

BEHAVIORAL ACTIVATION FOR LATINOS TREATMENT MANUAL

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Notes

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DEVELOPMENT OF THIS MANUAL

Behavioral Activation (BA) has a long history dating back to the 1970s, and several variants of BA have been developed. All variants of BA have maintained a primary focus on using behavioral techniques to schedule new activities for the client to engage in, with the hope that these new activities will result in improved mood and reduced depression (Kanter, Manos, Bowe, Baruch, Busch, & Rusch, 2010). As BA has evolved, the focus of activity scheduling has shifted from simple pleasant and enjoyable events to events determined to be functionally important to the client based on individual assessment. This broader focus of activity scheduling includes activities consistent with a client's life goals and values, active problem solving, functional alternatives to avoidance and rumination, activities that bring a sense of mastery or accomplishment, and other activities that do not necessarily bring about feelings of pleasure or enjoyment but are still functionally important to the client.

Over the years, BA has received a wealth of empirical support, documented in three meta-analyses (Cuijpers, van Straten, & Warmerdam, 2007; Ekers, Richards, & Gilbody, 2008; Mazzucchelli, Kane & Rees, 2009). Mazzucchelli et al. evaluated BA's empirical support in light of standards developed by the American Psychological Association's Division 12 Task Force on Promotion and Dissemination of Psychological Procedures (Chambless et al., 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995) and concluded that BA should be designated a "well-established empirically validated treatment."

As presented to clients, BA has a very straightforward rationale: People are more likely to become depressed when there are more negative events and experiences in their lives. Negative experiences may be major losses like the end of a relationship, the loss of a job, or a move to a new city. These experiences may also be interpersonal difficulties including a lack of friends, or conflicts with friends or family members. Daily hassles such as inability to pay the bills, confusion about how to use public transportation, and experiences of racism or discrimination can also be considered negative experiences.

The more negative events one experiences in one's life, the more likely one is to become depressed. When a client becomes depressed, he or she gives up, gets stuck, and becomes hopeless, passive and inactive in life. She stops putting in real effort to solve problems, and stops doing activities that used to be pleasant, meaningful and enjoyable. He may even stop taking care of himself, showering and brushing teeth, or getting out of bed. All of these changes may result in the depression getting worse, which starts a vicious cycle of depression. BA focuses on the negative events that cause people to get depressed in the first place, and on helping people get active again in life to break the cycle of depression. BA uses behavioral techniques to activate clients to solve problems help them persist in the face of seemingly overwhelming obstacles, experience pleasure and mastery in what they do and stay committed to active lifestyles in support of life goals and values.

Behavioral Activation for Latinos

In general, it has been recommended that psychotherapy for Latinos in the United States should provide strong guidance and support, take a problem-solving approach to life problems, and have a short-term, present-time orientation (Santiago-Rivera, Kanter, Benson, DeRose, Illes, & Reyes, 2008). Because of this, we felt that BA would be a particularly good fit for depressed Latinos, as it has all of these qualities. We also felt BA had great potential for easy training and dissemination to community therapists who work with Latino clients.

To begin the process of exploring BA with Latinos, we started with existing BA manuals (including Martell, Addis and Jacobson, 2001, and Lejuez, Hopko, & Hopko, 2001), assembled a bilingual and bicultural team, and began applying the approach to pilot cases in Spanish at the Sixteenth Street Community Health Center (SSCHC) in Milwaukee, Wisconsin. One of these first pilot cases is published (Kanter, Dieguez-Hurtado, Rusch, Busch, & Santiago-Rivera, 2008). This process resulted in a small manual describing how we applied BA at this clinic and we evaluated this manual in a small study funded by the University of Wisconsin-Milwaukee's Research Growth Initiative (Kanter, Santiago-Rivera, Rusch, Busch, & West, 2010).

Although we are strong advocates of the existing BA manuals and believe they are excellent, during this study we came to understand that the existing manuals could be improved in terms of cultural awareness and

adaptability. We believe that the previous variants of BA were developed within the context of the mainstream culture of the treatment developers, and in fact were somewhat specific to Anglo-American culture. However, these previous versions of BA were not explicit about the culture in which they were developed and in fact the cultural context was hidden. For example, the case examples and clinical excerpts are all Anglo-centric and not sensitive to culture or class. We also felt that the overall rationale for treatment presented was more complex than necessary and may be difficult to follow for some clients. Also, the treatment techniques in Martell et al. (2001) revolve around the use of three acronyms: TRAP, TRAC, and ACTION. These acronyms did not translate well and our population did not really understand or use acronyms anyway. Likewise, the treatment techniques in Lejuez et al. (2001) relied heavily on written therapy homework assignments, which may be specific to Anglo-American culture in that there is a norm that the client will be given assignments and forms to complete by the therapist. We did not know if this norm applied for Latino clients.

We believe that the changes we have made to BA in this manual are minor, do not impact the core mechanisms of BA, and are restricted to broadening the cultural adaptability of BA without inserting specific cultural adaptations. We believe the version of BA we have created is broadly applicable across cultures and is clearly and thoroughly consistent with what BA has been over the last 30 years.

The version of BA we describe herein represents an attempt to first remove culturally specific notions from BA before presenting guidelines for how BA may be applied within a Latino cultural context. We have most certainly failed in this attempt to remove culture from BA, because we too are embedded in a cultural context and cannot as human beings operate from outside this context. However we have tried to create a version of BA that is less embedded in a specific culture than previous versions. We did so by working with a diverse multi-cultural team, considering multiple cultural contexts, looking for key themes that cut across culture, and presenting those themes in unelaborated form in the manual. This multi-cultural team consisted of individuals from Anglo-American, Latino, African-American, Muslim, and Orthodox Jewish cultures. Our aim was to identify and isolate the core theorized mechanisms and basic principles of BA (Kanter et al., 2010), and then consider how to wrap flexible and adaptable treatment techniques around these mechanisms and principles. Our aim was to capitalize on BA's purported strengths as pragmatic, parsimonious, and therefore easy to train and easy to understand. This process resulted in what we consider to be increased simplification and flexibility of BA techniques, particularly the rationale for treatment and activity scheduling.

This manual was used as the basis of training in the randomized trial reported in Kanter et al. (2014).

WHEN AND HOW TO USE THIS MANUAL

Location of manual development

Spanish-speaking Latinos in the United States are a diverse group, representing a wide-range of countries of origin, socio-economic classes, and culturally specific issues. While we have tried to consider broad applicability in the development of this manual, it may be biased towards being most relevant to the clients with whom we have interacted to this date. We aim to test the relevance of this manual to Latinos from other regions in the United States in the future, as our hope is that this manual is broadly applicable. Currently, however, our experience has focused on the Sixteenth Street Community Health Center (SSCHC) of Milwaukee, Wisconsin. Thus, some understanding of these clients may be helpful in considering the generalizability of this manual. It is important that therapists adapt the presentation of the materials to match the characteristics of their own clients, and we have provided guidelines for how to do so later in this manual.

The SSCHC was created in 1978 to serve the south side of Milwaukee, which has been identified as a comprehensive health care, dental and mental health professional shortage area, and is the only community-based agency with a full-service bilingual (English-Spanish) mental health clinic in Milwaukee County. The area in which SSCHC is located has the largest concentration of Latinos in the state. In fact, the Latino population of Milwaukee grew from 45,000 in 1990 to 89,000 in 2002 and most reside in the area served by the SSCHC. The Behavioral Health Services (BHS) branch of the SSCHC serves a client population that is 80% Latino, the majority monolingual Spanish-speakers. Most of these clients are from Mexico, followed by Puerto Rico and then a variety of Central and South American countries. Many do not have health insurance and a significant number are illegal immigrants. The clients tend to be poor and unemployed or under-employed. A description of 36 clients receiving services at BHS we surveyed in a recent study is presented in the two tables below:

Demographic characteristics of 36 Clients at BHS in 2007	
Age	38.0 (8.4)
Female	83%
Yearly household income	\$11,315 (\$7,538)
# children	3.13 (1.6)
Married/common law	50%
Years in U.S.	12.75 (9.10)
Country of birth	19 Mexico 16 Puerto Rico 1 Cuba

Cultural Characteristics of 36 Clients at BHS in 2007		Scale Range
Importance of Family	21.39 (3.65)	5 – 25
Importance of religion	6.05 (1.67)	1 – 7
Acculturation	21.53 (5.94)	12 – 60
Pressure to acculturate	7.84 (7.45)	0 – 35
Difficult immigration?	72%	

These data suggest that the typical BHS client is a female in her 30s or 40s, with very low income, 3 children, who may or may not be married or have a partner. Almost all clients state that their families and their religion are very important. Most clients report a difficult immigration experience. Although many clients have been in the U.S. for many years, others are newly transplanted clients undergoing the process of change and adaptation. Even those who have been in the U.S. for several years are not well acculturated and are not feeling excessive pressure to acculturate, perhaps because the Latino community in Milwaukee is a legitimate enclave in which Latino culture, language, and customs are intact.

The BHS clinic is very active. In 2004 the clinic provided over 10,000 counseling and/or psychiatric evaluation sessions and 3,800 medication management sessions. Currently, it provides a full range of outpatient mental health services such as services for alcohol and other drug abuse problems and emotional health screening and diagnosis, individual and group counseling, psycho-education groups, case management, and medication management via psychiatry services. The current staff consists of 5 psychiatrists, 4 licensed psychologists, 6 master-level psychotherapists, a psychiatric nurse, and a graduate intern, for a total of 17 providers of which 11 are fully bilingual. The majority of the patients are direct referrals from internal SSCHC pediatric and family practice medical providers, but referrals from throughout the Milwaukee area are received because there are few other options available for Spanish speaking clients in the area.

Therapist qualifications

A premise of our approach to Behavioral Activation is that the treatment provider may learn these techniques quickly and it does not require extensive training. Any therapist working with clinical depression and using this manual should have access to clinical backup and supervision and/or consultation from licensed mental health professionals. All therapists should be trained in specific protocols to deal appropriately with suicidal behavior and domestic violence, and a specific referral network should be in place for handling acute crises.

Supervision

As with integrating any new techniques into one's therapeutic repertoire, it is recommended that those wishing to become proficient in the practice of BA receive feedback and guidance from a supervisor. The necessary qualifications of the supervisor will depend on the attributes of the therapist. Therapists who have practiced BA, but are unfamiliar with the Latino culture should enlist supervision from someone trained in cultural sensitivity. Therapists trained to be culturally sensitive and with experience treating Latino clients should seek out supervision from an experienced BA therapist.

Client qualifications

This manual was developed to be appropriate for clients who meet criteria for major depression, other clinical depressive disorders, and those who have significant depressed mood along with another diagnosis. It should not be used with clients who (a) have bipolar depression, (b) are psychotic, (c) have a primary disorder other than depression for which empirically supported treatments exist and are available to the client unless it is felt that depression should be the immediate focus of treatment, or (d) have ongoing primary substance dependence.

BEHAVIORAL ACTIVATION: OVERVIEW

*Don't ask yourself what the world needs. Ask yourself what makes you come alive and then go do that.
Because what the world needs is people who have come alive.
-Howard Thurman*

In this section of the manual we present an overview of the primary components of BA.

