

BEHAVIORAL ACTIVATION: AN EFFECTIVE INTERVENTION FOR LATE LIFE DEPRESSION

Dolores Gallagher-Thompson, Ph.D.
Director, Stanford Geriatric
Education Center
Professor, Dept. of Psychiatry and
Behavioral Sciences, Stanford
University

Kim Bullock, M.D.
Clinical Associate Professor
Behavior Medicine Clinic
Dept. of Psychiatry and Behavioral
Sciences,
Stanford University

Sponsored by
Stanford Geriatric Education Center
in conjunction with
American Geriatrics Society,
California Area Health Education Centers,
and
Natividad Medical Center

April 12 2012

This project is/was supported by funds from the Bureau of Health Professions (BHP), Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS) under UB4HP19049, grant title: Geriatric Education Centers, total award amount: \$384,525. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by the BHP, HRSA, DHHS or the U.S. Government.

Applying Best Practices to Diverse Older Adults
April, 2012 – WEBINAR SERIES

"Behavioral Activation: An Effective Intervention for Late Life Depression"

Natividad Medical Center CME Committee Planner Disclosure Statements:

The following members of the CME Committee have indicated they have no conflicts of interest to disclose to the learners: Kathryn Rios, M.D.; Anthony Galicia, M.D.; Sandra G. Raff, R.N.; Sue Lindeman; Janet Bruman; Jane Finney; Tami Robertson; Judy Hyle, CCEP; Christina Mourad and Nobi Riley

Stanford Geriatric Education Center Webinar Series Planner Disclosure Statements:

The following members of the Stanford Geriatric Education Center Webinar Series Committee have indicated they have no conflicts of interest to disclose to the learners: Gwen Yeo, Ph.D. and Kala M. Mehta, DSc, MPH

Faculty Disclosure Statement:

As part of our commercial guidelines, we are required to disclose if faculty have any affiliations or financial arrangements with any corporate organization relating to this presentation. Dr. Gallagher Thompson and Dr. Bullock have indicated they have no conflicts of interest to disclose to the learners, relative to this topic.

Dr. Gallagher Thompson and Dr. Bullock will inform you if they discuss anything off-label or currently under scientific research.



Dolores Gallagher-Thompson, Ph.D

• **Dolores Gallagher-Thompson, PhD, ABPP** received her doctorate in clinical psychology with a concentration in adult development and aging from the University of Southern California in 1979. Since that time, she has been a funded researcher in the areas of late-life depression, stress and family caregiving, and ethnicity and dementia caregiving.

Currently she is professor of research in the Department of Psychiatry & Behavioral Sciences, Stanford University School of Medicine, and director of the Stanford Geriatric Education Center.

She is a licensed psychologist and sees patients at the Geropsychiatry Outpatient Clinic at Stanford.

She also serves in several volunteer positions with the Alzheimer's Association in northern California and is currently developing online intervention programs for caregivers of older persons with significant memory loss.

She has published numerous books and peer-reviewed journal articles in her areas of expertise.



Kim Bullock, M.D.

• **Dr. Bullock** is a psychiatrist and Clinical Associate Professor in the Department of Psychiatry and Behavioral Sciences. She sees a wide variety of patients in the Behavior Medicine and Neuropsychiatry Clinics at Stanford and specializes in the application of cognitive behavior therapy to Somatoform disorders. She teaches and supervises medical students, graduate students and residents how to implement cognitive behavior therapy. She is also a consultant for the national Veteran's Administration's Cognitive Behavior Therapy Dissemination Project for depressed veterans.



Behavioral Activation: An Effective Intervention for Late Life Depression



Dolores Gallagher-Thompson, Ph.D.
Director, Stanford Geriatric Education Center
Professor, Dept. of Psychiatry and Behavioral Sciences,
Stanford University

Kim Bullock, M.D.
Clinical Associate Professor
Behavior Medicine Clinic
Dept. of Psychiatry and Behavioral Sciences,
Stanford University

Outline of What This Webinar Will Cover

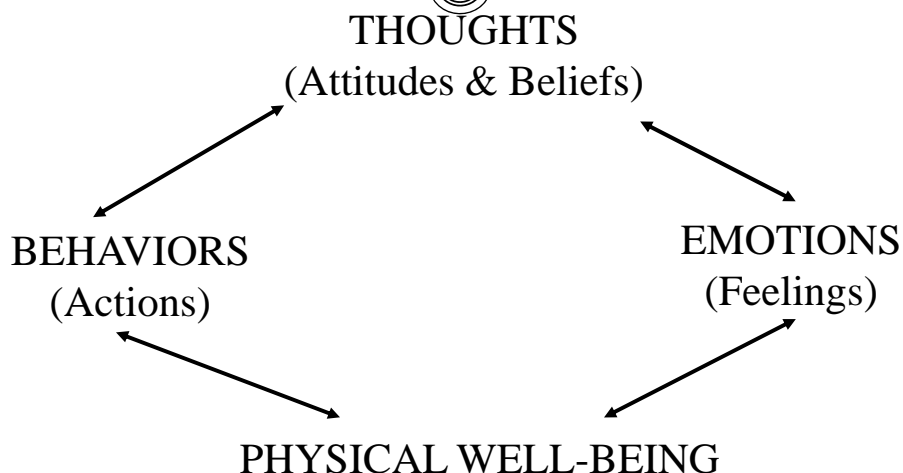


- **Theoretical Background on CBT and Behavioral Activation (BA)**
- **Evidence-base for BA and its use with Ethnic Minority Clients**
- **Steps in the BA process**
- **Case Examples**
- **Questions/ Discussion Time**

WHAT IS CBT?

