

signments are both important predictors of outcome in BA. Moreover, it is important to note that we used a number of client characteristics as exclusionary criteria in our treatment research. For instance, if a client was acutely suicidal, such that his or her risk could not be managed on an outpatient basis, then we would refer him or her for more acute and intensive treatment. In addition, if a client had a comorbid diagnostic disorder that was more severe and prominent (more interfering and the primary focus of the client), and necessitated another evidence-based treatment (e.g., obsessive-compulsive disorder), then we would also refer him or her to a more specifically appropriate treatment. We also carefully evaluated any potential medical problems that may have contributed to depression and referred clients for appropriate concurrent medical treatment, if necessary.

CASE STUDY

Background Information

The following section presents the treatment of Mark, a 43-year-old man with a long history of depression, who sought treatment after the end of his second marriage. Mark was in treatment for 19 sessions across 4 months. The description here is presented to illustrate the implementation of core BA principles and strategies. Earlier sessions are described in greater detail to provide the reader with “how-to” information regarding the primary principles and strategies. Later sessions emphasize a thematic focus for which the same types of principles and strategies are applied. It is important to emphasize at the outset that this case description is not intended to communicate a prescriptive course of treatment, and readers are advised against following the sequence of strategies in a lockstep fashion. BA is a highly idiographic treatment in which the choice of specific activation strategies is driven by functional analysis; given this, the reader is encouraged to attend to the ways the therapist conceptualizes Mark’s difficulties and implements treatment strategies over the course of therapy. It is our hope that this detailed illustration will inspire readers to apply the basic principles and core strategies in a flexible and idiographic manner.

Mark sought treatment at the urging of his primary care physician. His recent episode of depression had lasted without remission for 3

years. Mark also had a history of alcohol abuse. His early alcohol abuse had caused significant problems in Mark’s first marriage, which ended in divorce when he was in his early 20s; however, problems with alcohol were not a cause of current concern. He had been in therapy previously, during his separation and divorce 4 years earlier. However, Mark described it as unstructured and unfocused, and reported that he stopped going after a few sessions. He lived alone, although he had joint custody of his twin adolescent daughters; he and his ex-wife alternated parenting every other week.

Mark reported that he had had periods of depression for “as long as I can remember.” In particular, he recalled his first episode of depression at age 12, shortly after his father abruptly left and severed all contact with Mark and his family. Mark reported that he had believed that his parents were happily married and, at that time, blamed himself for his father’s departure. Mark reported that his mother and older siblings never discussed his father. In describing his mood during adolescence and adulthood, he reported, “I have periods when I’m able to function OK. I go to work and all that, but I’m never really happy.” Mark’s primary depressive symptoms included depressed mood, loss of pleasure in nearly all activities, excessive guilt, fatigue, difficulty concentrating, and occasional passive thoughts of death.

Mark had had a social network that revolved primarily around his former marriage, but he had been withdrawn from that network since his separation and divorce. Currently, he spent most of his time alone, with the exception of caring for his daughters. Mark was college educated and worked as an accountant for a local manufacturing company. He also wrote children’s stories and, prior to his most recent episode of depression, was working on a number of stories as a member of a local writer’s group.

Case Conceptualization and Overview of Treatment

Mark’s depression was conceptualized as being controlled by a pattern of interpersonal avoidance that was negatively reinforced by reductions in grief and anxiety. Specifically, Mark had trouble fully engaging in his significant relationships and, instead, avoided intimacy in

various ways that included ruminating about mistakes he made in the past, and failing to express commitment to the relationship and what he thought or felt about various topics on a regular basis. Over the course of treatment, the therapist and Mark hypothesized that avoiding close interpersonal connections in his adult life kept Mark detached enough that he would not feel subsequent losses as acutely as those he felt as a child. However, these patterns of avoidance also maintained his depression by limiting Mark's experience of reward in many of his current contexts. Treatment focused initially on increasing activation and addressing many secondary problems and routine disruptions that had become established. Although Mark increased activation relatively quickly, his mood did not improve significantly. This led to a primary focus on Mark's rumination and the ways it functioned to avoid intimacy in his relationships, and experimentation with new behaviors designed to move Mark closer to his goal of having a close intimate relationship.

Session 1

Session 1 focused on reviewing the results from the assessment process, presenting the treatment model, encouraging questions and feedback, and tailoring the model to Mark's specific experiences. The review of the assessment process is typically brief; in this part of the session, the aim of the therapist is to ensure that he or she has a solid understanding of the client's presenting problems, relevant history, and previous experience with treatment, if any. The therapist also reviews the basic diagnostic formulation to ensure that the assessment outcome matches the client's subjective experience of his or her current problems. Discussion of the treatment typically forms the bulk of the early sessions. The following transcript provides an example of the therapist presenting the treatment model and responding to frequently asked questions about the etiology of depression. Specifically, the therapist puts forth the idea that depression is treated behaviorally, regardless of etiology.

THERAPIST: Let me tell you a little about the basic model that guides BA. The first idea is that there are often things that happen in people's lives that make it hard for them to connect with the kinds of experiences that would normally help them feel good. These

shifts can be clear and easy to detect changes like major losses or disruptions in life. And they can also be smaller things, like the kind of things that just bug you a little but they keep happening, or you have a bunch of them happen all around the same period of time. The most important part is the idea that the effect of these events in your life is that it's harder to connect with the kinds of experiences that could give you a sense of pleasure or accomplishment in your life, and that could help you feel better.

MARK: I would say that is true for me. There isn't much that helps me feel better. Even things that I think should help me feel better don't do much.

THERAPIST: Yes, exactly. What we find often happens is that people can respond to these changes by pulling away from their lives even more. This pulling away can happen sometimes in obvious ways, like staying in bed or calling in sick to work, or canceling social engagements, and sometimes in more subtle ways, like being focused more on your thinking than on the activities you are engaged in. The problem with pulling away like this is that it tends to keep people stuck in feeling depressed, and the pulling away can become a problem in its own right. So, the ultimate goal of our work together is to figure out what sorts of experiences may potentially have a positive effect on your mood, and then help you activate and engage to connect with these experiences. And to figure out how to solve the problems that are creating stress or dissatisfaction in your life. How do you see this fitting with your experience? Do you have questions about what I've said? Parts that fit or don't fit?