The key to BA is identifying, assigning and reviewing activities designed to improve the client's mood and reduce depression. Every individual or group session essentially involves reviewing last week's assigned activities and assigning new activities. Activities are assigned in detail, with the client and the therapist reviewing what, when, where, with whom activities will be completed. Obstacles to completing activities are also discussed, and clients may be asked to visualize or role-play an activity. Being so focused on concrete activities as the central theme of the individual or group session may be new to many therapists, but it is the primary emphasis in BA.

Activity is the focus in BA but BA is not a superficial approach to treatment. The goal is for the therapist and the client to identify the client's core issues and develop activities related to those issues. The goal is not simply to have the client engage in pleasant activities, although pleasant activities likely will be a component of the case conceptualization. More importantly, the therapist and the client together determine the problems that have caused the client to feel bad and become depressed. When these core issue are identified, the goal is to activate new behavior related to the issue.

Providing a treatment rationale and case conceptualization. The initial treatment rationale in BA focuses on the negative life events that the client has experienced or is experiencing and how the client has reacted to those events. The simplest version of this rationale is depicted as the "2 circles" model with arrows showing how negative life events lead to common responses which may lead to more negative life events (Figure 1). In this model, *common responses* includes cognitive, emotional, and behavioral responses of the client including negative thoughts, lowered self esteem, depressed mood, anger, irritability, avoidance, passivity and giving up; in other words, the full psychological response of the client is relevant here. When giving the rationale, it is emphasized to the client that these responses are natural and normal and make sense given the negative life events, but unfortunately they tend to produce even more negative life events and create a spiral into depression. Working with Latinos in Milwaukee involved many culturally specific negative life events (e.g., the immigration process, racism and discrimination, language difficulties) and common responses (e.g., a client who reported a *presencia negativa* that was following her because of her depression, behaviors consistent with *machismo*, *familismo* and *marianismo*). It is important for the therapist to understand and be sensitive to the kinds of negative life events common among many Latino communities, and the ways individuals may respond to these experiences, but not to stereotype clients by assuming these cultural factors are always an issue. Instead, knowledge of potentially relevant cultural factors may guide assessment to ascertain what is relevant for each client.

BA helps clients respond to life events proactively with *action steps* rather than common responses. This is done by giving the client specific activation assignments based on their specific problems and areas of avoidance. Activation requires sensitivity to the complexity of these issues as well as the cultural values that support some of the responses.

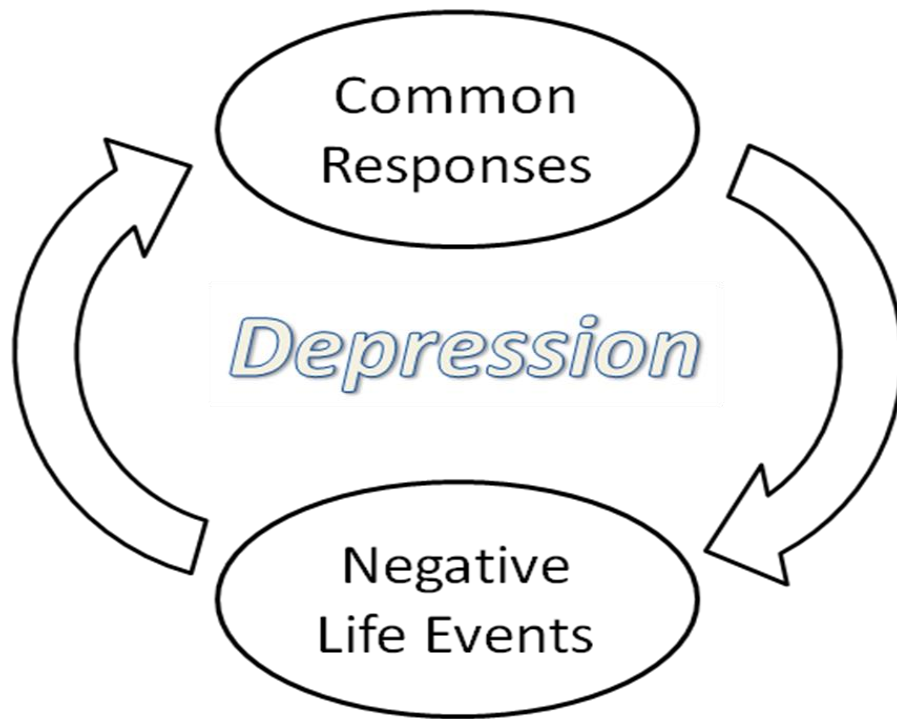


Figure 1. Simplified BA model

Assessment to Determine Activities to Schedule. In BA, a variety of strategies are used to determine which activities to schedule with clients. Simply put, the therapist and the client (or group) work together to figure this out. Scheduled activities should not just be about enjoyment and pleasure but should target the client’s core issues and problems that the client is experiencing. In general, the therapist tries to identify activities to schedule in three areas:

1. Meaningful and valued activities.
2. Routines and regularly scheduled activities.
3. Fun and enjoyable activities.

Usually, the therapist and clients determine activities to schedule simply by discussing issues, but particular forms are also available that may help this process. These forms include a “values assessment” (therapist and client versions; Appendix A) discussed below, and an “activity monitoring form” (Appendix B), discussed below.

When an initial set of activities to schedule has been determined, these activities may be listed on an “Activity List” (Appendix C). This activity list provides a running list of all the activities a client engages in over the course of treatment. The list provides a space for the client to list how difficult each activity is expected to be (easy, medium, hard, and very hard), when the activity is assigned, when the activity is completed, and how difficult the activity actually was. The client may share progress with completed activities with the therapist or the group and receive encouragement and feedback as this occurs.

This manual highlights the importance of engaging in culturally sensitive behaviors. In the context of activity scheduling, the importance of taking cultural values into consideration when determining activities to assign is emphasized. For example, sometimes activation needs to be sensitive to cultural values that lead clients to engage in, or not engage in, certain behaviors. Examples include a wife who would not confront her husband who was not treating her well. The value of *familismo* made it inappropriate to do traditional BA which may

have encouraged activation of the clients to communicate with her husband. In general, BA aims to empower our clients to take action steps to overcome the difficulties and triggers that caused depression that consider any relevant specific cultural values.

Scheduling Activities (Activation). The most important component of BA is scheduling activities. This manual provides specific tips for how to schedule activities successfully. These tips help the therapist think very carefully about the nature of each activity that is scheduled to maximize the chance that the activity will be successful. A primary theme in activity scheduling is that it is helpful for the scheduled activities to be very concrete and specific. In general, clients leave individual or group sessions with 3 – 5 planned activities for the week, with perhaps 1 or 2 of these activities having been designed and reviewed in detail with the therapist or the group. It is also important for the therapist and clients to predict potential obstacles that may interfere with activity completion and develop solutions to those obstacles in advance.

Additional strategies. A variety of additional strategies are used in BA to engage clients in treatment, maximize the success of activation, deal with problems that arise throughout therapy, and plan for termination.

THE THERAPEUTIC RELATIONSHIP

BA therapists display a genuine concern and compassion for their clients. The therapist should accurately reflect what the client is saying, and the therapist should continuously reflect that the details of the client's life and how the client feels make sense and are understandable. The therapist should always maintain hope and optimism about change.

The therapist should be collaborative and open to the client's influence. The therapist should recognize that he or she is not always right and that he/she and the client are working together as a team. In groups, the therapists likewise should respect the voices and power of the group and facilitate the group members helping each other. It may be helpful for the therapist to explain to clients that the therapeutic relationship is like one between a good teacher ("maestro") and a student. The therapist is an expert, has studied the situation, and can offer guidance, advice and support. But the clients must do the work, and the clients have access to the details of their environments and behavior that the therapist does not have. Thus, they must work together collaboratively. It is important for the therapist to have confidence in the approach but must not force it on the clients or make assumptions without checking with clients if the assumptions are valid.

To put this issue differently, the therapist should have confidence in the basic therapeutic process of activating clients via specific, concrete assignments but should not claim to know exactly what the best activation assignments should be. Activation assignments should be determined collaboratively, using feedback from clients on what clients feel would be graded improvements, what clients feel their environments will respond positively to, and what clients feel will be accomplishments. Likewise, the therapist should not guarantee the outcome of activation assignments. Activation assignments should be presented as experiments, things to try, and the outcomes should be discussed and decided on collaboratively.

Although this is important for all clients we emphasize that the therapeutic relationship should be one of mutual *respeto* (respect), and the cultural values of *confianza* (trusting relationship) and *personalismo* (warm and friendly interpersonal interaction) are necessary elements. From this cultural context Latino clients may respond better to activation assignments if the therapist comes across as a caring, warm, and friendly person (e.g., Miranda, Azocar et al., 2003). *Equally important*, client *respeto* toward the therapist may likely lead clients to view the therapist as someone with a great deal of authority, similar to a medical doctor. The deference to the professional's authority may result in the expectation that the therapist will tell clients what to do. In early sessions this authority can be used to maximize compliance with homework assignments and with session attendance. However, over time, reliance on authority and relegation of decision making to authorities may come to be seen as an avoidance pattern for certain clients.

In these cases it will be important to work toward less therapeutic authority but still maintain a confident and respectable therapeutic stance. With respect to maintaining client *respeto*, starting by addressing clients with formal titles (e.g. Mr., Mrs., Senor, Senora, Señorita) and the use of *Don* and *Doña* for the older adults may signal mutual respect, but the therapist should discuss with clients early on how he or she prefers to be addressed. Similarly, the therapist should start the therapy relationship with "usted" and only start using "tu" when clients have given permission or it is obvious that the relationship has become more informal (e.g., by how clients are addressing the therapist).

Platicar (personable small talk) is a common communication style among Latinos (Mexicans primarily). This involves engaging in conversation about things that are unrelated to therapy (e.g., talking about a current social or religious event in the community, a popular television program). The therapist might want to engage in such conversation at the beginning of the session or during the initial stages of therapy as a way to demonstrate *personalismo* while easing clients' anxieties about treatment. This is particularly important in beginning individual sessions when the therapist should take the time to get to know the client and let the client tell his or her story.