- A form of psychotherapy developed by **Dr. Aaron T. Beck** in which client and therapist work together to identify and resolve current problems of everyday life.
- Clients are taught the “CBT APPROACH”: how they can feel less depressed by changing their negative thinking patterns, as well changing their behaviors & their emotional responses.
- CBT is an **evidence- based program (EBP)** – its found effective in over 400 outcome studies for numerous disorders including; depression, anxiety disorders, substance abuse, and depression associated with common medical problems (e.g. irritable bowel syndrome, chronic fatigue, hypertension, fibromyalgia, cancer, diabetes, & chronic pain disorders).

Beck's Basic CBT Model Emphasizes the Primacy of THOUGHTS



Lewinsohn's Model Emphasizes The Relative Importance of Behavior

5

○ Two behavioral patterns are commonly associated with depression:

1. Low rate of response-contingent **positive reinforcement**, especially from others:
 - Depressed individuals do not get enough **pleasure** from their interactions with their environment and with other people.
2. High rate of **punishment**:
 - Depressed individuals may have excessive or persistent involvement with aversive or noxious events or people.

Reasons for Low Rates of Positive Reinforcement

6

1. Depressed older adults often lack the social skills needed to engage in positive interactions with others and obtain positive feedback from others – e.g., they may be overly passive or overly aggressive in interpersonal situations.
2. The potency of former positive reinforcers may be diminished – e.g., things that used to bring pleasure, no longer do. This is a very common complaint of older depressed individuals.

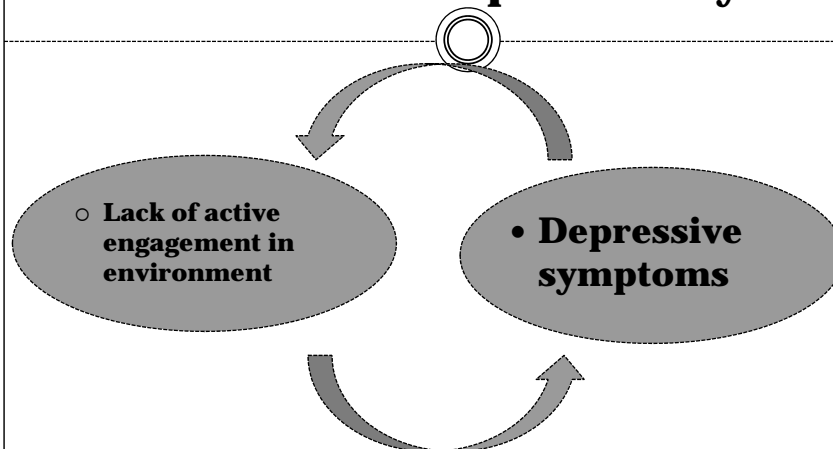
High Rates of Punishing Experiences

7

○ Depressive feelings are reinforced when:

- There are many “punishers” in the environment (people who are aversive to be around, environmental stress, negative situations that can’t be changed –e.g. significant chronic health problems).
- Also, the older client may lack needed social skills to cope with negative events, people, or experiences that re-occur – e.g., having long standing stress with adult children and years of “conflict” in these relationships. Such clients often feel that they are unable to modify the environment – in this case, improve their interpersonal relationships with family members –although this may be crucial to maintaining their depression.

Lewinsohn's Depressive Cycle

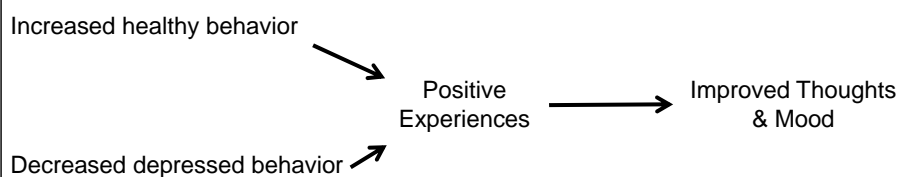


Simply Put: What is Behavioral Activation?



- BA helps depressed people improve their mood by learning skills to help them change their everyday behaviors & institute new patterns.
- By doing so, patterns of **avoidance, withdrawal, and inactivity** are challenged and changed. This helps to reduce feelings of depression at any age.
- The goal of BA is to learn specific skills to increase engagement in everyday positive activities. This in turn will lead to more positive reinforcement for the client and less depression. BA may also impact clients' negative thinking processes (since now they are doing more than they thought they could) and that in turn may improve their sense of physical well-being – as suggested in the basic CBT model.

