age youth*, experience a unique developmental stage (Arnett, 2000). This developmental stage typically begins at age 18 (although it can begin as early as age 14) and continues to age 25 or 30 (Arnett, 2000; Davis, Green, & Hoffman, 2009). Arnett differentiates this stage from that of late adolescence and early adulthood, indicating that the former is characterized by rejection of authority and initial identity formation while the individual is still under the supervision of a parent and the latter is characterized by achievement of adult goals such as having a long-term job, long-term romantic relationship, and possibly children. The interim stage, emerging adulthood, comprises ongoing identity formation while the individual is independent of a parent, and consists of a series of short-term jobs and romantic relationships (Arnett, 2000). The intervention that the authors devised is intended to address this developmental stage, when individuals may still demonstrate rejection or distrust of authority figures and may also have difficulty with being consistent about attending psychotherapy treatment.

Though prevalence estimates vary, using the conservative prevalence estimate of 6.5% of young adults with mental illness (Government Accountability Office, 2008), applied to 2014 Census estimates (http://www.census.gov/popest/data/national/asrh/2014/files/NC-EST2014-AGESEX-RES.csv), indicates that approximately 3.2 million emerging adults (EAs) have a mental illness in the United States. Notably, many mental health (MH) conditions have onset during this age range, and three quarters of all MH conditions have onset before age 25 (de Girolamo, Dagani, Purcell, Cocchi, & McGorry, 2012; Kessler et al., 2007). In addition, findings from some studies of adult interventions have efficacy in older adults but not in those younger than ages 25 or 26 (Burke-Miller, Razzano, Grey, Blyler, & Cook, 2012; Uggen & Wakefield, 2005). Taken together with the legal, health care coverage, and service system changes that typically come with achieving legal adulthood, the stage of emerging adulthood is of great interest when it comes to improving MH care and retention in care. Young people with MH needs during the transition to adulthood can have tremendously compromised functioning in the realms of work, independent living, and staying out of legal trouble (Davis & Koroloff, 2007; Davis & Vander Stoep, 1997; Embry, Vander Stoep, Evens, Ryan, & Pollock, 2000; Newman, 2009; Planty et al., 2008). The *majority* of youth with a serious MH condition will be arrested by age 25, and

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most will have multiple arrests, often with serious charges (Davis, Banks, Fisher, Gershenson, & Grudzinskas, 2007; Fisher et al., 2006). Just as EAs in the general population have higher rates of alcohol and drug use and abuse than any other age group (Epstein, 2002), emerging adulthood is the peak age for substance abuse (36%) among individuals with MH conditions (Epstein, 2002; Sheidow, McCart, Zajac, & Davis, 2012). Further, EAs with MH conditions are at high risk for other poor outcomes including homelessness (Embry et al., 2000), unwanted pregnancy (Vander Stoep et al., 2000), school dropout (Planty et al., 2008), and unemployment (Haber, Karpur, Deschênes, & Clark, 2008).

Although office-based MH treatment is accessed by over 760,000 EAs each year (Olfson et al., 2002), its impact is limited because this age group is up to 7.9 times more likely to drop out of treatment than mature adults (Edlund et al., 2002; Olfson et al., 2002). Psychotherapy dropout also contributes to system inefficiencies, expensive psychiatric service utilization, and clinic income loss (Carpenter, Del Gaudio, & Morrow, 1979; Ogrodniczuk, Joyce, & Piper, 2005). It is also associated with lower medication adherence, poorer outcomes, and more distress (Hoffman, 1985; Pekarik, 1992). Treatment dropout has additional consequences in EAs insofar as it blocks support of critical psychosocial development needed for successful assumption of adult roles (Chung, Little, & Steinberg, 2005). The significance of addressing MH conditions at this time of life is clear. Current research suggests a minimum of 11–13 psychotherapy sessions for 50–60% of clients to achieve recovery (Hansen, Lambert, & Forman, 2002; Lambert, 2007). A simple and potentially cost-effective step to improving EA functioning and reducing system inefficiencies is to provide effective treatment attrition (TA) interventions.

Targeting Attrition in Psychotherapy Treatment

There are systems-level barriers to retention (e.g., age-related changes in Medicaid eligibility or clinic coverage), but some barriers may be accessible to therapist intervention. However, the literature on malleable correlates (i.e., factors that can be therapist targets) of TA focuses on children or adults (Block & Greeno, 2011), so little is known about the specific reasons for dropout in EAs. It is likely, though, that they share some of the most common correlates of TA in adults. Poor working alliance is consistently associated with TA and is composed of therapist–client affective bonds and agreement on therapy goals and tasks (Johansson & Eklund, 2006; Lingiardi, Filippucci, & Baiocco, 2005; Meier, Donmall, McElduff, Barrowclough, & Heller, 2006). Alliance may be particularly impeded in EAs because of the developmental stage. Identity formation, which continues into young adulthood and involves rejection of authority (Lodi-Smith & Roberts, 2010), may interfere with therapeutic bonds when therapists are viewed as authority figures, if authority figures endorse therapy, or when EAs disagree with the therapist. Developing confidence in one's own capacities can lead to resistance of gestures, ideas, or actions from those the EA views as parental or authoritative (as therapists can seem).

In addition, TA is associated with negative or misperceptions about treatment (Dyck, Joyce, & Azim, 1984; Grimes & Murdock, 1989; Kokotovic & Tracey, 1987; McNeill, May, & Lee, 1987), such as the length and efficacy (Edlund et al., 2002; Pekarik & Wierzbicki, 1986; Pulford, Adams, & Sheridan, 2008). A recent review of extant literature on TA in adult psychotherapy made specific recommendations to reduce attrition: pretherapy description and exploration of roles that client and therapist play; use of motivational interviewing; use of a multidimensional approach that increases client choice and planning of therapeutic options; and incorporating client feedback to therapists to guide treatment strategies and serve as an early warning system that a client is thinking about dropping out (Barrett et al., 2008).

Recent reviews report no therapist-implemented psychotherapy TA interventions with efficacy evidence for adolescents (Block & Greeno, 2011; Kim, Munson, & McKay, 2012) and only a small range for adults (Ogrodniczuk et al., 2005; Sims et al., 2012). Establishing attrition efficacy in EAs requires randomized controlled trials (RCTs) of the intervention exclusively in EAs, or conducting age group difference analyses in adult RCTs that include EAs in sufficiently powered sample sizes to detect differences (Davis, Koroloff, & Ellison, 2012). Given the higher dropout rate and developmental uniqueness of EAs, efficacy of adult interventions used for EAs cannot be assumed. Only one therapist-implemented psychotherapy TA intervention has some evidence of efficacy specifically in EAs: motivational enhancement therapy (MET). METs are derived from motivational interviewing (MI), which is an interpersonal style of therapy characterized by affirming client choice and self-direction, using both directive and client-centered components, in the context of a strong working alliance, to resolve ambivalence about the client's problems, and increase perceived self-efficacy to address the target problem (Miller & Rose, 2009; Söderlund, Madson, Rubak, & Nilsen, 2011). In MI, the therapist is intentionally directive, with a focus on a particular target behavior, using an interviewing style of questioning and clarification statements and attempting to guide the client to resolving ambivalence by having the client explore his or her own thinking and perception. The therapist's role is therefore transformed from being the expert giving advice into collaborating with the client, learning about the client's perspective, and having the client take the lead in decision making.