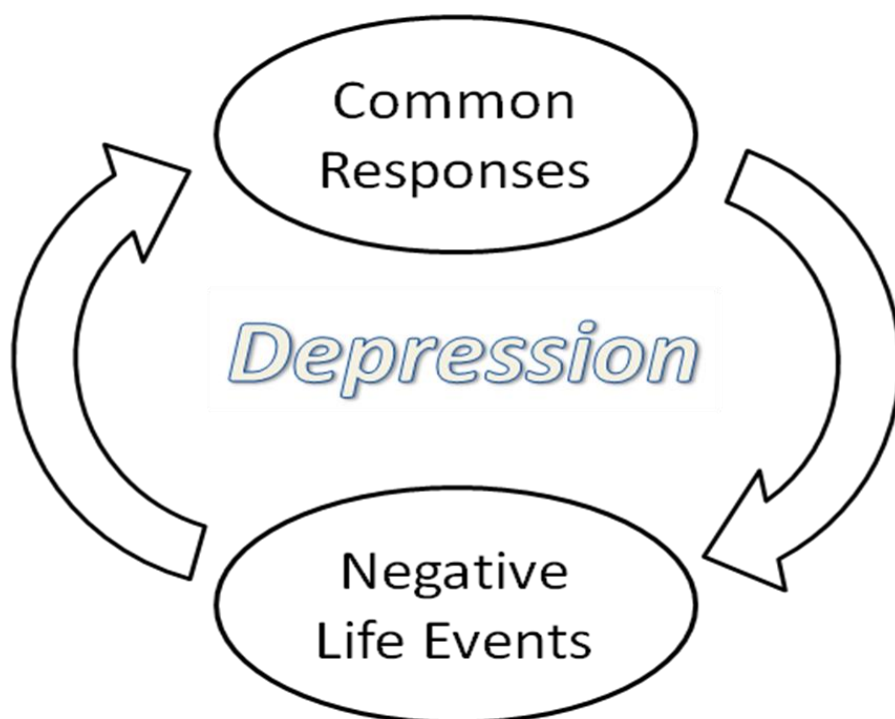
Working with illegal immigrants and illegal behavior. It is important for the therapist to stress to clients that everything clients say in sessions is confidential and only under certain circumstances (i.e., if a minor is being abused, if client is suicidal or homicidal, if a court subpoena is issued) will confidentiality be broken. Even illegal activities (e.g., selling drugs or drug use of a family member, gang involvement of a son,

immigration status) can be discussed and will only lead to confidentiality issues if the therapist acquires knowledge that someone is in imminent danger of being harmed.

Ethnic match of client and therapist. In some cases BA may be delivered by a therapist who is not Latino. This may result in clients feeling that the therapist may not understand some issues, such as racism or what it is like being Latino in a white culture. It is important for the therapist to behave with cultural sensitivity by acquiring knowledge about issues relevant to the client's cultural/ethnic group of origin and using the knowledge to guide assessment about what matters to the client in seeking treatment, demonstrating to clients that the therapist is open to and understanding of the client's experience. We provide more guidance on how to do this in later sections of this manual.

PROVIDING THE BA RATIONALE

Here we discuss the specific skills needed to provide the BA rationale, presented typically as the “2 circles” model, and then we discuss how the BA therapist may respond to specific client responses to the rationale.



Specific Skills Involved in Presenting the BA Rationale

Identifying and Discussing Negative Life Events

Clients may present in therapy with a variety of negative life events, problems, daily hassles, stressors, and the like. These *negative life events* can include:

- Experiences of trauma and violence
- Disruptive “positive” events including pregnancy and childbirth
- Poor social support, marital dissatisfaction
- Major losses such as divorce, widowhood, death of loved ones
- Difficulties with obtaining, maintaining, and upward mobility in employment, or even if successfully employed being paid a wage that makes it impossible to pay bills or escape from poverty.
- Health problems of all sorts including obesity, physical pain from injuries, and chronic health conditions such as diabetes.
- Daily hassles that are increased exponentially when living in poverty such as use of public transportation, car maintenance, paying the bills, finding quality daycare if employed, and lack of insurance.
- Direct and indirect experiences of racism and discrimination.
- For Latino clients, problems stemming from not being able to speak English such as not fully understanding contracts or bills, difficulty negotiating agencies such as the Department of Motor

Vehicles or social service or medical agencies, and being unable to venture out of the Spanish-speaking community thereby restricting options for problem solving and entertainment.

- For Latino clients, stressors and fear associated with being undocumented and not having a social security card (e.g., unable to get food stamps, official employment, fear of the police and getting deported, driving without a license)
- For Latino clients, other acculturation problems including values conflicts with other family members and within one's self (i.e., wanting both to acculturate and to retain ties to the culture of origin).
- For immigrants, consequences of the immigration process such as isolation from family and friends and loss of an extended social support network and community.

The first stage of BA involves determining collaboratively with the client the specific nature of the problems and stressors. Some clients may report just one or two discrete problems or losses, such as death in the family, divorce, or recent unemployment. Others will report on the accrual of multiple smaller hassles and stressors. Others will have been living in chronically stressful and deprived environments for so long that they will at first have no losses to report on, because nothing new has happened or changed in quite some time. Regardless, undoubtedly there will be problems, and it is the job of the BA therapist to emphasize that many of the symptoms of depression make sense given these problems.

In the first individual or group session of BA, the therapist should develop a list of these negative life events that the client or clients have experienced, write them down and share them with the clients. The therapist may start the discussion simply by stating to the client, "Tell me about the kinds of things that are going wrong in your life," or asking, "Why did you decide to seek treatment?" These questions, typical for the beginning of most therapy relationships, are also key questions to begin to explore the BA model with the client. The therapist may call the client's issues "negative life events" (in Spanish, "eventos negativos"), write them down on a whiteboard or paper to share with the client, and draw a circle around them.

Identifying and Discussing Common Emotional and Behavioral Responses

After the therapist has understood the client's negative life events, the next step is for the therapist to understand the client's psychological (emotional and behavioral) responses to these events. The therapist may ask, "Given all this that has happened in your life, how have you been feeling?"

It is a natural human response, when bad things happen (either major events, the accrual of smaller events, or the combination), to feel bad. In BA, we call this a *common response* to emphasize that it is in fact common and that the client isn't weak, unusual or crazy for feeling this way. The client will feel sad, down, depressed, or blue. The client may cry more frequently or experience increased irritation. The client may feel tired, lethargic, lacking in energy. The client may feel that nothing is fun anymore. The important point for the BA therapist to stress is that these responses are common and make sense. Anyone would feel this way given the client's situation. Some common emotional responses include:

- Sadness
- Feeling down
- Feeling blue
- Crying more
- Feeling depressed
- Experiencing less pleasure in things
- Grief reactions
- Fear
- Stress
- Physical symptoms

- Fatigue
- Anger, irritability
- Guilt
- Shame
- Despair
- Hopelessness

It is possible that a client will emphasize physical rather than emotional symptoms, for example, feeling tired or in pain. This is not a problem and the client does not need to be convinced to talk in emotional terms. Treatment does not need to shift in this way. The therapist should use the client's language and terminology for how they are describing their experience, and use the somatic symptoms directly in the model. Usually these somatic symptoms can be seen as "common responses" and the therapist will want to focus on activating the client to maintain healthy lifestyles in the presence of these symptoms.

It is also important to assess the client's behavioral responses to the negative life events. Typically, client's behavior becomes passive and avoidant when they are depressed. This passivity and avoidance expresses itself in many ways, including:

- Not wanting to go out any more (e.g. to Church)
- Staying in bed
- Sleeping too much
- Calling in sick to work
- Withdrawing from friends/family
- Stopping housework
- Stopping looking for work or pretending to look for work
- Drinking too much, smoking, using drugs, overusing prescription meds
- Filling every minute of the day to avoid facing problems
- Watching television
- Lashing out at others including family and children
- Eating too much junk food
- Trying to kill oneself
- Acting like life is already over

BA therapists should be focused on identifying the clients' various avoidance responses. It may be helpful to label these responses "secondary coping" as this suggests that the client is indeed trying to cope with the feelings that have surfaced in response to negative life events. Other therapists simply may label them "avoidance."

BA therapists may choose to list the client's emotional common responses and behavioral secondary coping/avoidance responses separately or together, depending on how the conversation goes with the client. For example, some clients may not report any feelings in response to the events and may have difficulty distinguishing feelings from behavior. For example, in response to the question, "How are you feeling in response to all this?" the client said, "I can't do anything anymore. This is fine and the therapist does not have to help the client understand or report on her feelings. In this case the therapist may just focus on the client's behavior, which is important to assess in any case. After completing the first "negative life events" circle, the therapist may develop a list of the clients' common responses, write them down, and label them "common responses" (in Spanish, "respuestas") or something similar depending on the language the client has been using to describe the problems.

Validating Responses as Natural, Normal, and Common

It is the therapist's task in BA to understand the clients' common responses to the negative life events, whatever they are, and validate and normalize them. To do this, the therapist may draw an arrow from the negative life events circle to the common responses circle to show that the responses are an understandable response to the events. The therapist should say things to the client like:

I want you to understand that the way you have been responding makes perfect sense to me. I do not think you are crazy or weak for having these reactions, and I do not think you are lazy or that there is anything wrong with you. I think your feelings and reactions make sense. They are normal and natural and anyone would feel this way given the negative life events in your life.

The validation of the client's experience as normal and not "sick" is extremely important to BA. The therapist should be very matter-of-fact in his or her style here. The therapist should empathize with the client as another human being, for whom these same problems could have occurred. The therapist should treat the client as an equal adult in this exchange.

Discussing How Responses Lead to More Negative Life Events: The Spiral or Cycle of Depression

The next step in presenting the BA rationale is to discuss with the client the consequences of his or her responses to the negative life events. The therapist may ask the clients:

- So I understand that it makes sense that you have been reacting the way you have, but when you respond this way, what happens?
- What does your sitting and watching television all day do about these problems?
- How has your relationship with your wife changed since you stopped communicating with her?

Clients are usually very aware that their passivity and avoidance are making problems worse, and it is the therapist's job to gently and compassionately point this out to the clients. To make the point, the therapist may draw an arrow back from the "common responses" circle to the "negative life events" circle as in the figure.

The therapist may state that this sets off a spiral or cycle into deeper and deeper depression, and use examples from the client's life to discuss this. The therapist may say:

I really see the difficulty of your situation. You have been having trouble finding a job, and the longer you have been unemployed, the worse you have felt. That makes sense to me. And the worse you feel, the harder it has been to keep looking for work, right? And that makes sense too. But there is a problem here, isn't there? Now you've stopped looking for work completely, which is not helpful in finding a job. So you are going to keep feeling worse and worse, and it will keep getting harder and harder to break this cycle. Do you see this trap you are in?

Explaining the Goal of BA: Activation to "Break the Cycle"

When the clients understand this cycle, the therapist can then discuss what they are going to do about it. Specifically, BA directly targets how clients have become stuck, passive, and inactive. The goal is to help the client activate behaviors that proactively address the initial negative life events. Stay active. Solve problems. Get out of bed and apply for jobs. Go to church and force oneself to interact with others. Call the friend with whom one had an argument. Do the dishes that have piled up in the sink. The therapist's job is to collaborate with the clients to identify the negative life events and the common responses and then collaboratively design

activation assignments that are attempts to solve the initial problems rather than the common responses. The therapist should explain that activation will be very focused on the things that the client has been avoiding doing, the things that are hard for the client to do on his or her own and that the client would continue to avoid without intervention through therapy.

The therapist may say:

So I would like to suggest to you that our work together may be about breaking this cycle by getting you active again. We can develop action plans and goals for you, and then help you act according to these goals and plans rather than according to your feelings. We can work from where you are now, and decide together what your goals and action steps should be each week. I can help you think about the best things to do and the best way to start. Then, over time, as you break this cycle and get more active, you will start to feel better again, and your life will start to improve. This can create a different cycle, in which you get active, feel better, and improve your life. But the key is to start by getting active.

If working with Latino clients, a Spanish *dicho* (saying) that may be useful here is, “Al que madruga dios lo ayuda,” which means, “God helps those who help themselves,” or “God helps the early riser.” This conveys to the client that this approach is about getting active and getting things done. Another useful *dicho* is, “Poco a poco, se anda lejos,” or “Little by little one goes far,” which conveys the idea that BA will involve small action steps that over time will help overcome depression.