Treatment Rationale



(Lejuez, Hopko, & Hopko, 2001)

The EVIDENCE BASE for BA



- Robust effects have been found in reviews of behavioral activation for depression. (see Dimidjian et al., 2011 for most recent review)
- For example, large-scale treatment studies with younger persons found BA to be more effective than cognitive therapy and equivalent to medication for treating depression. (Spates, Pagoto, & Kalata, 2006; Dimidjian et al., 2006)
- A well-validated treatment manual for a brief form of BA is available from Lejuez, Hopko, & Hopko (2001).
- Research with older adults found similar results, indicating that older individuals respond well to BA when it is modified to meet their needs. (Gallagher-Thompson, Hanley-Peterson, & Thompson, 1990; Scogin et al., 2005; Scogin et al., 2012; Thompson, Gallagher, & Breckenridge, 1987; Thompson, Coon, & Gallagher-Thompson, 2001)

Research with Ethnic Minority Individuals: Hispanic/Latino Clients



BA-Latino/a or BAL

- Several adapted versions of BA in Spanish have been developed and some are available in manual form from the authors (Kanter et al., 2008; Kanter et al., 2010; Martell et al., 2001; Munoz & Miranda, 1986; Munoz et al., 1996; Munoz & Mendelson, 2005; Munoz et al., 2005; Organista et al., 1994; Santiago-Rivera et al., 2008)
- Most of the controlled studies with Spanish-speaking clients from a variety of countries and cultures have been done by Munoz and associates and Kanter and associates. The most recent one (by Kanter et al., 2010, was done with predominantly women clients, mean age = 40, seen for an average of 12 sessions) found a clinically significant 50% drop in depression scores on both the BDI-II and Hamilton Rating Scale for Depression. (Kanter et al., 2010). This again supports the efficacy of this approach with Hispanic/Latino clients.

Why does BA work with Latino Clients?



- Presenting BA as an educational learning tool fosters empowerment and treatment engagement, and enables the therapist to be seen as “teacher and helper” and as a guide to help the client become aware of new choices and options.
- BA-L pays attention to Latino cultural values and how they influence activation – e.g., activating a client who does not wish to confront her husband about his aggressive behavior towards her while respecting the values of *marianismo* and *machismo*; or activating another client to go to church who feels she is being followed by a *presencia negativa*. These can be challenging cases requiring cultural knowledge & sensitivity.
- BA-L recommends free or low-cost, and culturally sensitive activities (e.g., walking, attending local festivals, going to church, going to the park with family), which is consistent with the cultural value of *familismo*.

(Alegria et al., 2004; Bein, Torres, & Kurilla, 2000; Kanter et al., 2010)

BA-L (continued)



- It is recommended that in early sessions, basic information about depression is presented to the client. This minimizes potential for early dropout.
- Explain depression as an understandable response to life’s difficulties – particularly when one is passive and avoidant, rather than active. Thus, the key in treating depression is to overcome avoidance and passivity, take action to solve problems, and schedule activities that bring meaning and pleasure to one’s life.

Research with Ethnic Minority Individuals: Chinese Clients



- Similarly to what was just reported for Hispanic/Latino clients, numerous studies have demonstrated the effectiveness of CBT in treating depression and self-esteem issues among Chinese clients.
- With a few modifications, BA appears to be a viable model to help depressed Chinese American clients in a short-term therapy setting or in the beginning phase of therapy. (Dai et al., 1999, Lin, 2002; Miller & Yang, 1997; Yang, 1992)

Why does BA work with Chinese clients?



It is noteworthy that there are many parallels between Chinese cultural norms and the philosophy of CBT: (Chen & Davenport, 2005)

- (1) Importance of logical thinking: As goes a well-known Chinese proverb. “Originally there is no disturbance in the world, but people make themselves feel worried.”
- (2) Therapeutic relationship: seeing the therapist as a “teacher” (who is highly respected) who has the knowledge and expertise
- (3) Chinese American clients “tend to have lower tolerance for ambiguity, and tend to prefer structured situations and practical, immediate solutions to problems”. Some researchers have also indicated that Chinese clients prefer therapists who apply a directive, rather than a nondirective, approach.

Suggested Modifications for Working with Chinese Clients

- a) **Therapist-client relationship:** Educate Chinese clients about the therapy process to help them be less anxious & have realistic expectations; set up a warm, supportive but also directive, atmosphere for therapy. This is consistent with Chinese cultural values of respect for authority, and the norm of “hard work leads to a better life.”
- b) **BA often involves some assertiveness training:** Help Chinese clients recognize that they can be assertive in some situations and not in others – particularly interpersonal ones, where there is considerable current conflict.
- c) **Recognize and respect the “Somatization tendency”:** Acknowledge their physical complaints but also explain how improving physical well-being may result after depressed mood improves.
- d) **Respect Chinese cultural values of collectivism and interpersonal harmony.** This means that BA may involve developing a list of SHARED positive activities that the family can do together, as well as learning skills to obtain positive reinforcement outside the family, if that will enhance harmony.

(Chen & Davenport, 2005)

Research Specifically with Ethnic Minority Older Adults

Healthy IDEAS (Identifying Depression Empowering Activities for Seniors)

- A successful community based program that incorporates 4 evidence-based components into the ongoing delivery of care-management. These are 1) screening and assessment; 2) education about depression; 3) referral and linkages; 4) behavioral activation.
- Evaluation of the program (with approx.100 low-income, predominantly Hispanic and African-American women, mean age =72, cognitively-intact clients) found that Geriatric Depression Scale scores significantly reduced over time, clients reported that increased activities helped them feel better, and they experienced less pain. There was also an increased knowledge of how to get continued help. (Quijano et al., 2007)
- More information (program and intervention manual and technical assistance) can be found at: www.careforelders.org/healthyideas . More than 30 agencies in 15 states have adopted and implemented this program, as of May 2010.