MARK: I understand what you are saying, and I think some of it fits, but I guess I don't understand why I get so depressed. I mean, other people have stressful things in their lives and they seem to function. Other people get divorced or have crappy jobs, and they move on. I mean, come on, I've been divorced for 4 years now. I think depression runs in my family. My older brother has been depressed forever, and I sometimes wonder if my dad was depressed when he took off. Sometimes, I can't really identify anything that has happened in my life. I mean, I am never really happy and then, it's just like a switch goes in my brain and I'm back in that

dark hole again. But how does that fit with what you are saying?

THERAPIST: That is an excellent question. What I mean as I talk about depression is that some people are more vulnerable than others. And, there are many ways that you may be vulnerable to depression—through genetics, biology, or experiences in your history. What this treatment emphasizes is that it's possible to change depression by making changes in what you do.

MARK: That makes sense to me. One part of what you said definitely fits for me—the part about pulling away more. I definitely do that. Sometimes I don't talk to another person or get out of bed all weekend. I know it makes it all worse. But I still do it. I guess I don't really understand that part either. It fits, but it doesn't make much sense to me.

As the therapist replies to these very common questions, she seeks to normalize avoidant responses to depression. It is essential for the client to experience the therapist as someone who understands and has sincere empathy for his or her struggle. The therapist must communicate that the client's behaviors make sense, even though they may not serve the client well in the long term. In this way, the client is more likely to experience the therapist as an ally in the change process as opposed to someone who oversimplifies or "doesn't get" the challenges of making changes. Additionally, the therapist also emphasizes to Mark the importance of guided activity, highlighting her role as an expert and the importance of careful assessment. She emphasizes the difference between assignments derived from a list of pleasurable activities and those that are guided by functional analysis, a key aspect of the treatment, to which the therapist will return many times.

THERAPIST: Those are great observations and are really on target with what I have noticed for a lot of people as well. What many people experience is that when they start to activate and engage, they can actually feel worse initially! The troubling fact about pulling away or avoiding is that it does provide some short-term relief. But in the long term, it sets up a downward spiral and can keep you trapped in depression.

MARK: That makes a ton of sense to me. I just don't want to do anything. Making a meal

makes me tired. I feel irritated by the sound of silverware scratching on plates. It's kind of crazy, but I just want to crawl in a hole, to turn out a light in my head and make it all go away. Then, I end up feeling worse when I do stay in bed. I used to drink, too. I knew it would make it worse, and I don't do it much anymore, but it helped in the moment, even though I knew it didn't *really* help. I guess I felt better temporarily and that was enough.

THERAPIST: Yes, exactly. Avoidance is a perfectly natural response to depression. What unfortunately happens, though, is that you are not in touch with all those things that can give you pleasure and a sense of accomplishment, *and* you are not engaged in solving the problems that create stress in your life.

MARK: I know that would help, but it just all feels so overwhelming. Just the thought of it . . .

THERAPIST: Yes, I know. That is where I come in. It's important to emphasize that this treatment is not just about me saying you should "do more" in general. Sometimes I tell people that it's not the Nike approach to therapy, where I tell you each week to "just do it." You have probably received feedback like that from other people in your life, and you may even say something similar to yourself.

MARK: Yeah, guilty as charged.

THERAPIST: My assumption is that if this were easy to figure out, you would already have done it. The reason that you are here is that it's not so easy, and that is where my expertise comes in. A major part of this treatment is the idea of *guided activation*. This means that you and I will be working together to identify specific ways in which you can experiment with activation. My expertise lies in figuring out, first, where the places are that would be the most helpful in increasing your activation and engagement, *and* second, what small and manageable steps you can take to get started. You can think of me as a coach or consultant to you in the process of change. We will work together, in small steps, all along the way. How does that sound?

MARK: The idea of it sounds good. I guess it's worth trying.

THERAPIST: I'd like to ask you to read a short

pamphlet about this treatment, between now and the next time that we meet. It will provide you with more information. When we meet next time, we can talk more about how we will put the ideas into practice.

With this initial session, the therapist has begun to teach the client about the treatment model and is getting the client actively involved in and on board with the rationale. The therapist has oriented the client to their roles in treatment and has given the client his first homework assignment (reading the treatment rationale pamphlet). These critical tasks of the first session set the stage for additional discussion in Session 2.

Session 2

In Session 2, the therapist carefully follows up on a number of the key orienting tasks, including ensuring that Mark is on board with the basic treatment model and explaining the structure of the therapy. The therapist attends to these topics in the opening of the session:

THERAPIST: It's great to see you today, Mark.

MARK: Thanks. It's good to be back here.

THERAPIST: That's great. You know, when I was thinking about our session last time, I realized that there were a couple of points I wanted to emphasize more. One of the important ones is that this is a very collaborative approach to therapy, and one that is also fairly structured. So each time we meet, we will start out by setting an agenda for the session, and we will do this collaboratively. In fact, over time, you will set the agenda more and more, though I may have more to say about it in the beginning. The idea is that I'm the expert on how to get over depression, and you are the expert on yourself and your life, and what things help or don't help.

MARK: That sounds reasonable to me.

THERAPIST: Great. So in terms of the agenda for today, I have a couple of things. I'd like to talk more about the treatment approach and your reaction, and more about how we put some of the ideas into practice. Do you have items you want to be sure we address today?

MARK: No, that sounds good. I did read the pamphlet, and it really hit home. It was like

they wrote it about me, basically. I thought, "Thank goodness somebody has figured this out."

THERAPIST: That's great. I think one of the core ideas of the model is things happen that tend to trigger depressed mood, and then people tend to do things, or not do things, that make the depression worse. For you, my understanding is that the main trigger was your divorce.

MARK: Yeah, I've really pulled back on a lot, like not exercising and not doing things with other people or even with my girls. We used to cook these great dinners together and now it's like an effort to get organized to order pizza. It's kind of like that everywhere—at work, too. I'm just managing the minimum and, honestly, a lot of times I'm not even doing that.

THERAPIST: I know. It can be very hard to keep doing the sort of things that will keep you feeling well. And that is where this therapy comes in. From our session last time and from your reading, what is your understanding of what we are going to be doing in here, and how I am going to be helpful? If you were to tell a friend of yours what we were going to do in this therapy, what would you say?

MARK: I guess I would say that we are going to pinpoint the activities that give me some pleasure or help me feel like I'm handling things well. Then, we will figure out how to help me get into the position of being more involved in some of those things.