Using the Client’s Language Instead of Jargon

Although BA is a behavioral treatment, the BA therapist does not have to use behavioral terms like “stimulus” or “reinforcement” with the client. In fact, with very few exceptions, BA therapists do not use this technical language with clients. Instead, BA when providing the rationale the BA therapist uses the client’s language and plain language to discuss issues.

Clients will vary considerably with respect to knowledge about depression and familiarity with psychiatric terms such as “symptoms” and “diagnosis.” In BA, it is *not* important that the therapist educate clients about depression or the symptoms of depression. The BA therapist does not have to use the word “depression” when describing the clients’ responses to negative life events. Instead, the therapist should learn the client’s language and descriptors of their responses, and fit the BA model to the client’s language. The therapist should provide a good rationale for treatment that links the treatment techniques to whatever psychological responses with which the client presents.

For example, a client presented primarily with complaints of irritability and anger and said he was not depressed (although he met criteria for Major Depression according to the assessment interview). In such a case, the therapist may state that treatment will target those issues of irritability and anger. According to the 2 circles model, irritability and anger would be seen as a “common responses” to negative life events. Thus, treatment would involve activating alternate more functional behaviors instead of anger expression.

Seeking Feedback and Verifying the Client’s Understanding of the Rationale

It is important in BA to collaborate with the client at every point in therapy, and to continually seek feedback from the client on the appropriateness of your interventions as a therapist. This is most important with respect to the treatment rationale. When soliciting feedback from the client, make sure that you do NOT ask questions which the client can answer with a simple “yes” or “no,” such as “Does this make sense to you?” The client may answer that question with a yes, but you have not learned what about the rationale makes sense and what does not. Instead, ask questions such as:

- Can you tell me what makes sense to you about what I am suggesting?
- What fits your expectations about our work together, and what doesn’t?

- What are you thinking and feeling in response to what I am saying?

Obviously, when a client endorses strong agreement with the rationale, the therapist should feel confident to continue with treatment. We also believe, however, that not every client will believe that BA is a good fit, and therapists should take client feedback very seriously. You want to have an honest discussion with your clients about the goals of treatment and reach a collaborative decision about what to do. A client may express some initial confusion about or disagreement with the BA model, and the therapist should try to clear that up. However, clients with strong negative reactions to the model should be taken very seriously. Alternate treatments for depression are available and therapy will not succeed if the client and therapist are not in agreement about what therapy should entail.

Addressing Client Responses to the BA Rationale

Here we discuss four common responses to the BA rationale and how the therapist may respond to these responses by staying within the BA model. As stated above, it is important for the therapist to never argue with the client, and if the client expresses strong disagreement after the therapist has tried to respond by staying within the model, it is the therapist's task to join with the client and develop an alternate treatment plan that does not involve behavioral activation.

The “Just Do It” Issue

A client may respond to the rationale that they have already tried and failed to get active: “If I could just do it and get myself active, then I wouldn't need a therapist!” In this situation, the therapist should validate that activation can be very challenging and without a coach or support system in place it is difficult to activate on one's own. The key is that the therapist will be very helpful in working with the client to activate and to try strategies that the client has not tried before. The therapist may say (Kanter, Bowe, Baruch, & Busch, 2010, p. 133):

I really appreciate all that you have tried to do and how hard you have worked. And I appreciate that what I am suggesting is not easy. The difference between what I have to offer you, and what you have already tried, is that I have lots of tips and tricks and ideas that help people make changes. People think it is easy to change their behavior, but if it was so easy you probably wouldn't be here and you would have figured it out on your own. So we can look very closely at what behaviors we should change for you, how these behaviors should be broken down, and where we should start. Also, we can look very closely at how you and others respond when you do activate, and try to make sure that the right consequences are in place. It is not just about doing more things randomly; we are going to be very strategic about what you do, when you do it and create a plan that over time will get you where you want to be.

The “Inside Out” Issue

Some clients respond to the rationale by feeling that behavior change will be too hard because of how badly they feel: “If I just felt like I had more energy [or more motivation] then it would be so much easier to do things. I wish I didn't feel so terrible all the time.”

The therapist may respond by validating this response as understandable, emphasizing the difficulties with it, and talking about BA's “outside-in” approach (Martell et al., 2001, p. 95):

I understand what you are saying. It would be so much easier for you if you didn't feel the way you feel and that if you felt better, it would be easier to change what you do. This is typical to think of acting from the ‘inside-out’ where we wait to feel motivated or inspired before completing tasks. The problem

is that we may be waiting a long time for this to happen. I would like to suggest that we try to do it a little differently. Instead of trying to change how you feel on the inside first, we can try to get you moving now, before you feel better. This would be more of an “outside-in” approach, where we behave first and feel later. Over time, this behavior will change your mood, and you will feel better. Can you think of times when you were feeling lousy, but got up and did something, and that helped you feel better?

Alternately, the therapist may talk about the importance of acting according to goals rather than acting according to moods:

I totally understand what you are saying. What I would like to try with you is, instead of focusing on how you are feeling, let's focus on your goals, and help you learn how to act according to a plan and your goals, not a mood. Have you heard of the phrase, ‘plan your work and work your plan’? I am wondering how you feel about trying that? In here we could come up with the plan that you will work on during the week. As you start making progress moving toward your goals, you may start to feel better. What do you think?

The “Broken Brain” Issue

In our society, it is increasingly common for clients to hear from various sources that depression is a medical illness, a medical disease, a biochemical imbalance, or something else that has gone wrong in the brain. It is important, if the client brings this up, for the therapist not to argue with the client about what are the real causes of depression and to validate and “roll with” the clients view of depression. In fact, research indicates that there are multiple causes for depression, and different causes are important for different individuals. So it is certainly the case that when a person becomes depressed, the brain changes. The therapist may want to emphasize to the client that there are many ways to change the brain, and that research has shown that BA can in fact change the brain.

The “Super Active” Client

For many depressed clients, the BA rationale will feel like a very good fit, because they are quite aware of how their behavior has changed and how they have stopped doing things that they used to do. For some clients, however, they are depressed in the context of very active and busy lives so the activation rationale may not make as much sense. For these clients, it is not immediately clear how the BA rationale fits their life situation. This may particularly be the case of clients living under or near the poverty line. Their lives are filled with daily hassles and stress. They are working very hard to make ends meet and to try to stay out of poverty. For these clients, it is easy to see how the “negative life events” circle and the “common responses” circle of the BA model apply, because their lives are filled with difficulty (negative events) and they feel stressed (common response), but it is harder to determine what should be done, because simple activation does not seem to be relevant.

For these clients, the BA work will be trickier. First, it is important for the therapist to validate the hard work that the client is already doing, and emphasize that this work is in fact keeping the client from being even more depressed:

It is pretty impressive how much you are doing, and I want to say that I want our work together to really capitalize on your strengths here. You are persistent and you are not going to quit, and that is extremely important. If you had let these depressed feelings really get the best of you, you would have shut down completely and then you would really be in trouble. It is fantastic how you are working so hard to stay afloat.

In this situation, the client and the therapist will have to work together, not simply to schedule new activities, but to look at all the specific activities that the client is engaging in, how to maximize success with those activities by engaging in strategic problem solving and getting social support, and how to make sure that at least some of the activities each week actually bring fun and enjoyment into the client's life. The therapist may say:

I really appreciate all that you are doing. I am hoping one way I can be helpful is by really working with you to make sure that all of your hard work is as effective as it can be. I would like to really talk with you about what you are doing and how to be really strategic about things, and to make sure that each day, you wake up with a good plan and then execute it. Our goal for each day could be something like this:

1. Wake up at a scheduled time.
2. Commit to an active day.
3. Keep trying to solve problems.
4. Talk to friends and family members.
5. Do something enjoyable.
6. At end of day, say, "My problems still remain, but today was a perfect day."
7. Wake up in the morning and do it again.

OBTAINING INFORMATION TO GUIDE ACTIVATION ASSIGNMENTS

The primary goal of initial work in BA is to obtain information useful for scheduling good activation assignments that are tailored to the client's life problems and values. The assessment process here is broad and can include:

- What have clients stopped doing?
- What are clients doing ineffectively?
- What are clients actively avoiding doing?
- What gives clients a sense of pleasure?
- What gives clients a sense of mastery?
- What are clients' long-term goals and values?

Much important information can be obtained from clients simply by listening and asking clients informally about their lives. This informal interviewing, which may be done in initial individual sessions or with the group, provides information useful to the conceptualization, particularly about things clients used to do and have stopped doing, and problems in the clients' lives that need solving. The key is for the therapist to remain fairly concrete, focused on the details of the activities that clients used to do and have decreased or stopped doing altogether, and what would be required to complete and reengage in the activities (e.g., a bike to go biking), without getting distracted by other possibilities that would complicate the conceptualization.

Use of Values Assessment

The therapist may choose to explore various life domains with the clients using a "values assessment." This discussion, covering family, social, educational, recreational, occupational and other areas of functioning, should be a rich source of information for the therapist.

Use of Activity Monitoring Forms

In BA the therapist may ask clients to complete the activity monitoring form (or chart). While the informal clinical interview described above is helpful in identifying what clients are not doing and problems to be solved, activity monitoring is helpful in identifying what clients already are doing. In individual therapy, the therapist may suggest:

Therapist: I want to understand what your week looks like in more detail, so I'd like to ask you to complete this chart for your first homework assignment over the course of this next week. It simply asks you to describe your activities over the course of the day, hour-by-hour. For example, here [pointing to correct cell in the grid] you would put "therapy," and here [pointing to another cell] you would put "went to lunch" as we already discussed. It would be ideal if you could fill this out at the end of every day.

Client: Ok, it seems like a lot of information, though.

T: It is, and it is not something I will suggest you do every week. But my goal with you at this point is to really get a sense for what your life looks like, hour by hour... how you are spending your time, what you are doing, and what you

are not doing. I want to be a fly on the wall as you go about your week, and this is the easiest way to do that.

There are several forms of activity charts, and the form chosen depends on the preferences of clients and therapists. Some clients may prefer to chart in an existing daily or weekly planner and others may prefer simple lists. The important point is that the therapist gains useful information about the nature, breadth and frequency of clinically relevant client behavior over the course of the week. The activity chart is useful for showing clients the relation between activity and mood.

Activity monitoring assignments may also be elaborated in several ways. First, they can be tailored to track specific behaviors of interest that will be targeted later in therapy, such as job searching behaviors, studying, or watching television. In addition, the activity chart may include space for clients to rate their moods during specific activities. For some clients, we have found the categories mad, sad, scared, happy and bored work well, but other clients may prefer to supply their own descriptors rather than picking from a pre-defined list. Similarly, other ratings can be obtained, depending on the particulars of the client, including ratings of pleasure, accomplishment or mastery, pain, and consistency with values.