Steps in the Behavioral Activation Process



1. **Activity Monitoring –(Step 1)**

How is client spending their time now? (**Activity Log**)

What positive activities could be ADDED IN to their days, to boost mood?

2. **Activity Scheduling –(Step 2)**

Get positive activities scheduled in.

Track progress. (**Tracking Form**)

3. **Modify–(Step 3)**

Modify the list based on feedback, barriers, and culture. Schedule new activities. (**Activity Schedule Log**)

**** Continue Tracking and Doing for as long as necessary! ****

Activity Monitoring (Step 1)



- Self-reports are not as accurate as a log of activities kept for a week between sessions. Depressed persons tend to underreport positive experiences, emphasize negative perceptions, and focus more on failures than on successes.
- The weekly (**Activity Log**) form is typically assigned as homework **but** should be started in session to ensure that the patient understands the concepts & knows what is expected.

Activity Log I

Write in each box: (1) Activity, (2) Mood rating (0-10). Mood I am rating: _____

Time:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6-7 A.M.							
7-8 A.M.							
8-9 A.M.							
9-10 A.M.							
10-11 A.M.							
11-12 P.M.							
12-1 P.M.							
1-2 P.M.							
2-3 P.M.							

Worksheet 10.4: Tracking Activities – Weekly Activity Schedule

Activity Monitoring (Step 1)



How to do it?

- 1) **START IN SESSION:** Bring out a copy of the form, and ask the client to fill in her activities for each time block before the treatment session beginning with the day of therapy.
- 2) Encourage client to write in activities that actually occurred, no matter how mundane. e.g. bathing, dressing, eating, traveling, talking with others watching TV, and sleeping.
- 3) Ask them to **rate (simple 1 -10 scale)** the degree of *enjoyment* experienced for each, **or** the sense of *mastery* or *accomplishment* that was associated with the activity. We do this to understand which activities are associated with positive mood for that person.

Activity Monitoring (Step 1)



- 4) Some simple tasks might receive high ratings for mastery. Clients should try to give themselves credit for small accomplishments, because progress is generally made in small, incremental steps.
- 5) Low ratings of pleasure should be expected for two reasons:
 - a. If there is little involvement in activities that most people would consider highly pleasurable and
 - b. If the capacity for experiencing joy or pleasure is blunted

** Encourage the client to at least give a rating of 1-3 if minimal pleasant feelings were experienced.*

Suggested Questions to Stimulate Thinking

Are there specific periods of time when the person experiences enjoyment or pleasure?

* *What kinds of activities seem to give the person pleasure?

* * Can these pleasurable activities be repeated on another day?

What activities appear to give the person a sense of accomplishment?

Can these types of activities be scheduled for other days?

Are there certain times of day that appear to be **low** on mastery or pleasure?

What can be done to improve activity patterns during those times of day?

* * * Do the ratings tend to be higher for activities that involve other people? If so, can social contact be increased?

* * * * What activities did the patient do in the past that have been stopped or reduced? Are there opportunities for rekindling interest in these (or similar) activities?

* * * * Are there **any** types of activities (e.g., exercise, music, spiritual involvement, art, crafts, reading, volunteer work, cooking) that the patient is ignoring but that may be of interest? Is he/she open to considering adding new or different activities to their weekly schedule?

Activity Log for 331

Time of Day	Day 1 Date:	Day 2 Date:	Day 3 Date: 10/12	Day 4 Date: 10/13	Day 5 Date: 10/14	Day 6 Date: 10/15	Day 7 Date: 10/16
6 to 7 AM				Woke up/ felt "so so" (5)		Walked dog (7)	Got up (5)
7 to 8 AM			Got up, picked up Alice my niece & we had breakfast (6)	Stayed in bed (6)	Got up, got ready (6)	Back to bed (3)/ not much to get up for today (3)	Took a shower (6)
8 to 9 AM				Got up (6)	Took shower & made coffee (8)	couldn't sleep, got up, took a shower, started to feel better (6)	Made coffee (6)
9 to 10 AM			Dentist appt (5)	Took shower (7)	Took off to art class at Moss Landing studio (9)	Made breakfast for myself (6)	Made healthy breakfast for myself & my neighbor (9)
10 to 11 AM				Made coffee (7)	Very enjoyable! (9)	Stayed home all morning/ not much to do (4)	--
11 to 12 Noon			Watched TV with Alice at home (some good moments) (4 - 6)	Saw a movie by myself (6)	(illegible) (10)	Nice call from	Stayed home / not much to do (3)