THERAPIST: Yes, that is a big part of it. Sometimes in people's lives something that is completely beyond their control triggers depression, and then what I call secondary problem behaviors get triggered or made worse. These are the behaviors that involve pulling away or avoiding, as you were saying, like stopping fun activities with your girls or withdrawing at work. And in those cases we work on the secondary problem behaviors, and that is the core of the therapy. Other times, we also need to address larger problems in your life that may be related to what makes you vulnerable to depression. In those cases, therapy can involve *both* directly addressing the secondary problem behaviors *and* working directly on the problems, after we have kind of cleared the path for doing

some problem solving by getting you activated and engaged.

MARK: That sounds like it's probably the case for me, because I know I had a lot of problems relating to Diane that were part of our divorce, and those are not any better.

THERAPIST: Yes, we will talk more as we go along about what set off the depression for you. In a global sense, we know now that it was the divorce. But, as we start following your mood and activities day to day, we will see the ways that your mood has ups and downs. We will work together and look at that carefully, asking what set that off, how you responded to your mood hitting that point, and whether it would help if you tried something different.

The therapist has now stated twice that generally a contextual event triggers depression, while earlier acknowledging that several things can contribute to vulnerability. This is a subtle but important point, because clients sometimes believe their depression came "out of the blue" or that it is simply "biological" and not modifiable by behavioral means. By emphasizing an environmental antecedent (e.g., a loss of positive reinforcement), the therapist sets up the idea that rather than depression being completely beyond patients' control, their depressive response makes sense, and more importantly, it is possible to make behavioral changes to regain or establish new reinforcers in their lives. Moreover, the therapist has continued to emphasize the importance of carefully monitoring and assessing the relationships among mood, activity, and context as a key part of designing effective behavior change plans. The therapist then builds on this foundation as she moves into the other main focus of Session 2—the initiation of activity monitoring. Here, the therapist explains to Mark why activity monitoring is important, begins to teach him how to complete an Activity Record (see Figure 8.1), and links it directly to some of his recent experiences.

THERAPIST: One of the main tools that we use in this therapy is called an Activity Record. This is one example (*hands Mark the record*); as you can see, it has blocks for each hour of the day. I'd like you to use this to start recording your activity and your mood. It's basically a way to keep track of how you

are spending your time during the day and how you are feeling. We want to learn what you are doing on an hour-by-hour and day-to-day basis. What things in your life help you feel better, and what things make you feel worse? You and I will review these very carefully together, focusing on how you are spending your time and how you feel. Sometimes the Activity Record tells us right away where changes need to be made, and other times we have to look at it over a couple of weeks.

MARK: OK.

THERAPIST: Is there anything you have been doing since you started to feel more depressed that is different from what you normally do?

MARK: Yes, exercising less, watching more TV, and just the amount of time I spend thinking about all this. It's just crazy.

THERAPIST: It's hard not to do that, but also it's not helping you very much. And it's very difficult, which is why you are here. We can start to figure this out together. It's great that you are already aware of those patterns, and those are good examples of looking concretely at what you are doing. This therapy is about increasing your awareness of how your mood is affected subtly from activity to activity and increasing those that tend to be more rewarding.

MARK: So, should I write all this down? Do you really want me to do this every hour?

THERAPIST: Here's the guideline that I use: I want people to record their activity frequently enough that they are not relying heavily on memory. The problem with memory when you are depressed is that your awareness can be dulled or biased by the depression. So you don't have to do it every hour. We have to be realistic about the rest of your life! But you may want to experiment with doing it every 3–4 hours. Sometimes, people like to do it at breakfast, lunch, dinner, and before bed.

MARK: That might work for me.

THERAPIST: Let's go over what to write down. You put your activity down for each hour block and then for each hour block you also assign a mood rating from 0 to 10. Let's look at today as an example. What were you doing in the hours before you came here?

MARK: I was at work.

THERAPIST: Okay, great. What were you doing at work?

MARK: I was teaching a new employee how to use our computer system. It was really frustrating because she wasn't picking it up and I didn't have much patience.

THERAPIST: That's great information to record. Why don't you write down "working-teaching new employee." Now, I also want you to record your mood on a 0- to 10-point scale of depression, so let's see if we can get some anchors here. What would be 0 mood for you? This would mean that you feel really good, absolutely no depression or feeling down at all. What would be 10? This would be when you feel your absolute worst, the worst you could possibly feel. It might be helpful to think of some activities that are a 5 or in between, when you're not feeling your best but you're not feeling particularly bad either. Which activities might be associated with each?

The therapist and Mark then worked together to identify activities that were associated with the low, middle, and high ends of the scale. This was completed to provide Mark with anchors to use when completing the monitoring at home. It should also be noted that therapists may ask clients to rate mastery and pleasure associated with activities (Beck et al., 1979). Mastery and pleasure may be rated instead of or in addition to mood. Often we begin by asking clients to record mood ratings given that this is an easier starting place for many clients because it requires less discrimination of subjective experience; moreover, the mood rating provides essential information about the relationships between specific activities and depression. For some clients, it is helpful to build on this by teaching them how to how to distinguish between mastery and pleasure, and the ways in which both can be helpful in regulating mood. In the case of rating mood or mastery-pleasure, it is important to review carefully the method and scale we want clients to use.

THERAPIST: Given this scale, what was your mood rating for the 2 hours of "working" today?

MARK: Probably a 5.

THERAPIST: That's exactly it. Now, sometimes

what happens is that people don't fill it out because they think, "I wasn't doing anything." It's important to realize that even if you are not doing an activity, we want to know that, too.

MARK: What do you mean?

THERAPIST: Well, when people think "activities," they often think of things like "going to the store," "watching a movie," "picking up my child from school." But, we are conceptualizing activity more broadly. It might be driving by Diana's house, or having a significant phone conversation with someone, or even lying in bed, spending time thinking about Diana.

MARK: That would be true on a lot of days.

THERAPIST: Yes, and you can write that down. Those are some of the most important things. In some ways, the more detail, the better. We want to start noticing subtle changes. We want to build on those times that you feel just a little better, and we want to figure out what the problem is when you feel worse.

MARK: I think I got it.

THERAPIST: Great! People usually come away from this thinking that it sounds really simplistic. And it does. It sounds simple, but in practice it is not that simple. It can be difficult to do in the beginning, to really look at all your activities and figure out how your mood is related to them. It takes skill and hard work on both our parts.