The therapist and clients may spend a few minutes discussing completion of the charts. The therapist should ask clients if they will be able to complete the chart and what might get in the way? Together they should come up with solutions to potential barriers. They may discuss where clients are going to keep the chart (on nightstand, on refrigerator, by tv, etc.), possibly telling another family member about the assignment, and possibly having the client reward herself for completing the assignment (can they do the chart and then watch tv, versus putting on the tv immediately?).

SCHEDULING ACTIVATION ASSIGNMENTS

Scheduling good activation assignments is the heart of BA. The activation assignments are not always about doing “fun” things. Good assignments help the client do many things, including:

- Become active in life again
- Experience more pleasure and accomplishment
- Start doing what the client has stopped doing because depression set-in
- Approach the things the client is avoiding
- Solve major life problems
- Act consistently with what the client really cares about.

Many clients will feel that it would be much easier to do activation assignments if they felt better. Therapists can say to this that we can’t simply wait for the client to feel better, we’ve got to act first, and this will help the client feel better. Action is the key to feeling better, and the hardest part is just getting started. It is like pushing a car from a standstill. It is very hard to get the car moving at all, but once it is moving it is easier to keep it moving. Once you start moving again, it gets easier and easier, and then you start to feel better.

A similar issue is that clients will say they don’t have the motivation to do anything. BA therapists can ask, “What can we do to help you feel more motivated?” Here, when we use the term “motivation,” we are not talking about an internal state or feeling. Instead, we refer to external things that help someone do something. Alternately, the therapist can ask, “What can we do to help you do this even if you don’t feel like it, don’t feel motivated?”

Use of Activity List and Activation Homework Sheet

When assigning activities the therapist and clients should collaboratively determine what is most important to do, and what clients are capable of doing. Ideally we want a variety of activities to be scheduled, some fun, some difficult, some about solving problems, some about deep values, and so forth. It is up to the therapist to discuss options with clients and figure out where to start. One idea is for the therapist and clients to keep a list of all the activities generated as potential assignments for each client, ranked in terms of difficulty. This is called an Activity List.

The Activity List includes columns for noting when the activity was assigned, when it was completed, and the actual difficulty of the activity (to be compared with the expected difficulty). The “assigned” and “completed” columns are flexible in that they can be completed with yes/no responses, check marks, dates, or hash marks (for activities that repeat regularly) as appropriate.

We recommend use of an Activity List over the entire course of treatment, with new assignments added to the bottom of the list as they are developed and assigned. The list thus serves as a running record of the client’s behavioral activation assignments throughout therapy, as well as a record of if and when each activity was completed and how difficult it was to complete. By the end of therapy, the list becomes a rich reminder and succinct overview of specific treatment targets, how much the client has accomplished, and what remains to be accomplished.

Activation assignments should be as structured as possible (e.g., the when, where, who, and what of the assignment should all be specified), barriers to completion of the activity should be discussed and problem solved, and back up plans should be developed. The therapist may use the Activation Homework Sheet to help with this (Appendix D).

Specific Activation Ideas

It is important that the therapists become familiar with the local resources and community of their population. Free or low-cost activation assignments that are culturally sensitive are crucial. Therapists should read the “entertainment” and “events” sections of the local papers, community newsletters, and weeklies for ideas, and should also become familiar with the costs and hours of operation of various options (e.g., museums, zoos). The benefits of such simple research should not be underestimated.

All BA therapists should have city maps and bus schedules/maps in session, and information about how the maps work, in Spanish. Does the client know how to read a map or use the bus? Clients can be taught these skills in session, as well as taught strategies for interacting with English-speaking bus drivers.

In our pilot study, free or low cost activation assignments that clients found helpful included:

- Dancing
- Walking (outside or in a mall in Winter)
- Exercising, playing sports
- Community center activities and groups, such as relaxation group, stress management group
- Borrow fitness DVDs from library (Zumba is very popular)
- Go to museum (often museums have free days once a week)
- Seasonal free concerts (in park or at mall)
- Visit friends
- Go to church
- Various church activities and events
- Call family in country of origin (the client can be activated to obtain a calling plan with very inexpensive rates)
- Playing with children or grandchildren
- Gardening
- Listening to music
- Window shopping
- Cooking
- Cleaning house
- Knitting

Here are some other activation assignments that occurred in our previous study:

- Going to a diabetes management group
- Attending social events
- Going to the library
- Getting to work on time
- Visiting neighbors

- Employment seeking
- Calling social service agencies and working on related problems (e.g., immigration status)
- Going to medical appointments
- Attending festivals
- Planning for a trip
- Talking with husband about parenting issues
- Asking others for help
- Saying no to requests
- Maintaining personal hygiene
- Making a budget
- Looking for a used car
- Taking English-language and computer classes

Other Considerations for Activity Scheduling

An important consideration in assigning activities is that these new behaviors need to become a routine. It is not enough to go out to dinner once with friends but have no provision for doing this regularly, nor is it enough to spend one day looking for a job. We want to help clients create active lifestyles comprised of a mixture of proactive problem solving and active engagement in pleasant activities that becomes constant and predictable.

A second consideration is that there is really nothing special about creating activation assignments. It calls for simple assessment, logical analysis of the problems and a “never give up” attitude. A client may respond that she has already tried and failed to solve to the problem, and activation may simply be to keep trying. This is especially the case with problems such as unemployment or making friends – these things take time. A client may say that he no longer enjoys reading books – the therapist should encourage the client to try the behavior in hopes that enjoyment will follow.

The therapist should employ a variety of strategies to make completion of the assignment more likely, including:

- Asking the client to mentally rehearse completion of the activity
- Role playing the activity if it involves a difficult interpersonal interaction
- Asking the client to tell someone else about the activity
- Setting up reminders to make it more likely the activity will get done (e.g., sticky notes, a phone message to oneself, or moving one’s wedding ring to a different finger)
- Reinforcing oneself for completion of the activity

Some clients may respond with a series of “yes, but” replies to specific activation ideas, coming up with reason after reason for not doing an assignment. For these clients, the therapist should adopt an experimental attitude, such as “You may be right, all these obstacles may come up...or, you may be wrong. Can you try this out and let’s see what happens? If you are right we’ll come up with a different plan. If we just listen to your ‘yes buts’ we’ll never try anything new.”

Activation assignments for difficulty sleeping. A common problem for depressed clients is difficulty sleeping. Most sleep hygiene tips are consistent with BA. In particular, if a client can not sleep, the therapist should encourage the client to get out of bed and engage in

boring, passive alternatives consistent with sleeping that are incompatible with rumination. This could include reading a book or watching t.v. (but nothing too exciting on t.v.). If the client has trouble ruminating at night which keeps her up, cognitive distraction techniques as an alternative to rumination may be useful, such as counting sheep (this is an old one but it actually works), or thinking of vegetable names in the order of the alphabet (apple, banana...). Some clients have found it helpful to stand up next to the bed and say to themselves how nice it will feel to get back in bed. Relaxation breathing exercises also can be helpful.

Addressing acculturation difficulties and discrimination. The BA therapist may work with clients to overcome barriers related to acculturation, such as fear of authority, low wages, language barriers and citizenship status, to keep the clients active in the face of what seems like insurmountable obstacles. The therapist should recognize that the issues are sufficiently complex problems that would tax the problem solving skills of even very high functioning people who are not depressed. It is not easy and will take time. The therapist should work on acceptance of this reality combined with continued, strategic efforts to define problems, break them down into steps, and set reasonable expectations for outcomes. The therapist should emphasize that the process of solving problems is as important in situations with a long-term focus as the product of the process, because the product might not be seen for quite some time. The goal is for client to say to him or herself at the end of the day, "Well, my problems still remain, but today I worked hard at it and today was a good day."

It also is important for the therapist to address how it is difficult to experience discrimination, but that to prevent being treated this way, clients need to use alternate coping strategies. This may consist of speaking to a supervisor, looking for a new job, and/or enduring difficult and uncomfortable situations.

Addressing medical issues. In our pilot study we noticed that a large number of clients had either considerable chronic pain and/or other serious health conditions (diabetes, seizure disorders, lupus, etc.). Addressing these issues early in treatment is important. There may be an increased focus on activity scheduling including: doing doctor recommended exercises, scheduling doctor's appointments, attending doctor's appointments, and taking medication. For extremely passive clients who are not being active out of session, the therapist may have the client call and make a doctor's appointment directly from the session. Like all activities, it is important to determine what obstacles are preventing the client from attending to his/her medical care. Discussing the importance of attending to their medical conditions and the impact it has on mood is very important. If the client is unaware of this connection, the therapist may use the activity chart to monitor both mood and pain (or specific difficulty). Then the activity chart and client ratings can be used to more closely describe this relationship.

For example, a 56-year old Puerto Rican female began BA complaining of severe depression and severe chronic pain. The client reported that she had not been doing her doctor recommended exercises and was not scheduling or attending doctor appointments. Early in treatment the client and therapist worked to schedule these appointments and then determine specific times when the client would do her exercises. Once the client began being more active and compliant with her doctor's recommendations, the therapist and the client began to integrate and prioritize additional activities (e.g., spending time with grandchildren, attending religious services). In addition, when a client is medically non-compliant bringing a supportive family member into session may be particularly helpful. By doing this, the family member can help reinforce the client's behavior and/or remind the client of specific homework assignments.

Addressing anxiety. Many clients will be struggling with anxiety as well as depression. When dealing with an anxious client, it is important to take the anxiety into consideration when assigning activities. Clients should be asked how difficult it will be to complete an assignment, or how anxious it will make him or her, and assignments should be developed that the client feels ready for. In this way, in addition to scheduling activities for depression, the assignments also facilitate exposure to anxiety to treat anxiety. Relaxation exercises also may be appropriate for some clients.

Reviewing Activation Assignments

It is as important in BA to spend time reviewing homework as it is assigning homework. When reviewing homework completion, it is important for the therapist to highlight the importance of homework completion to the client's improved mood. The BA therapist should focus on even small improvements. For example, consider this therapist response to a client who took several very small steps towards his goals between sessions:

Listen, I don't want to make too big a deal of it, but I just want to say that from my perspective, what you are doing here is really important, perhaps more important than anything else I can think of, actually. Often what people need to do is simply STAY ACTIVE. And when you are active, doing things important to you, not actively avoiding everything, then you feel better. And ultimately, over time, you get better at staying active on a continual basis, and then you are engaged in life and depression gets farther and farther away. So let's spend some time today talking about how you did this and how you can keep it going...

It is also important to focus on partial successes, rather than partial failures. The therapist may say to the client, "Since you are not feeling perfect, I will not expect your homework to be perfect either." Consider a client who did most of his homework assignments but was self-critical because he did not fully complete his activity monitoring chart. The therapist responded: "This is great, this is great, and all the stuff you did is fantastic, and when I look at homework I look at it altogether, maybe you didn't keep track the later part of the week but look at all you did."

GENERAL ISSUES WHEN CONDUCTING BA

What to do when treatment is not a priority

One difficulty that we encountered in our initial trial was that treatment was often not a main priority for many clients. This causes two main problems: (1) clients began treatment in a heightened crisis because prior to this point they did not see a need for treatment and (2) once clients began to feel better they terminated treatment. It is very difficult to address clients beginning treatment in a heightened crisis, but preventative care can be taken to address clients terminating treatment early. For example, in Session 1 of individual therapy, the therapist discusses the expected course of treatment. It is important to address in this session that often clients do begin to feel less depressed during the course of treatment, but that it is important not to terminate treatment immediately upon feeling better. The therapist should state that the goal of treatment is to teach the client a new skill – the skill of responding with activation when negative life events happen and you feel bad. Learning a new skill takes time and it is important to come to sessions and learn this skill, even if you start to feel better immediately. We state that therapy will involve 12 sessions and we would like the client to commit to at least 6 sessions, even if they feel better beforehand.