Activity Log for 331 Con't

Time of Day	Day 1 Date:	Day 2 Date:	Day 3 Date: 10/12	Day 4 Date: 10/13	Day 5 Date: 10/14	Day 6 Date: 10/15	Day 7 Date: 10/16
12 to 1PM			Cooked for Alice (8)	Got ready to come to appt	--	cousin in Fresno, we talked about an hour (6)	Watched favorite show on TV. (7)
1 to 2 PM			Watched movies again on TV at home for the afternoon (5)	Drove to appt	--		--
2 to 3 PM			same	Had my meeting (8)	Left to go to see Helen at the hospital (3; sad re how sick she is)	Went to cemetery as its anniversary of my mother's death (30 years)	--
3 to 4 PM				Drove home, felt pretty good, hopeful (8)	Saw Helen's family & MD	Took Vicky flowers for her son & my mother (4)	Stayed home & did chores (5)
4 to 5 PM			Took Alice home/ sad she had to leave (4)	Had a bite to eat			Made Dinner (6)
5 to 6 PM			Back home, fixed dinner for myself, lonely (5)	Went back to	at hospital / glad to see them (7)		Went for walk (7)
6 to 7 PM			Started painting the cross / art project (7)	hospital to see my friend Helen.	Stayed & talked (6)	Went to	TV news (5)
7 to 8 PM			Same	She seems to be getting worse (3)	Got upset though because Helen	eat out, alone, in	Saw TV, disappointed (5)
8 to 9 PM			Watched TV: it was OK (5-6)	Stayed & tried to comfort her (4)	was sent to Stanford by	Seaside (4). Food was good! (8)	Called a friend to talk (7)
9 to 10 PM			Went to bed / asleep	Went home (4)	helicopter; she's sicker than I thought (2)	Home/ saw movie (8) I liked on TV	TV was OK (8)
10 to 11 PM				Went to bed (4)	Went home, went to bed (3)	Went to bed	Went to bed

Activity Scheduling (Step 2)





- First, it's necessary to **identify activities** that, in the past, gave the client a sense of pleasure or mastery. It is a very individualized process.
- Then it's necessary to **discuss the barriers** to doing any of these things & to problem solve with the client so that a plan can be made.

Activity Scheduling (Step 2)





- After the client sees relationships between activities and mood, then we want to increase those activities likely to have the most positive impact on mood.
- How do we do this?
 - 1. Generate a list of pleasurable activities. Include the ones from the monitoring exercise (**Activity Log**) that had the highest ratings for pleasure.
 - 2. Brainstorm with the patient to list some **new** ideas that may be worth trying (**Tracking Form**).
 - 3. Collaboratively determine which activities to add to the person's daily routine.
 - 4. Select specific times and write them on the schedule as a plan for the following week (**Activity Schedule Log**) .

Tracking Form - Pleasant Events and Monitoring Your Mood							
Name:	Days						
Pleasant Events	1	2	3	4	5	6	7
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
Total							
* Mood Score							

	1	2	3	4	5	6	7	8	9	
very sad					"so-so"					very happy

Pleasant Activities Log for 331							
	Mon 17 th	Tues 18 th	Wed 19 th	Thurs 20 th	Fri 21 st	Sat 22 nd	Sun 23 rd
Pleasant Events	Days						
	1	2	3	4	5	6	7
1. Seeing smelling flowers/plants		X	X			X	
2. Being loved							
3. Getting out of the city		X	X		X	X	
4. Visiting a museum							
5. Watching a horror movie		X	X	X	X	X	
6. Thinking about pleasant memories		X	X		X	X	
7. Thinking positive about myself		X	X		X	X	
8. Teaching Alice crocheting							
9. Saying something clean		X		X	X		
10. Thinking something good in the future			X	X		X	
Total	0	6	6	3	5	6	0
Mood Score* Extra painting		8	7	5	8	8	5

*Mood Score Rating Scale

	1	2	3	4	5	6	7	8	9	
very sad					"so so"					very happy



MODIFY (Step 3)

- Modify scheduling based on feedback, barriers, cultural considerations, and what was successful for the person (what activities actually improved their mood is the key question).

MODIFY (Step 3)