The therapist ended the session by asking Mark to review his understanding of the homework assignment, encouraged him to make contact by phone if any questions arose, and offered encouragement about the likelihood that she could be helpful to him.

Session 3

As noted earlier, one of the necessary competencies of a BA therapist is the ability to review an Activity Record and glean information that will help to customize activation and engagement strategies. Session 3 focused heavily on reviewing Mark's Activity Record (see Figure 8.2) and using the information collected as a springboard for more detailed assessment of key problem behaviors. Again, the therapist's

Instructions: Record your activity for each hour of the day, and record a mood rating associated with each activity. Use the scale below with the anchors that you and your therapist develop to guide your mood rating. Aim to make entries on your Activity Record at least every 3–4 hours each day.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
5-6							
6-7			Awake, thinking in bed (9)				
7-8							
8-9		At work (7)					
9-10			Getting ready for work (8)				
10-11			At work (7)				
11-12							
12-1							
1-2							
2-3							
3-4	Working/ teaching employee (5)	Home (7)					
4-5							
5-6							
6-7	Therapy (5)	Making Dinner (6)					
7-8		TV (9)	TV (9)				
8-9							
9-10							
10-11							
11-12							
12-1							
1-2							
2-3							
3-4							
4-5							

Mood Ratings: 0: Feeling really good; not depressed at all (*Examples of associated activities:* writing; playing with my kids)
5: Intermediate (*Examples of associated activities:* doing a work task that is only moderately interesting but I'm focused and concentrating)
10: Feeling the worst (*Examples of associated activities:* thinking about how I've screwed everything up)

FIGURE 8.2. Sample completed Activity Record (hourly) (assigned on Monday and reviewed on Thursday).

focus in these early sessions is on increasing activation in areas that will improve Mark's mood; this work will set the foundation for later work on avoidance modification and problem solving.

THERAPIST: Shall we go over your Activity Record?

MARK: Okay. (*Hands the therapist the record.*)

THERAPIST: Why don't you walk me through it? (*Hands the record back to Mark.*)

MARK: I'm not sure if this is what you had in mind. I started the next day after our last session. I went to work that day, but I was feeling so lousy that I left early and came home. I was just kind of fiddling around the house until dinner. I felt really down all day up to that point; I rated my mood as a 7. I did make dinner, which was a little better for me. I used to love to cook for Diana and myself, and we would make these big feasts sometimes with the girls. Since the divorce, though, sometimes I just grab a bag of chips or something like that, or on a good night, I might order a pizza. When I was cooking, I felt a little better then, about a 5.

THERAPIST: This is terrific. You did a really great job with this. You completed the record exactly as we talked about—writing down your activities and also your mood rating—and all of this information is extremely useful. I want to ask you some more questions about specific parts of the day in a minute, but right now let me just get an overall sense of things.

Notice how the therapist is careful to reinforce her client's efforts early in the review process. Clients are often uncertain about how to complete the record, and it is not uncommon for them to return with partially or improperly completed records. In such cases, therapists must balance the need to provide corrective feedback and to reinforce the client's efforts. Frequent client errors include writing down activities very globally (e.g., "at work" for 6 hours), failing to record mood ratings, or failing to record anything because they did "nothing." In such cases, the therapist should address these problems in a straightforward and matter-of-fact manner.

THERAPIST: What happened after you made dinner?

MARK: Well, after dinner, I started watching TV, and everything kind of tanked from there. I sat and watched TV until 2:00 in the morning. I guess it helped in that it kept my mind off of worries about work and just feeling lousy about Diana, but I was really depressed the whole time. In fact, I rated my mood as a 9.

THERAPIST: That is really important information. I see that you were also up the next night watching TV until 1:00 A.M. Is this true of a lot of nights for you, or are these two more like exceptions?

MARK: I wish they were exceptions, but no, it's been more the rule. And then what happens is that I just can't get up in the morning. Well, I guess I do wake up, but I just lie there in bed. I've been getting to work pretty late, and some days I just call in sick.

THERAPIST: So we'll use this log to pick up themes of specific activities that can help you feel good and those that may be contributing to your depression. It seems like there are a few that might be important. I'm thinking that the watching TV and going to bed late is one big one, and the other two are cooking and how you are doing at work.

MARK: I think the TV is a really big one.

Notice here that the therapist identified a few broad areas that appear to be related to the maintenance of the client's depression. The BA therapist is also alert to disruptions in the client's normal routines; in Mark's case, both eating and sleeping routines appear to have been significantly altered. The therapist then works collaboratively with Mark to target a specific area for further assessment and problem solving (i.e., nighttime TV watching). At this point, the therapist begins the more explicit process of functional analysis.

THERAPIST: OK, why don't we start there? Let's get clear first about what the problem is, because it doesn't sound like it's watching TV in general.

MARK: That's true. Normally, I would watch some TV, like I might watch for an hour. But, actually, come to think of it, I was more involved in my writing then, too. So, normally, I

might watch TV until about 9:00 P.M. and then turn off the TV and write for another hour. Or, if I had the girls, we might watch a show together and then turn off the TV and read or play a game, or just hang out together, or maybe I'd be on a phone call or something.

THERAPIST: So, this is different for you. The problem, then, is that you don't turn off the TV at 9:00 P.M. and instead watch it for an additional 4–5 hours.

MARK: Yes, that's the problem.

THERAPIST: Are you doing this every night of the week or just on work nights?

MARK: I hate to admit it, but it's pretty much all nights, not always so late, but pretty much always later than is good for me.

To this point, the therapist has worked successfully to define the problem in specific and behavioral terms. With a clear and mutual understanding of the problem, the therapist and client can begin to consider the contingencies that may be maintaining the problem and what may be amenable to change.

THERAPIST: We should probably look at what gets in the way of turning the TV off, since it does not seem to have a great effect on your mood. If you were to turn off the TV at 9:00 P.M. now, what do you think would happen?

MARK: I thought about turning it off last night, but I just didn't want to think about all of this stuff.

THERAPIST: By "all this stuff," do you mean the divorce and the pressures at work?

MARK: Yes, both of them.

THERAPIST: So, that is what you are actively avoiding. And the TV helps you to distract?

MARK: Yes, I just don't have the mental awareness now to start writing. I can't focus on it, and I'm just not interested.

THERAPIST: I think you have the right idea in terms of distraction, but the problem is that you are distracting yourself with something that doesn't give you much pleasure and not much accomplishment.