A BA therapist may wish to present these issues visually in the form of a contract that the client may sign.

In addition, the importance of returning to Session 2 is emphasized, and returning to Session 2 is treated as an activation assignment like any other. Thus, the therapist and the client discuss possible avoidance patterns that missing Session 2 would represent, obstacles to returning to Session 2 and how to overcome them, and employ other BA techniques to maximize the possibility of a return (e.g., tell someone about the appointment, put reminders in key places).

When a stable decrease in the client's depression is noted it may be advisable to move individual sessions to bi-weekly then bi-monthly if possible before terminating. By doing this, the therapist is better able to monitor whether the changes and activities discussed in sessions are continuing to generalize outside of treatment when decreasing client and therapist contact.

When clients terminate because of medication

Similar to the example above about when treatment is not a priority, clients may take medication and as soon as the medication relieves depression somewhat they will terminate treatment. Again, discussing this early in treatment is important. The therapist should specifically discuss with the client research that suggests that the combination of psychotherapy and medication is very effective, but medication without psychotherapy may lead to relapse if the medication is discontinued.

When clients are unreliable in attendance

Missing sessions is very common with many clients with lots of environmental stressors. A variety of logistical issues can get in the way, such as transportation, childcare, difficulty getting time off work, family crises, and so forth. Furthermore, if a client does not improve quickly when treatment begins, coming to therapy may become less reinforcing.

These issues are important to address. Session attendance should be treated as a treatment target and submitted to the BA model. This should be done in every session at the end of the session. In other words, obstacles to session attendance should be predicted in advance

and plans to overcome these obstacles should be discussed and scheduled. Avoidance of session can be treated like other forms of avoidance and discussed with the client. Collaborative arrangements can be made for the therapist to provide a reminder call the day of the appointment, or to call the client after a no show, and contingency contracts with the therapist for session attendance can be made. The therapist may write a letter to a client after several no-shows in a row.

Doing BA on the fly

In addition, during treatment development we came across a variety of situations when BA therapist reporting doing “BA on the fly”. This typically occurred over the telephone. In each of the situations described below, we encouraged the BA therapists to make these phone calls consistent with the BA model and to reference issues that had been discussed in therapy.

Client cancels appointment because not feeling well. One example consists of a client calling to cancel an appointment and when asked what the reason for the cancellation is, states something similar to, “I just feel really down. I am just going to stay in bed. I will come in next week when I am feeling better.” This is an ideal opportunity to use BA techniques. The therapist can discuss with the client that by staying in bed they are falling into an avoidance pattern. The therapist can briefly discuss the potential short-term benefits of this avoidance pattern and emphasize the long-term problems that will arise from staying in bed (e.g., missing a therapy appointment, not problem solving). Then the therapist can suggest that coming into the clinic for their session would be taking an active step towards feeling better.

Client discusses termination over the phone. In addition, if a client calls over the phone to terminate treatment it is important to stay consistent with BA. Specifically, if the client is terminating and you feel as though the client is ready to leave treatment this situation would be treated differently than if you felt that termination was a form of avoidance. In either situation it would be important to try to get the client in for an additional session. If the client decides during the session it is important to try to review the termination materials in that session (see Session 12 Outline). If the decision to terminate treatment is deemed an avoidance pattern, then it is important to use this as an example to walk through the model.

Client calls about a crisis. Another example consists of a client calling in crisis. Assuming the client is not actively suicidal (in which case hospitalization would be considered), this is another ideal situation for BA to be implemented “on the fly”. It is important in such a situation to get a brief, yet clear idea of the current situation. Then by walking the client through the specific avoidance patterns they are engaging in and identifying action steps they can take to address the difficulty. If a crisis is discussed and coached through over the phone it is essential to put that interaction on the agenda for the following session.

CULTURAL ISSUES

This treatment manual evolved out of the premise that BA techniques that emphasize perseverance, action and empowerment in the face of seemingly overwhelming environmental hardships may both be more acceptable to Latinos and ultimately more efficacious than techniques that locate the problem of depression within the client (e.g., cognitive or biological factors).

In addition, we felt that the BA model was a good fit for Latinos because it dictates that the therapist conduct an individual assessment of the client's behavior and the contextual variables that maintain it. In other words, the BA therapist enters the relationship with very few cultural assumptions and allows the assessment to determine the activation targets. Furthermore, this assessment focuses on contextual factors which, compared to intrapsychic factors emphasized by some other treatments, may be less likely to be imbued with culturally specific meanings. However, therapists need to be culturally aware in order to assess the relevant variables. During our pilot study, this was facilitated because our primary BA therapist was herself Latina and was fully aware of the cultural nuances and beliefs of her clients in most cases. This manual was written in that spirit and assumes that therapists have cultural familiarity with their clients.

The Process of Assessing Cultural Variables

It is important to keep in mind the cultural context, but to do so carefully by ascertaining the applicability of such factors for the specific client (López, 1997). The clinician is expected to:

- Be aware of traditional Latino cultural norms while appreciating the heterogeneity among Latinos in the degree to which specific norms are held
- Assess the specific client's adherence to the cultural norm
- Assess the client's sociocultural worldview that may not be specific to the traditional norms based on ethnicity

Essentially, the goal is to consider the cultural context without stereotyping. Lopez has found that ignoring cultural variables results in over-pathologizing Latino individuals (Lopez & Romero, 1988). However, focusing too much on cultural variables results in over-normalizing distress and problems exhibited by Latinos. The goal is to find the right balance for each individual.

Cultural Values and Issues

Several Latino-specific values and beliefs are important to assess and be aware of (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). During our pilot study, we found that issues related to these values came up repeatedly and were important to case conceptualization. It should not be assumed that a particular client will endorse these values, as clients will vary, but these issues are important to consider and assess.

Familismo: Valuing of close connections and relationships with ones family

Personalismo: Valuing of relationships in general and responsiveness to the personal dimension of relationships

Marianismo: Women are to be self-sacrificing toward their families and children, pure, long-suffering, nurturing and pious.

Machismo: Men are to provide for, protect, and defend the family. They are to be honorable and respected for having this responsibility.

This, of course, is only a partial list of values. Notice, however, that together these values tend to center on the importance of family and maintaining a particular hierarchical structure within the family with authority given to husbands and fathers, and that this is an overriding issue for many Latino/a clients. Simply put, the important issue for treatment is that depression should be understood in the context of these values, and activation assignments should be sensitive to and not contradict them. Integrating these cultural issues into the implementation of BA is somewhat of an abstract exercise. No specific changes to the treatment are suggested, instead what is required is therapist sensitivity to these issues as the therapist implements the treatment. This may come naturally to many therapists if they are already a part of and familiar with the culture. For others, however, this may require considerable consultation, literature review and support.

Here we provide several examples of what we mean by culturally sensitive activation assignments. First, consider a 46 year-old Mexican male who was seen by a BA therapist. The client had two daughters who had been raised in the United States and he felt that they were not being raised according to his values, and in particular they demonstrated a lack of *respeto* toward him. *Machismo* and *familismo* made this issue very important to him, at the same time he did not have the effective skills to manage his resulting anger and he became violent, which resulted in a restraining order. He attempted to apologize and his daughters refused to speak to him, confirming the *falta de respeto* he felt. He stated he would not attempt to speak to them again. A typical BA assignment at this point would have been to view his decision as avoidance and encourage him to continue to try to make contact with and apologize to his daughters. However in the current case this was felt to be insensitive to the larger context of cultural values. The therapist discussed these values with the client to assess what was most important to him – to speak to his daughters or uphold respect for his status as the patriarch? An activation assignment could be effectively created after clarifying these values. In addition, the therapist provided some education to the client about the discrepancy between his cultural values that likely stemmed from being raised in Mexico and his daughters’ cultural values that resulted from growing up in the United States. This tension, intergenerational or cultural conflict, is constant in working with Latino families.

Second, consider a 24-year-old woman “Lucia” who lived with her husband and son. Lucia reported that approximately once a month her husband would leave with his friends for several days to use cocaine. When her husband did this Lucia would become very depressed and passive. Lucia also reported that her relationship with her husband was verbally aggressive and during a recent disagreement her husband broke an object in their home and she called the police. Lucia did not want to discuss these issues directly with her husband. Typical BA may have seen her response as avoidance and activated her to communicate with him. Again, that intervention would have been insensitive to the larger cultural context. In fact, Lucia felt conflicted about these events. On the one hand, she did not like the situation and how she felt. On the other hand, consistent with *familismo* and *marianismo*, she recognized that her husband worked very hard, deserved respect, and was the patriarch in the family. She felt that it was not her place to confront him. Thus, the therapist worked closely with Lucia to be both sensitive to the larger relevant cultural factors and to proactively address the situation with the husband in a way that maintained respect for those cultural factors. For several weeks, they discussed the

issue and clarified Lucia's values about it. In the end, Lucia decided on her own to talk to her husband, in a positive context after several months during which he had not used cocaine.

The third example is somewhat different. A 47 year old depressed Latina who was very religious and complained of a "presencia negativa," a negative presence that followed her around. She reported that this presence made her feel sad, fearful and nervous. This negative presence is culturally seen as an energy that is not controllable by the person who experiences it and therefore the symptoms that accompany the "presencia negativa" are not controllable by the client. It is understood as a "spirit" who is wandering and can not rest but has chosen to accompany a person. On the one hand, typical BA may view the presence as an avoidance pattern because the presence allowed the client to cast off all responsibility for her feelings or control over changing them. However, this would have been pathologizing the cultural phenomenon. Instead, after some discussion with the client the activation assignment involved the client going to church, which she also had stopped doing, and praying in order to give peace to the presence. The idea was that this response represented active problem solving that was consistent with her view of the presence and did not challenge it.

A final example concerns a 26-year-old woman who was encouraged to engage in social activities out of her house, but she reported that her husband did not agree with the idea of her being out of the house and socializing with people he did not know. In order to be sensitive to the client's cultural values of *familismo* and *marianismo*, the assignment was modified to include activities that did not involve socializing with others but spending time with her children, including going to the library, going to the park, and visiting area museums. However, this severely limited the client's adult social interaction and support, so it was agreed that the client could visit family and her *comadres*—very close friends sometimes met through church activities, usually known by the family and perceived as a positive influence and supportive of Latino values—but not *amigas* who were unknown to the husband.

Essentially, the main idea is that the therapist must work within the system. A husband may be over-controlling and the therapist should not assume that the client is ready or wants to confront the husband. Instead, the therapist should look to activate the client in the context of what is possible in relation to the husband.

Marianismo is a gender role that is often challenged when one immigrates to the U.S. and also is being increasingly challenged in Latin American and South American countries as well. The men in the women's lives may become controlling and jealous, and it is important to work with the woman to help her learn how to negotiate with the man. In other words, we do not challenge *marianismo* but we help the woman execute the role successfully, so they feel good about it.