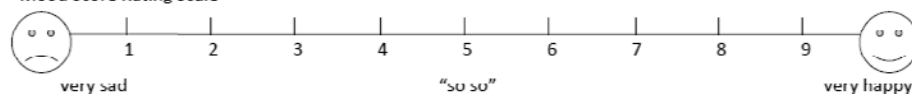
Common Obstacles with Older Adults

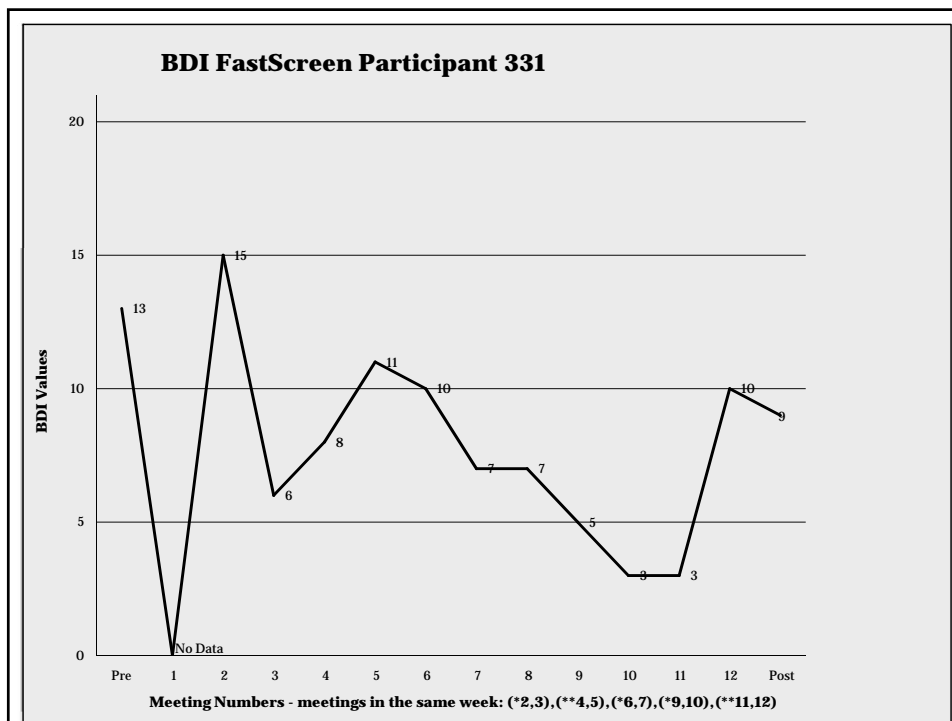
- There are many obstacles: **“I don’t feel well enough to do anything” – “I’m too tired” – “There’s no one left of my old friends to play cards with”**. These negative thinking patterns need to be addressed before the person can really engage in BA.
- Some older depressed persons don’t seem to want to increase their activities & often believe that there’s NOTHING left that will bring them enjoyment. This means that BA will be challenging, but not impossible:
- You will have to start small & go slow in order to see change.

Revised Pleasant Activities Log for 331

	Mon 24 th	Tues 25 th	Wed 26 th	Thurs 27 th	Fri 28 th	Sat 29 th	Sun 30 th
Pleasant Events				Days			
	1	2	3	4	5	6	7
1. Seeing/smelling flowers/plants	X						
2. Getting out of the house					X		X
3. Watching horror movies			X		X	X	X
4. Thinking about pleasant memories				X	X	X	X
5. Thinking positive about myself		X		X			
6. Crocheting	X		X		X	X	
7. Saying something clear		X		X	X		
8. Thinking something good in the future							
9. Painting		X	X	X			
10. Baking	X						
Total will be seeing Andria today for Halloween	X, 4	3	3	4	5	3	3
Mood Score*	7	8	7	8	7	7	7

*Mood Score Rating Scale





Detailed Case example: Mr. A.



72 year old widowed man; ancestry is part Latino and part Native American. He has 3 adult children who live nearby and many grandchildren. Although Spanish is his first language, he is fluent in English as well. Mr. A went to high school and worked in construction & landscaping earlier in life. He now is employed part time as a musician in his church. He has significant medical co-morbidities including severe arthritis, Type II diabetes that he has difficulty keeping under control, and history of heart disease. He has had to significantly reduce his activities due to his health problems and low income. He reports his annual income to be below \$20,000.

Cognitive Behavioral Skills Training Packet Participant ID: 00 Date: Page 7

ACTIVITY LOG FOR: _____

Time of Day	Day 1 Date: <u>9/23</u>	Day 2 Date: <u>9/24</u>	Day 3 Date: <u>9/25</u>	Day 4 Date: <u>9/26</u>	Day 5 Date: _____	Day 6 Date: _____	Day 7 Date: _____
6 to 7 AM		3	Visited Waldo	Worked on video	Came home 5		
7 to 8 AM		Woke up and finances	at mental Hospital 5	↓			
8 to 9 AM	3	Work on video		↓			
9 to 10 AM	Ate breakfast 4	↓	Made love to girl friend	↓ 5			
10 to 11 AM	Therapy 4	↓	10	aqua therapy 5			
11 to 12 Noon	Mulling tailspin	5	talking to sister	↓			
1 to 2 PM	Aqua therapy 5	↓	1	Apple class 5			
2 to 3 PM	Pick up friend at airport	↓					

Pleasant Events		1	2	3	4	5	6	7
1. Laughter		5	6	6	6	6	5	6
2. Aqua therapy		5	7	7	6	7	N/A	7
3. Playing Music		5	5	5	5	5	5	5
4. Classes at Apple		8	7	7	9	N/A	N/A	N/A
5. Peaceful times with Girl Friend		8	6	6	N/A	N/A	N/A	N/A
6. Hanging with son		N/A	N/A	N/A	N/A	N/A	N/A	N/A
7. Walking Beach		N/A	N/A	N/A	9	N/A	9	N/A
8. Grand Kid time		N/A	N/A	N/A	N/A	9	N/A	N/A
9. Working		N/A	9	9	9	6	6	6
10. Visiting Hawaii		9	9	9	9	9	9	9
Total		5	6	6	7	6	5	5
Mood Score*		40	49	49	53	42	34	33