MARK: And meanwhile the house is a mess. I haven't paid my bills in months, and . . .

THERAPIST: I think it might be good to help you solve the problem of watching TV. It might

be simple to solve, but my guess is that there is more to understand about it.

Notice how easily the client can become overwhelmed and hopeless in response to the myriad problems in his life. The therapist is alert to this possibility during sessions and is careful to refocus the client on the problem at hand. In addition, the therapist also takes a keen interest in the "minutiae" of the client's day-to-day behavior, particularly if such behavior is related to mood. This detailed level of interest is critical. Its intent is twofold: First, such discussions guide the choice of activation targets and specific assignments; and second, it is the intent that such discussions will teach Mark to take a similar interest and begin to notice patterns that are more and less helpful in working his way out of depression.

THERAPIST: Let's understand better what happens with the TV. Does it come into your mind, the thought that you might be better off if you turned off the TV?

MARK: Typically, I think, "I should go to bed." But I know that if I go to bed, I'll just lie there awake anyway, thinking about what Diana is doing, thinking about how much I am going to hate being at work the next day. So, then I think I might as well watch TV and distract myself.

THERAPIST: Is that what happens in bed? You lie there and ruminate about Diana or things you have done or haven't done at work?

MARK: Pretty much exactly.

In this transcript, the therapist has effectively identified a number of key relationships. These include the following: (1) nighttime TV watching is associated with deteriorated mood; (2) nighttime TV watching is associated with poor performance at work; and (3) nighttime TV watching is potentially maintained via a process of negative reinforcement in which negative affect (specifically, grief and anxiety) are reduced when the client is watching TV. The therapist has done so in a collaborative and nonjudgmental manner, and the client is on board. At this point, the therapist explicitly examines her hypothesis with Mark about the relationship between TV and mood. On the basis of this understanding, they can then consider possible activation strategies.

THERAPIST: I'm wondering if part of what is happening is that watching TV is helpful in the short run, because it takes your mind away from these topics that are connected to a lot of potential sadness and also anxiety about the future.

MARK: Yeah, that's true.

THERAPIST: But the tough part is that while it works in the short run, it's that same vicious cycle in the long run, because watching TV gives you almost no pleasure and it keeps you from doing activities that you previously got a lot out of, and it sets you up for having problems at work.

MARK: Yes, exactly. It's crazy, I know, but it's such an easy way out when I'm just beaten by the day.

THERAPIST: Absolutely! So we have to take that into account when we think about making any changes here. I'm thinking that you could try going to bed in spite of that, and we could work on the ruminating. Or, if you are going to be up, you could do things that are better than the TV. Which do you lean toward?

The therapist attends to the function (distraction) of the problem behavior (TV watching), while engaging in problem solving in a very collaborative manner.

MARK: Probably finding other things, better than the TV. I used to go to a book group one night a week. It was made up of other writers and I liked a few of the people a lot, so when I was doing that, I was also doing reading in the evenings, too.

THERAPIST: OK, does reading seem more of a way you could start getting back into some of your writing, versus jumping in with writing itself?

MARK: Yes, there is no way I could write now. I would just be staring at a blank page, feeling like crap.

THERAPIST: OK, that makes sense. So what about starting with this? One option is that you could have a limit for yourself of 9:00 P.M. for TV and we could work on identifying a book that you could read instead.

MARK: It's a good idea. It's more a question of my doing it.

It is very important that the therapist not gloss over comments such as Mark's final statement. When clients express doubt about how or whether they will implement an activation strategy, it is essential to attend to this in detail. Additionally, it is helpful for the therapist to be attentive to statements such as "I'll just have to make myself do it," which generally indicate that the therapist and client have not sufficiently identified the contingencies that control the behavior. In our experience, use of sheer willpower is unlikely to meet with great success, and suggestions of such signal that further assessment is required, as the therapist illustrates.

THERAPIST: So we need to be sure we are getting at the real problem, instead of just saying, "Oh, you are going to do this," and leaving it at that. What kind of reader are you? Are you someone who can get really involved in a book?

MARK: I do get really involved. In fact, I'll think about the book a lot during the day, if I'm already into it.

THERAPIST: But getting yourself to do it is hard.

MARK: Yes, it's getting started on things.

THERAPIST: That is great to know. So, we have to somehow get you involved in the book so that when 9:00 P.M. rolls around, you are already involved, so it will be easier to turn off the TV.

MARK: That would make it easier.

THERAPIST: What if you were to buy a book on the way back from our session and begin reading it in the café of the bookstore.

MARK: Oh, yeah, that is right on the way back. I can do that.

THERAPIST: Mark, I think the trick with all of this is to figure out what is going to help you move toward the things that will be beneficial for your mood. And this is what is really hard—getting yourself to go back to the things that you used to enjoy, when you have no interest in them right now. When you feel good, you take it for granted that it's easy to do things like reading, spending time with friends or your girls, and even writing. When you don't feel good, you really notice it. The problem is that you're in this vicious cycle again. The longer you do not do things, the

more badly you feel and the less you want to do. The trick for us is to figure out ways to help you start to do some of the things that will give you pleasure again.

The therapist acknowledges to the client that the new behavior will be hard to initiate because of mood, and that it is necessary to do so anyway. Many times, clients employ an “inside-out” or mood-dependent approach to their depression; that is, they passively wait for their mood to improve before making behavioral changes. BA therapists teach clients that when they feel down, they cannot afford to wait for a better mood to strike them. The goal is to get active when they feel bad (as hard as that is). Increasing activation will eventually improve mood, even if not immediately, and it will interrupt the pattern of secondary problems created by withdrawal and avoidance. Addressing mood-dependent behavior (or talking about an outside-in vs. inside-out approach) is a sensitive point in therapy, in which a great deal of empathy for the experience of feeling depressed is required. *The therapist must skillfully balance encouragement for action with validation of the difficulty of activating when depressed.* In addition, heavily reinforcing the client (frequently with the use of significant praise) for any steps taken is essential in supporting the process of change.

MARK: Yeah, I know. A lot of the time I might know what I need to do, but I have no idea how to get myself to do it. I’ve just dropped a lot of stuff, like anything social in the evenings. I don’t try to make plans. And, like I said, for almost a year I was going to that writer’s book group every Thursday. But then I said to myself, I’m not writing. This whole divorce is wiping me out. What is the point of going? I have nothing to add.” But, it’s true that when I went, I used to get a lot out of it. I’m just not interested now, though.