Acculturation Issues

Many Latinos in the United States who have emigrated from their countries of origin feel a conflict between wanting to acculturate to the U.S. while wanting to retain a connection to their culture and its customs. They are moving from a mono-cultural to a bi-cultural and multi-cultural context. This may be an issue for people who are new immigrants as well as for those who have been here for a while but still have not acculturated. Lack of acculturation can be a problem for people because it may restrict opportunities for success in the new culture. At the same time, losing connection with one's original culture can be a problem because it is experienced as a loss of something very valuable and meaningful. In BA, the therapist should acknowledge the conflict and develop goals and activation assignments related to each goal. In

other words, they do not need to be incompatible. The goal in BA is to help the client achieve what feels like a good balance. The therapist should recognize that it is complicated to be part of two worlds but that is the goal. It is often the case that younger people will more easily become bi-cultural compared to their parents.

Working with the Church and Religion

Many clients will have strong religious values and it will be important for the therapist to work within these values. For some clients, going to church and praying will be good activation assignments. One client stopped going to church because she felt people would judge her, ask her how she's feeling, and talk about her. She was first encouraged to pray at home, pray at night, and consider other alternatives to church. At the same time, the therapist and the client discussed her fears of going to church and how to overcome them.

For others, however, praying could be seen as a form of avoidance, e.g., a passive problem solving style. For these clients, it is important to activate alternatives while not necessarily blocking the praying. With such a client, the therapist may use the phrase, "Work like it depends on you, pray like it depends on God." Another idea is to consider why the client is praying to God. We could encourage the client to, "Pray for God to give you the strength to do the work yourself," versus, "Pray for God to do it for you."

Biblegateway.com is a good source for Christian bible passages that may be helpful to employ with religious clients.

Involving the Family in Treatment

In general, we believe that involving family and social support early in treatment is important with this population, although further research is needed to fully assess the importance of including this component in treatment. We have provided specific suggestions for how to discuss family involvement in treatment with the client in the first session. First, the therapist should tell the client that it is up to him/her how much their family can be involved, but the therapist would like the family to be involved to help the client with the primary goal of treatment—taking action. Family members can be useful in reminding clients about activation assignments and encouraging completion of assignments. Thus, ideally family members are fully informed about the treatment plan and the functional conceptualization of depression as presented in BA. Often, family members will appreciate meeting with the therapist to learn about the diagnosis of depression, what it means, and the treatment plan.

In addition, often family members inadvertently reinforce avoidance, passivity, and other depressed behaviors by taking responsibility from the client, offering sympathy for sick-role behaviors, and so forth. While BA does not suggest that family members should be cold or uncaring toward the client, the family should be focused on responding to the client in ways that will be helpful in the long run. This may involve contracts between family members that the client will be lovingly encouraged to continue household responsibilities, to get out of bed, and so forth, and that family members will not do the client's dishes, laundry, etc. if so doing will reinforce depressed and passive behaviors.

The therapist should tell the client that family members can be invited to session, and ask the client how he/she feels about inviting family members in to session. If the client is interested in bringing a family member in to treatment, the therapist needs to develop an understanding of the nature of the relationship with the family member. If the person is clearly supportive and helpful, arrangements should be made to bring the person to session as soon as possible and

involve the person as much as possible. Ideally, the family member should come to the second session. If a husband is being invited to treatment, the therapist should get the client's permission and call the husband him or herself rather than relying on the client. The therapist should really try to sell the treatment to the husband, convincing the husband to come: "Would you be willing to come to our session next week? It would be so important for you to come to a session and learn about what we are doing."

If the relationship is more complicated and not clearly supportive, the therapist should tell the client that they will need to figure out how to get the family member to be helpful, and it may be an important aspect of treatment. If it is unclear whether the family member can be helpful in session, it is not suggested that the therapist encourage family involvement early in treatment. Instead it is best to spend some additional time with the client determining how and if the spouse can be supportive. It obviously is important to work with the client to address the difficulties that may arise in the home if the spouse is not supportive. In the BA-Latino pilot study these difficulties only arose with female clients in relation to husbands who were not supportive, although it is important to note that these difficulties may also arise with a male client.

In the pilot study, roughly half of the clients agreed to bring a family member into session with them. The majority of clients brought in parent or a child and the vast majority of female clients stated that their husbands could not join the sessions. As discussed above, some of these clients stated that their husbands were unsupportive of treatment. The remainder indicated that the spouse did not have time because of a busy work schedule. In this situation it would be important to discuss with the client that even if the spouse is busy that it would help facilitate treatment if they could find a time when the spouse could come into session. This may include having sessions in the evening or on weekends (if the clinic operates during these hours) or having the spouse come for a short period of time (e.g., half the session).

INDIVIDUAL THERAPY PROTOCOL SESSION ONE

- **Language:** Ask client what language the client would like to speak in, if necessary. Ask in the language the client has been using.
- **Review BDI:** Check Item 9 of the BDI for suicide risk.
- **Talking about client's life story:**
 - Begin the session by getting to know the client, the client's life, the client's story.
 - For some clients it may be helpful to suggest that the client does not have to give away family secrets or divulge what he/she does not want to.
 - As you listen to and ask about the client's story, you should be warm, validating and responsive.
 - As you listen to and ask about the client's story, you should be trying to obtain information to guide future activation assignments and thinking about potential activation assignments that can be given to the client at the end of the first session.
 - As you listen to and ask about the client's story, your goal is to collect information so you will be able to link the client's story to the "2 circles" model later in the session:

Negative life events:

- Learn about the difficulties that have been occurring in his/her life, both currently and historically. Take your time with this and try to cover all the important past and present issues. Write these issues down as a list to show the client later in the session. Call them "Negative life events."
- Consider the list of negative life events presented in "**PRESENTING BA'S MODEL OF DEPRESSION**" above.

Common responses:

- Listen to and ask the client about his/her responses to the life events. How has the client been feeling or responding? Listen for and ask about ways the client has gotten stuck.
- Take your time with this and write the responses down to show the client later. Call this list "common responses" or something like that.
- Consider the list of common responses presented in "**PRESENTING BA'S MODEL OF DEPRESSION**" above.
- The important point is that when people have these negative life events, they naturally feel this way.
- The way the client is feeling is not an illness or a weakness. It is an understandable response to life's difficulties.
- Really emphasize how the responses make sense given the client's negative life events. **THIS POINT CAN BE STATED REPEATEDLY.** If there is one thing we want the client to get from this session, this is it.
- You can say that depression does not mean the client is going crazy, or that there is something wrong in the client's head. It is understandable.

- **Summary of model:**
 - Show the client the 2 circles with the lists you have made. Do this to explain the model but also to express compassion and give the client the sense that you have been listening deeply and empathically to the client's life story.
 - Express to the client that this treatment is about getting active in life again. It is about taking action steps to solve problems, rather than avoiding, feeling overwhelmed, and shutting down to avoid feeling so terrible. The focus of the treatment is on coming up with action plans and taking action, to help the client start doing things that he/she used to do before he/she became depressed, and things that the client doesn't have the energy to do. The goal is to get the client back on track in life.
 - Tell client this is an active treatment, it will require work. The key is to do things differently in life. Treatment will be about figuring out what needs to change and how to change it. This will be done by the therapist listening very carefully to the client's story and then the client and therapist together will come up with plans for what to do differently during the week.
 - It is key to the model that activation will lead to improved mood and that the client can not afford to wait until he or she feels better to start solving their problems.

- **Ask for feedback about the model:**
 - Discuss with the client what he/she likes and doesn't like about the approach?
 - Discuss with the client what makes sense about it?
 - You may ask the client to state in his/her own words what they are understanding.

- **Discuss coming to the second session:**
 - Tell client that treatment will last up to 12 sessions, and you expect that client will have started to feel better well before that. But the goal of treatment is not just to feel better but to teach the client a new skill—the skill of learning how to respond to negative life events and feeling bad with action steps so you do not get stuck. It takes time to learn this skill and we ask the client to commit to at least 6 sessions even if they start to feel better immediately.
 - Tell client that it is very important to come to sessions, and ask how they feel about coming weekly.
 - Discuss the next session time. Ask if there are things that will get in the way of the client coming to next session? Problem solve barriers to coming to the next session.

- **Session review:**
 - Make sure you leave time to review the session. This should not be rushed, especially in the first session.
 - Ask client for feedback about today's session. What do you think about our approach? Are there things you think will be particularly helpful? Unhelpful?
 - Address and problem-solve any negative reactions client might be having.

OPTIONAL ISSUES FOR THE FIRST SESSION:

- **Initial activation assignments:**
 - It is always a good idea to give the client an initial activation assignment or two at the very first session, to set the tone and get the client moving quickly. As you were listening to client's story, ideas for activation assignments may have occurred to you. If they did, discuss them with the client.
 - Discuss these initial assignments as you would any activation assignment in BA (see "SCHEDULING ACTIVATION ASSIGNMENTS" above).

- **Activity monitoring:**
 - Explain the activity chart as a way to get a sense of what the client's daily activities look like, so we can begin to figure out what needs to change.
 - Explain that clients should complete the chart at the end of each day.
 - *Depending on the client, you can also ask the client to rate his/her mood during the activities (0-10), or mastery/pleasure during the activities, or anything else that you think would be useful to know.*
 - Ask clients if they will be able to complete the chart? What might get in the way?
 - Try to come up with solutions to potential barriers. Be creative.
 - *Discuss where clients are going to keep the chart (on nightstand, on refrigerator, by tv, etc.).*
 - *Discuss telling another family member about the assignment. Possibly discuss rewarding self for completing the assignment (can they do the chart and then watch tv, versus putting on the tv immediately?).*
 - Phone call activity monitoring:
 - One possibility here is to have the client call you and report the activities over the phone.
 - This could be done twice a week.
 - Ask the client to call at different times so there is a good sampling and representation of important time periods.
 - The client needs to make the call, not his/her spouse or son or daughter, etc.
 - It may be a good idea to tell the family member that the client will be making the call.

- **If client has been prescribed medication, or is scheduled to see the psychiatrist:**
 - Explain to client that taking medication may be helpful but people are more likely to relapse if they stop taking it.
 - So the important thing is to figure out how to take action and take concrete steps to help deal with depression, and get started solving problems in addition to taking medication.

- **Family involvement:**
 - Tell client that it is up to him/her how much family can be involved but that it may help the client take action.
 - Tell the client that family members can be invited in to session.

- Ask client how he/she feels about inviting family members to attend future sessions.
- **If client is interested in bringing a family member in to treatment:**
 - Discuss with the client his/her relationship with this family member. Is this person supportive or part of the problem?
 - If this person is clearly supportive, schedule to bring the family member in as soon as possible. **Try to get the family member in for the next session.**
 - If this person is not supportive, tell the client that you will need to figure out how to get the family member to be helpful, and it may be an important aspect of treatment.