*Mood Scale Rating

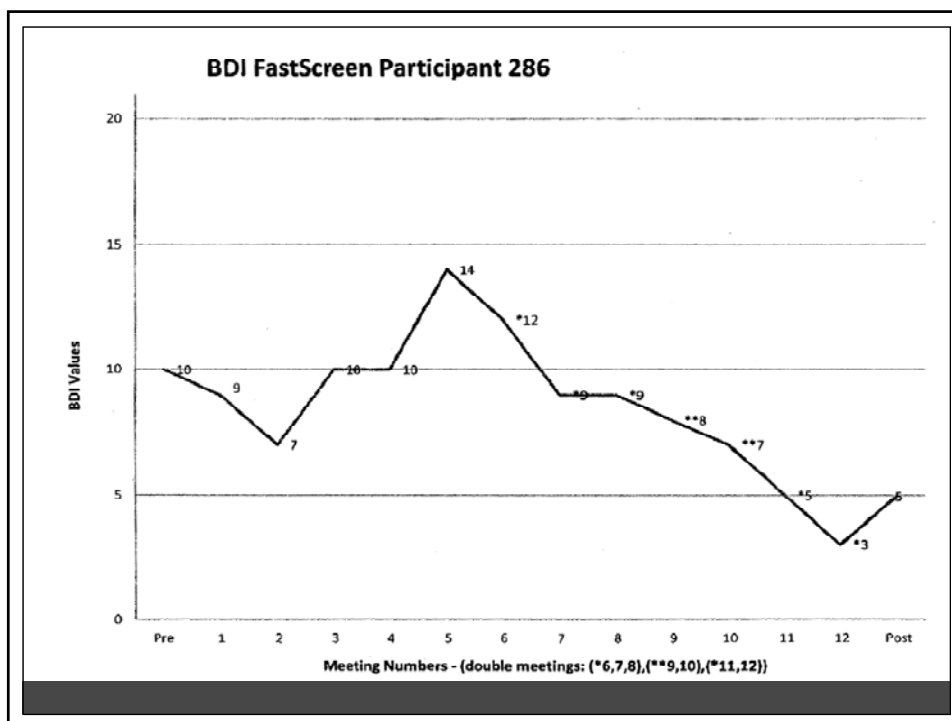
very sad
"so so"
very happy

Pleasant Events Tracking Form, Revised

Pleasant Events	Tues 1	Wed 2	Thurs 3	Friday 4	Sat 5	Sat 6	Sat 7
1. PEP meeting	✓						
2. Anna Therapy	✓	✓	✓	✓	✓	✓	✓
3. Play Music	✓		✓				
4. Chores at Apple	✓	✓	✓	✓			
5. Peaceful Times w/ GF					✓	✓	
6. Watching Baseball		✓	✓			✓	✓
7. walking at beach		✓	✓				✓
8. Spending time w/						✓	
9. Shopping for Grandchildren					✓		
10. Working	✓	✓	✓	✓	✓	✓	✓
Total	5	5	6	3	4	5	4
Mood Score*							

*Mood Score Rating Scale

 1 2 3 4 5 6 7 8 9 
 very sad "so so" *diverse mood* very happy
and was my self went well



SUMMARY of BA

1. Activity Monitoring –(Step 1)

How is client spending their time now? (**Activity Log**)

What positive activities could be ADDED IN to their days, to boost mood?

2. Activity Scheduling –(Step 2)

Get positive activities scheduled in.

Track progress. (**Tracking Form**)

3. Modify–(Step 3)

Modify the list based on feedback, barriers, and culture. (**Activity Schedule Form**)

Take Away Message:

Four Pleasant Activities a Day Keeps the Blues Away

- They don't have to be huge
- Just **Consciously Chosen**, and **Deliberately Done** to experience control.
 1. Events/ activities Control Mood.
 2. To some extent you can control activities & events.
 3. Therefore, to some extent, you can control (influence) your mood.
 4. By increasing this sense of control, you increase your sense of efficacy or mastery for reducing depression and improving your quality of life.

Discussion



THANK YOU FOR YOUR PARTICIPATION!

- Please feel free to contact us if you would like to learn more about CBT – particularly how to incorporate Behavioral Activation into your practice with older adults:

Dolores Gallagher-Thompson, PhD ABPP

Email: dolorest@stanford.edu

Kim Bullock, M.D.

Email: kbullock@stanford.edu

References (1)



- Alegria, M., Takeuchi, D., Canino, G., Duan, N., Shrout, P., Meng, X., et al. (2004). Considering context, place and culture: The National Latino and Asian Study. *International Journal of Methods in Psychiatric Research*, 13, 208-220.
- Bein, A., Torres, S., & Kurilla, V. (2000). Service delivery issues in early termination of Latino clients. *Journal of Human Behavior in the Social Environment*, 3, 43-59.
- Chen, S. W.-H., & Davenport, D.S. (2005). Cognitive-behavioral therapy with Chinese American clients: cautions and modifications. *Psychotherapy: Theory, Research, Practice, Training*, 42(1), 101-110.
- Dai, Y., Zhang, S., Yamamoto, J., Ao, M., Belin, T.R., Cheung, F., & Hifumi, S.S. (1999). Cognitive behavioral therapy of minor depressive symptoms in elderly Chinese Americans: a pilot study. *Community Mental Health Journal*, 35, 537-542.
- Dimidjian, S., et al. (2006). Randomized Trial of Behavioral Activation, Cognitive Therapy, and Antidepressant Medication in the Acute Treatment of Adults With Major Depression. *Journal of Consulting and Clinical Psychology*, 74 (4), 658-670.
- Dimidjian, S., et al. (2011). The origins and current status of behavioral activation treatments for depression. *Annual Review of Clinical Psychology*, 7, 1-38.
- Gallagher-Thompson, D., Hanley-Peterson, P., & Thompson, L.W. (1990). Maintenance of gains versus relapse following brief psychotherapy for depression. *Journal of Consulting and Clinical Psychology*, 58(4), 371-374.
- Jacobson, N.S.; Dobson, K.S.; Truax, P.A.; Addis, M.E.; Koerner, K.; Gollan, J.K.; Gortner, E. & Prince, S.E. (1996). "A component analysis of cognitive-behavioral treatment for depression.". *Journal of Consulting and Clinical Psychology* 64 (2): 295-304. doi:10.1037/0022-006X.64.2.295. PMID 8871414.
- Kanter, J.W., Rusch, L.C., Busch, A.M., & Sedivy, S.K. (2008). Validation of the behavioral activation for depression scale (BADs) in a community sample with elevated depressive symptoms. *Journal of Psychopathological Behavior Assessment*, 31, 36-42.
- Kanter, J.W., Santiago-Rivera, A.L., Rusch, L.C., Busch, A.M., & West, P. (2010). Initial outcomes of a culturally adapted behavioral activation for Latinas diagnosed with depression at a community clinic. *Behavioral Modification*, 34, 120-144.