THERAPIST: Yes, exactly. That’s where you and I will work together. I want to come back to the social connections and the routines around writing, but let’s stick with the reading and nighttime TV for a bit longer first, if that’s OK?

MARK: Yeah, that makes sense.

THERAPIST: Let’s think through this book plan again. Is there anything that might come up

between here and the bookstore that would derail that plan?

At this point, the therapist and Mark spend the remainder of the session discussing particular books he could purchase that would maximize his engagement, and they discuss potential barriers that might arise to derail him from the intended plan. They also continued to review the Activity Record to identify other key problems, including ruminating at work, withdrawing from social networks, and experiencing disruptions in routines that previously brought him pleasure (e.g., cooking, exercise). In each case, the therapist uses a similar method that she used with the problem of TV watching: defining the problem, identifying the antecedent and consequences, and checking out hypotheses about how the activity is related to mood with client. In each case, the therapist also continues to emphasize that simply deciding to “make myself do it” is not likely to be an effective activation strategy for Mark, and that it is essential to tie the activation plan to a clear understanding of the function of the problem behaviors. The therapist employs a combination of gentle prompting, consistent validation of the difficulty of the tasks and understanding of the temptation of withdrawal and avoidance, and repeated discussion of potential barriers to activation plans. Importantly, the therapist also highlights for Mark that compliance with the homework assignments may not bring immediate relief.

“What will be really good this week is to see what effect these things have on your mood. Even if they have just a little bit of a positive effect, then we know that we are on the right track. And, Mark, they might not have an immediate positive effect on your mood. It might be that the act of getting yourself to do it is the success itself, and that you need to keep doing it for a while before you start to feel good again. But, it’s my guess that some of this stuff will help your mood a little bit, even in the short run.”

The session concluded with the therapist and Mark reviewing the homework assignments, which included purchasing a new book, starting to read it in the café, and turning off the TV every night at 9:00 P.M. and reading. In addition, they agreed that Mark would return a

telephone call of an old friend, Mary, who lived in his neighborhood and had been trying to contact him recently.

Session 4

Mark returned to Session 4 with little improvement in the severity of his depression. He reported that he had increased his social contact, but that he was not feeling any better. Mark also had delayed the task of purchasing the new book and continued to watch TV late at night. The therapist addressed both of these problems in a direct, matter-of-fact way.

MARK: It was a really bad weekend. I did call Mary and ended up going to this kind of cocktail party at the community pool that she had organized. I was kind of shocked that I went, but I thought being outside would do me good. I was thinking about what we were talking about, and I thought about how much I used to love swimming. I was actually a lifeguard during summers in college. But I think I felt worse after I went. I suppose there were moments that were fun, but I was so frustrated by it all. I just spent the rest of the weekend holed up in my apartment.

THERAPIST: Would that be good to put on the agenda? Doing things that you used to enjoy and not enjoying them?

MARK: Sure.

THERAPIST: And I want to make sure we check in about how it went with the book versus the TV, too. Which do you want to talk about first—calling Mary and the party or the TV?

MARK: I guess we can do the TV first. I just bought the book today. On Friday, I was at that party, so I didn't get home and in bed until midnight.

THERAPIST: Did you watch TV then?

MARK: No, I do think I was more tired from being outside all night, so I just fell asleep when I got back.

THERAPIST: And what about Saturday and last night?

MARK: It was kind of par for the course. I stayed up late both nights.

Given the importance of attending consistently and regularly to the completion of home-

work, here the therapist assesses what interfered with Mark's full completion of the previous assignment.

THERAPIST: I'm glad you bought the book. What got in the way of getting it sooner? Am I recalling correctly that you were going to buy it on the way back from the session last week?

MARK: Yeah, I was, but when I left someone called me from work about needing to meet, so I didn't have as much time as I thought. But I thought I could do it after work, and then in the evening, I thought, "I'll get it on the weekend because I'll have more time." I don't know.

THERAPIST: If you go back to your leaving the session last time, when you got the phone call from work, was there anything else that derailed the plan?

MARK: No, that was really it. I was still pretty optimistic about getting the book. It was just that I didn't have as much time as I thought I would, and I had to get to work.

THERAPIST: OK, that is good to know. So your plan was to get the book on the weekend, and you just bought it today. On the weekend, did you think about getting it, or did it just come up again today?

MARK: I did, but I felt so bad after the party I just couldn't get myself to do it.

THERAPIST: It sounds like you were really down. Let's talk about the party in a bit. I'm curious how it was that you got yourself to get the book today. Are you feeling better, or is it something else?

MARK: I'm not feeling quite as bad, and given that I was already out, it was easier to go get the book. Plus I knew that we were going to meet and you were probably going to ask me about it.

THERAPIST: That is so great to know! So one thing we know is that I have got to keep following up about these things, because it helps you do them.

MARK: (*laughing a little*) True, not that I was enjoying imagining being called to task on it, but it did help, I guess.

THERAPIST: And getting yourself out of the house to buy a book this weekend was a lot harder than getting yourself out this morning, since you were already leaving to go to

work. Being out already made it easier to accomplish your task.

MARK: Right. That sort of thing seems to happen a lot lately.

THERAPIST: So one solution would be to not wait for the weekend when you've got a specific task to do, because that seems to be a harder time for you to accomplish things. The other thing would be for us to set up a system of phone check-ins when you are feeling particularly down, since it seems to help to know that we will be following up on these tasks when we meet. The other issue, though, is to figure out what brought you down so much this weekend, and what to do about that.

MARK: I think that is the biggest thing.

THERAPIST: Shall we talk a bit about the party and the weekend in order to figure out what is going to help most? How does that sound? And we'll make sure to come back to the TV and reading plan.

MARK: OK. I would like not to feel as lousy as I was feeling.

THERAPIST: Why don't we take a look at your Activity Record? (*Reviews the record.*) It looks like your mood ratings were moderate on Thursday and Friday after we met. Then, Friday, at the party and for the rest of the weekend, they were high, 7's, 8's, and 9's, too.

MARK: I'm not sure this is for me, honestly. I think I gave it a fair shot, calling Mary, going to the party. I didn't want to do either, but I did. And I felt worse afterwards.