SESSION 2 IF FAMILY PRESENT

- **Overall purpose:** Tell the client and family that the purpose of today's session is for you to learn how the client interacts with the family and to figure out ways for the family to assist with treatment
- **Meet individually with the client:**
 - Try to meet with the client individually for a short time before bringing in the family. This will allow you to determine any information that should not be shared and particular family members that may or may not be helpful collaborators. However, be flexible (you may have to do the whole meeting with the family members present).
 - Describe purpose
 - Review the previous session
 - This time will also allow you to review the activity chart and any other homework assignments from the previous session (often the client will not complete the first assignment and they may feel shamed if this is discussed in front of family members).
 - It is very important that it is the client's choice how involved the family is. Make this clear while meeting alone.
- **Discuss treatment with the family:**
 - Describe purpose of this meeting
 - Review model of depression with family. Focus on common responses (2nd circle) to make sure the family understands that what they client is feeling makes sense.
 - Make it clear that we do not think the client is crazy and emphasize the understandability of feeling depressed following negative life events.
 - Emphasize that it is good that the client is in therapy.
 - Let the family know that treatment takes time (so be patient) and enlist the help of the family in encouraging the client to come to session every week, even if they are feeling depressed. Let the family know that they can be a big part in helping the client get better.
- **Use the families inside knowledge to assist in your assessment**
 - Ask the family what the client was like and what he/she enjoyed doing before becoming depressed. It is possible that the client will overlook important areas for activation.
 - Ask the family in what situations the client seems most depressed and least depressed.
- **Enlist the family's help in treatment**
 - Give the family a rationale for and enlist their help in encouraging the client to be active (even in very small ways) while feeling depressed or not having the energy
 - Let the family know that the loving response is not always the response that will help the client. For example, taking over all of the clients household chores may function to maintain depression.
 - Use the information gathered in this session and Session 1 to suggest interventions for family members

- It may be particularly useful to involve supportive family members in the completion of homework assignments. For example, you could ask family member to discuss the homework for the week with the client each week after session and provide reminders, encouragement, and facilitation (e.g., transportation).
 - Make sure the family does not badger or criticize the client. Get permission from the client for the family to ask about completion of homework and provide reminders.
 - Schedule family member's asking about homework to avoid badgering (e.g., Wednesday evening the family can check in with client).
- **Give Homework:**
 - Activity monitoring.
 - Activation assignment (involve family if appropriate). It is often helpful to provide the client with a small calendar or day planner to facilitate scheduling activities.
- **Discuss barriers to completion of homework:**
 - Ask client if they will be able to do their homework assignments? What might get in the way?
 - Try to come up with solutions to potential barriers. Be creative.
 - Discuss family members role in helping with completion
- **Coming to next session:**
 - Remind the client and family members of the importance of coming to sessions.
 - Are there things that will get in the way of the client coming to next session?
 - Problem-solve barriers to coming to session.
 - Involve the family where necessary
- **Finish session alone with client to review session:**
 - Make sure you leave time to review the session.
 - You need time to address and problem-solve any negative reactions client might be having, especially reactions to having the family in the room.
 - Ask client for feedback about today's session. What do you think about our approach? Are there things you think will be particularly helpful? Unhelpful?

SESSION 2 IF FAMILY NOT PRESENT

- **Overall purpose:**
 - To further explain the model to the client
 - To devise and assign functional activation assignments.
- **Review the previous session**
 - Elicit client reactions to specific aspects of the previous session
- **Review the model and explain how you will apply it to the activity chart / outside events review**
- **Review homework**
 - Review the client's activity chart. Depending on the client it may be appropriate to review the mood that accompanied each activity or each day. Watch out for examples of activation and avoidance. Fit these into the model. *If possible, point out how activation leads to better moods, problem solving, and task completion, while avoidance leads to feeling OK, but bigger problems in the future.*
 - If the client did not complete the homework. First, assess the barriers to completing the homework, problem-solve barriers creatively, and stress the importance of completing future assignments. Reconstruct the basic activities of each day focusing on possible activation and avoidance examples and then follow above instructions.
- **If appropriate, review possibility of later family / friend involvement**
 - Family involvement does not need to involve attending sessions. Again, creativity is encouraged.
- **Assign activity chart and give activation assignment:**
 - Add mood during the activities (0-10), or mastery/pleasure during the activities, or anything else that you think would be useful to know to the activity chart if appropriate. Only do this if the client successfully completed the activity chart the first time. If not save it for later (BA assignments should always be graded).
 - Devise activation assignments that have a good chance of being accomplished, but will still be meaningful for the individual client. For client A this might mean going for grocery shopping and a 30-min jog and for client B this might mean simply leaving the house and walking around the block.
- **Discuss barriers to completion of assignments:**
 - Ask client if they will be able to complete this chart? What might get in the way? Try to come up with solutions to potential barriers. Be creative.
 - Discuss where they are going to keep the chart (on nightstand, on refrigerator, by television, etc.).
 - Discuss barriers to completing the activation assignment
 - For both assignments, ask, "What can we do that will make it more likely that you will be successful?" Then do it.
 - Discuss telling another family member about the assignment.
 - Possibly discuss rewarding self for completing the assignment (can they do the chart and then watch tv, versus putting on the tv immediately?).
- **Homework:**
 - Activity monitoring.
 - Activation assignment

- **Session review:**
 - Make sure you leave time to review the session.
 - You need time to address and problem-solve and negative reactions client might be having.
 - Ask client for feedback about today's session. What do you think about our approach? Are there things you think will be particularly helpful? Unhelpful?
- **Coming to next session:**
 - Tell client that it is very important to come to sessions.
 - Are there things that will get in the way of the client coming to next session?
 - Problem-solve barriers to coming to session.

SESSIONS 3-11

Sessions 3-11 should follow the basic structure of BA, which is:

1. Review BDI
2. Set agenda
3. Review homework and activity level since last session
4. Develop new activation assignments as homework
5. Other agenda topics
6. Session feedback

The heart of the session is items 3 and 4. Reviewing and assigning homework is crucial; without it the session is not BA. The therapist should make sure to review homework each week and assign new homework based on the client's goals each week. Therapists should collaboratively work with clients to schedule activities to block avoidance and solve problems as well as to simply produce more pleasure and fun in the client's life. Activity charts or calendars may be used to track and schedule activities and the Activity List and Activation Homework Sheet may be used. Therapists should pay attention to the level of difficulty of the tasks to be assigned, and how avoidant/scared of the task the client is, and collaboratively work with the client to schedule tasks that are graded in terms of difficulty and fear level. The important thing in earlier sessions is that the client experiences some mastery and success with the tasks, so they should not be too difficult. It is also important for the therapist to save a few minutes at the end of the session to review the session and ask for client feedback about what was useful and not useful.

FINAL SESSION

- **Before session:** Review ALL progress notes on the client.
- **Overall purpose:** Review progress and complete “Staying Active Guide (Appendix E).”
- **Review BDI.** In addition, it may be useful to graph the client’s BDI scores from over the course of therapy to highlight gains.
- **Set Agenda**
- **Review homework:** As in all sessions, this session should begin with a review of the previous week’s activation assignments.
- **Review progress**
 - The therapist and client should review the client’s progress. Client’s often do not remember how depressed they were at the beginning of treatment and how much progress they have made. It may be helpful for the therapist to review all the progress notes before the session, so the therapist will be able to remind the client of details from the past. Focus on how learning to take action has resulted in a better life.
- **Complete “Staying Active Guide”**
 - Complete this form collaboratively with the client. Ask the client the questions on the form but help shape the responses to be as appropriate as possible.
 - The form is for the client to keep in an important place and review weekly.
 - Make a copy of the form at the end of the session. This will be helpful if the client calls for help in the future, or if the client loses the form the client can call you for another copy.
 - You may want to add a personal note to the end of the form with your name and phone number.
- **Self-therapy**
 - The therapist could encourage the client to schedule “self-therapy” sessions once a week. In these sessions, the client would continue the work of looking at his/her avoidance and activity, and schedule new activities. Then, the next week the client should review the previous assignments. In other words, the self-therapy sessions should mimic the real therapy that is now ending.

Appendix A

Behavioral Activation Values and Goals Assessment Sheet: Therapist Version

You may choose to review this sheet with your client at the beginning of therapy to help determine specific activation assignments. Remember it is best if the “what type of person” responses are ideal behaviors that suggest directions to move in, not feelings. The “I” column may contain importance rankings (0 to 10), but not every value needs a ranking and some may have the same ranking.

Value	I	What type of person would you like to be in this area?	Immediate concrete goals?
Relations with family			
Relations with spouse or intimate partner			
Relations with friends			
Religion and spirituality			
Meaningful work (paid or not paid)			
Education and life-long learning			
Cultural roots			
Recreation, hobbies, creative and artistic expression			
Volunteer activity (community, church, politics)			
Physical well-being and health			
Security and safety			
Life organization and time management			
Finances			

Behavioral Activation Values and Goals Assessment Sheet: Client Version

Think about what you value in the following life areas. For the “I” column, rate how important that valued area is to you from 0 (not important at all) to 10 (extremely important). Then, describe what type of person you would like to be in this area. Then, list some specific, concrete goals you have that are in line with your values.

Value	I	What type of person would you like to be in this area?	Immediate concrete goals?
Relations with family			
Relations with spouse or intimate partner			
Relations with friends			
Religion and spirituality			
Meaningful work (paid or not paid)			
Education and life-long learning			
Cultural roots			
Recreation, hobbies, creative and artistic expression			
Volunteer activity (community, church, politics)			
Physical well-being and health			
Security and safety			
Life organization and time management			
Finances			

Appendix B
Activity Monitoring Sheet

6 – 7 am							
7 – 8 am							
8 – 9 am							
9 – 10 am							
10 – 11 am							
11 – 12 am							
12 – 1 pm							
1 – 2 pm							
2 – 3 pm							
3 – 4 pm							
4 – 5 pm							
5 – 6 pm							
6 – 7 pm							
7 – 8 pm							
8 – 9 pm							
9 – 10 pm							
10 – 11 pm							

Appendix D

BA Activity Homework Sheet				
Activity	w/w/w/w	Obstacles	Solutions to obstacles	Outcome

Appendix E
Staying Active Guide

Things to remember: What was helpful about therapy? What made me feel the best? What is important to remember?

1. _____
2. _____
3. _____
4. _____

How will I notice if I am becoming depressed again? What specific things do I do that suggest I may be depressed?

1. _____
2. _____
3. _____
4. _____
5. _____

Important activities to continue (both activities that I enjoy AND activities that are important to do but I would rather avoid doing):

1. _____
 - Obstacles to doing it: _____
 - Plan for overcoming obstacles: _____
2. _____
 - Obstacles to doing it: _____
 - Plan for overcoming obstacles: _____
3. _____
 - Obstacles to doing it: _____
 - Plan for overcoming obstacles: _____
4. _____
 - Obstacles to doing it: _____
 - Plan for overcoming obstacles: _____
5. _____
 - Obstacles to doing it: _____
 - Plan for overcoming obstacles: _____

Think about the next year of your life. What events—holidays, anniversaries, changes of seasons, specific things your partner may do or may not do—will be difficult for you to handle?

1. _____
2. _____
3. _____
4. _____

How will I cope with these events and situations? What specific actions will I take? This list could include talking to family and friends, and calling the 16th Street Clinic for help if you need it.

1. _____
2. _____
3. _____
4. _____

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