References (2)



- Lejuez, C.W., Hopko, D.R., & Hopko, S.D. (2001). A brief behavioral activation treatment for depression: Treatment manual. *Behavior Modification*, 25(2), 255-286.
- Lewinsohn, P.M. (1975). The behavioral study and treatment of depression. In M. Hersen, R.M. Eisler, & P.M. Miller (Eds.), *Progress in behavioral modification* (Vol. 1, pp. 19-65). New York: Academic.
- Lin, Y.N. (2002). The application of cognitive-behavioral therapy to counseling Chinese. *American Journal of Psychotherapy*, 56(1), 46-58.
- Miller, G., & Yang, J. (1997). Counseling Taiwan Chinese in America: Training issues for counselors. *Counselor Education & Supervision*, 37(1), 22-34.
- Munoz, R.F., & Mendelson, T. (2005). Toward evidence-based interventions for diverse populations: the San Francisco General Hospital prevention and treatment manuals. *Journal of Consulting Clinical Psychology*, 25, 325-343.
- Munoz, R.F., & Miranda, J. (1986). Group Therapy Manual for Cognitive-Behavioral Treatment of Depression. San Francisco General Hospital, Depression Clinic. http://www.rand.org/pubs/monograph_reports/MR1198.4
- Munoz, R.F., Mrazek, P.J., & Haggarty, R.J. (1996). Institute of Medicine report on prevention of mental disorders: summary and commentary. *American Psychology*, 51, 1116-1122.
- Munoz, R.F., Ying, Y., Bernal, G., & Perez-Stable, E.J. (1995). Prevention of depression with primary care patients: a randomized controlled trial. *American Journal of Community Psychology*, 23, 199-222.
- Organista, K.C., Munoz, R.F., & Gonzalez, G. (1994). Cognitive-behavioral therapy for depression in low-income and minority medical outpatients: description of a program and exploratory analyses. *Cognitive Therapy Research*, 18, 241-259.
- Quijano, L.M., Stanley, M.A., Casado, B.L., Steinberg, E.H., Cully, J.A., & Wilson, N.L. (2007). Healthy IDEAS: a depression intervention delivered by community-based case managers serving older adults. *Journal of Applied Gerontology*, 26(2), 139-156.

References (3)



- Santiago-Rivera, A., Kanter, J.W., Benson, G., Derose, T., Illes, R., & Reyes, W. (2008). Behavioral activation as an alternative treatment approach for Latinos with depression. *Psychotherapy: Theory, Research, Practice, Training*, 45, 173-185.
- Scogin, F., Welsh, D., Hanson, A., Stump, J., & Coates, A. (2005). Evidence-based psychotherapies for depression in older adults. *Clinical Psychology: Science and Practice*, 12, 222-237. Scogin et al. have a comprehensive update and revision of this paper in this book: In F. Scogin (Ed.), *Making Evidence-Based Psychological Treatments Work with Older Adults*. Washington, D.C.: American Psychological Assn Press. To be published in June, 2012.
- Spates, C.R.; Pagoto, S. & Kalata, A. (2006). A Qualitative And Quantitative Review of Behavioral Activation Treatment of Major Depressive Disorder. *The Behavior Analyst Today*, 7(4), 508–518.
- Thompson, L.W., Coon, D.W., Gallagher-Thompson, D., Sommer, B., & Koin, D. (2001). Comparison of desipramine and cognitive/behavioral therapy in the treatment of elderly outpatients with mild to-moderate depression. *American Journal of Geriatric Psychiatry*, 9(3), 225-240.
- Thompson, L.W., Gallagher, D., & Breckenridge, J.S. (1987). Comparative effectiveness of psychotherapies for depressed elders. *Journal of Consulting and Clinical Psychology*, 55(3), 385-390.
- Wilson, N.L., & McNeill, A.P. (2010). Supporting behavior change to address depression: Implementation of Healthy IDEAS. *Generations*, 34(1), 94-96.
- Yang, R.L. (1992). Rational emotive group therapy applied to sense of inferiority among university students. *Chinese Mental Health Journal*, 6(2), 74-76.