When clients report that they are increasing activation and their mood is not improving, it is important to assess a number of possible explanations. First, therapists may consider whether the activation assignments were too ambitious and did not incorporate successful grading. In such cases, it is important for therapists to acknowledge responsibility for this and recommend assignment based on smaller components of the task. Second, therapists want to consider whether the functional analysis was accurate. Is it possible that they are activating the client in a domain that is unlikely to yield improvements in mood? Third, therapists want to consider whether ruminative thinking is interfering with activation. In such cases, clients "physically" engage in the activation assign-

ments, whereas "mentally" they remain disengaged from their context and are less likely to have an opportunity to contact whatever reinforcement is available. Fourth, it is possible that although activation may not immediately improve mood, it may still be "on the right track," because clients are taking active steps toward solving problems and addressing important life goals.

In Mark's case, the therapist decided initially to pursue the possibility that rumination was interfering with activation, based on Mark's comments in earlier sessions about frequently ruminating about Diana and their divorce.

THERAPIST: I guess one thing we could explore together is what was on your mind during the party. When you were standing by the pool talking to other people, or even swimming in the water, what was on your mind?

MARK: You know, when I was diving into the water, I do remember that those were the pleasurable moments of the party. The sound of the water splashing, the coolness, the silence under the water, that was all great. That is what I used to love about swimming too. But the other part—I think I was mentally checking out. I was with a lot of people I really like. Mary is great, and her whole family was back visiting from the East Coast. I haven't seen them in years and I really enjoy all of them. They are great people. But, it didn't really matter. I just wasn't there.

THERAPIST: Were you thinking about Diana or yourself in relation to her?

MARK: Yeah, that was mainly it.

THERAPIST: Were the other folks there conversing with you?

MARK: Yes, and I was talking with them. I mean, I could hear the words coming out of my mouth, but I was just not there.

THERAPIST: So you have one rating on this record for the party, a 7. But, if we were to break these different pieces apart—the swimming, when you were fully engaged with the activity, and the talking, when your mind was elsewhere—what would you rate each?

MARK: The swimming . . . it was good. I guess that would be a 3, if 0 is feeling good; I mean it didn't take it all away. But the talking . . . that was terrible, a 9.

The therapist has successfully identified the problem that was interfering with the potential benefits of activation. She continues to assess the nature and scope of the problem.

THERAPIST: I'm trying to figure out if when you are actively engaged in an activity, which kind of requires some attention to it, are those the times that are more enjoyable?

MARK: Yeah, that's true.

THERAPIST: Is this a problem that also interferes with your mood and accomplishment of tasks at work?

MARK: Yes, exactly. I go into my office and it's like where does the time go? Hours go by and I haven't done a damn thing. I'm just wandering over and over things that happened with Diana, what I said, what I could have said. It's awful.

THERAPIST: OK, so we know this is an important problem to address. It's interfering with your enjoyment of times that have the potential to improve your mood, and it's interfering with managing your job well. Can we spend a little more time on what happened at the party?

MARK: OK.

THERAPIST: How would you normally be when talking with Mary's family, if you were not thinking about all these things? What would I see differently in those times than what I might have observed on Friday?

MARK: I'd be talking to everyone. I wouldn't be feeling so bad.

THERAPIST: Yes, that is exactly true. What I'm really curious about is, when you are not feeling so bad, what would you be doing differently? Would you be asking them more questions? Making more eye contact? Responding differently?

MARK: Yeah, all of those things. I'd be more active in the conversation.

THERAPIST: So you would be more engaged.

MARK: Yes, more engaged. Less of that heavy feeling; you know, that "this really sucks" feeling.

In the preceding portion of the session, the therapist has begun to define behaviorally what Mark does in interpersonal interactions when he is not depressed. Carefully specifying these behaviors is an important step in developing

some possible plans for targeted change in how Mark approaches similar situations.

THERAPIST: Do you think that if you could practice talking, when you weren't feeling down, more like you normally would with these people that you might feel better?

MARK: I don't know.

THERAPIST: I think the key is to notice what you do in response to the ruminating and to see whether that is helping or not helping your mood, and then for us to begin to explore what you may need to do differently. It seems that at the party, what you were doing when your mood was better, was to be more engaged.

MARK: It's true. But, when I'm like this, I don't have much to say.

THERAPIST: Yes, when you are depressed, you are more quiet and withdrawn.

MARK: Yes, because it's painful. I see Mary's parents and I think, "They've been married for 30 years. I could have had that with Diana." Then, I start thinking that she is with someone else. It just goes downhill from there.

THERAPIST: You are absolutely right. There is a lot of pain there. And what's happened is that in response to that pain, you have narrowed activity in your life. So you not only feel the pain of being reminded of that loss, but also there is not a lot else going on in your life. And even when you are doing things, you are not as engaged, because you are feeling so much pain. I think we need to get you back to doing the things you did before you had the breakup, and before the two of you got together. We need to get you back to your baseline, and once we do that, we can figure out how to get you feeling even better than that.

MARK: It sounds good.

THERAPIST: I know you are thinking this is like pie in the sky, but we can figure out how to do this. The key is to figure out some concrete and manageable steps to help you engage more when you are doing some of these activities, like going to the party. You are right. It's worlds harder to do when you are not feeling well, but these behaviors are partly why you enjoyed those occasions more in the past. We know that you enjoyed

Mary and her family in the past, and we know that you got a lot of pleasure from swimming when your mind was fully present with the activity. So the trick is not only to call your friends, like you did so wonderfully with Mary, but also to go to the gathering, and to get yourself really to interact instead of just being there at the party. For times when you find yourself withdrawing into your thoughts, we need to develop specific strategies to help you do less of that. Can you think of anything that would help you do that?

MARK: I don't know. I just don't seem to have much to say these days.

THERAPIST: I know it's hard. There are a variety of things you could try, such as asking more questions, and then closely attending to the response. Or you could focus on something more specific, such as voice or facial expression, to keep your mind from wandering. Sometimes it works just to notice that you've drifted and to take a deep breath to refocus on your goal in that moment.

MARK: I suppose I could try it. My mind just seems to keep wandering.

THERAPIST: I know. So your job here would be to practice being more vigilant as to when that happens, because it will happen. The more you notice you're drifting, the more you can practice refocusing yourself back on your friend. Does your mind wander in here?

MARK: I guess a little.

THERAPIST: Why don't we try it in here? Let's pick something to focus on, and then you can practice here.

MARK: OK. What do I do?

THERAPIST: I'm going to time us for the next 5 minutes and, as we talk, I want you to practice fully engaging in our discussion. Your mind is going to wander, particularly if we are talking about something that reminds you of Diana, I would guess. So let's pick something you can focus on to bring your attention back to our conversation. How about the sound of my voice, like changes in tone, how I articulate words, the pace of my speech?

MARK: I can try.

THERAPIST: Great. So, let's talk about some options for social connections that you could make this weekend.

The therapist and Mark continued this discussion for the next few minutes, at which time, the therapist interrupted their conversation to ask Mark for feedback about his experience.

THERAPIST: What did you notice?

MARK: I don't know, maybe you are talking kind of softly.

THERAPIST: How engaged were you with our discussion? Why don't you give me a rating, with 0 being not engaged at all and 10 being totally engaged?

MARK: I guess maybe 7. It wasn't that hard here, because I was really focused. I guess I did start to think about Diana a little when we were talking about my calling Mary. I did remind myself to pay attention to your voice, and I guess you just sounded so interested. It made it harder for me to wander off in my thoughts when you seemed to be paying so much attention to what we were talking about.

THERAPIST: That was my impression, too, that your engagement was generally high, and that you did appear to refocus your attention a couple times. That is terrific!

MARK: Yeah, but it was a little strange. I mean, usually people aren't that focused when they are just talking about usual stuff.

THERAPIST: That is very true. I might have been paying closer attention to what you were doing and saying than other folks are in typical social interactions. And this may feel pretty artificial now in general. My guess, though, is that once you get more engaged in social interactions, it won't be necessary to concentrate so hard. It will just come automatically again.

MARK: That makes sense.

In this way, the therapist generates a strategy to block avoidance (rumination) by substituting a new behavior in the form of attending to direct and immediate experience. Although, in this case, Mark experimented with directing his attention to interpersonal stimuli, clients may also be directed to experiment with attention to other aspects of sensory stimuli, such as sights, smells, and so forth. The in-session behavioral rehearsal is very important in that it allows the client to practice and receive direct feedback from the therapist, both of which increase the

likelihood of success outside of the session. The therapist then returns to the specific task of reviewing and developing behavioral assignments for the next session.

THERAPIST: Let's go back to your not getting out all weekend. Do you think going out to buy the book was too hard? Is there something easier you could've done to help you get a little more engaged this weekend?

MARK: I'm not sure. How hard is it to go out and buy a book?

THERAPIST: Very hard, when you're really down. Let's think about smaller steps. If you can do a smaller step and get a little reinforcement for it, then it becomes easier to move toward your goal.

The therapist and client continue along these lines with graded task assignment. Given that Mark has previously enjoyed socializing, he and the therapist came up with a plan that on the weekend, he would start by returning some phone calls from friends and inviting Mary for lunch. During lunch, he would focus specifically on attending to their conversation. The therapist also raised the possibility of swimming as an exercise activity. Mark reported that he thought his plate was full with the assignments they had already developed, and they decided to table further discussion of swimming. The therapist then uses the final moments of the session to review the homework, to instill hope in Mark, to validate the difficulty of change, and to reinforce the basic treatment model.

Session 5

At the outset of the session, Mark reports improvement in his mood and the therapist includes this as an item on the agenda. Their discussion allows the therapist to emphasize an important point about maintaining new behaviors in consistent and regular routines. In this session, the therapist continues to emphasize the pattern of social connections and to assess factors that increase Mark's vulnerability to exacerbated mood when alone.

THERAPIST: Let's understand in more detail how it is that you are feeling better?

MARK: I think the reading plan is helping. I finished the book.

THERAPIST: Great! So you probably need another book.

MARK: (*laughing*) I guess that's true. You don't think just the one cured the problem?

THERAPIST: (*laughing*) Oh, how I wish that were the case! Seriously, though, Mark, I think that is such an important question. There is a real temptation when you start feeling a little better to back off from some of the very things that are helping. It makes sense, because making these changes requires so much effort, I know. But maintaining the routines are so important.

MARK: It's true. I actually think I've been doing pretty well with that this week. I've been reaching out more to other people.

THERAPIST: This is fantastic.

MARK: And Mary called me again. So, I guess I didn't do what we talked about in terms of calling her, but I did ask her about lunch when she called. I didn't really want to, because I was feeling down when she called. I had just gotten a letter from the lawyer about some new money stuff with Diana. But, I did ask Mary, and I took the girls, too. I think they enjoyed it a lot. I did really focus on asking them all a lot of questions during lunch. I think that helped, too.

THERAPIST: Mark, you have definitely had more social contact in the last few days! You are doing a huge part of this treatment, which is acting in accordance with the goals and plans that we are setting here, as opposed to being directed by how you feel in the moment.

MARK: I tried.

THERAPIST: You did it! You talked about having lunch with your coworker. Did you do that?

MARK: I did do that.

THERAPIST: You did a lot! That's great. OK, I may be pushing our luck here, but what do you think about adding swimming to our agenda?

MARK: I knew you were going to ask about that again.

THERAPIST: (*laughing*) You know me too well. What's your thought about it?

MARK: It's probably a good idea. There is actually a swim lesson that the girls like to do on the weekends, and I could take them

and do laps at the same time in the other pool.

THERAPIST: Fantastic! Do you have them with you this weekend? Could we schedule that for the weekend?

MARK: Yeah, I think that would help.

THERAPIST: Mark, do you think that reconnecting with people and some of these activities, like reading, are connected with your improved mood?

MARK: Yes, that definitely had a lot to do with it. I am still not sure that we are getting to the real problem with all of this, but you are right that it does help.

THERAPIST: So we should talk about that, too. Before we move to that, is there anything else that you think is contributing to your positive mood, or is it mostly having more social contact, which you find reinforcing?

MARK: It's the social contact and trying to distract myself with the reading.

THERAPIST: That is so great! Good reminder, too. Let's talk some about another book and how to keep up that schedule.

At this point, the therapist and Mark focus on developing a specific plan for selecting and purchasing a new book to continue the reading routine. Next, the therapist returns to Mark's comments about whether the interventions are addressing what is most important.

THERAPIST: What you mentioned before about the real problem . . . I'm curious what you meant.

MARK: I guess I'm still thinking about Diana a lot. I think that there is a part of me that has to let go, yet just isn't letting go. I am thinking, just asking myself, "Is there still a chance for us? What did I do to screw it all up so badly?" And then I start thinking, "Is this all I have now—having lunch with people, reading by myself at night?" You know, the kind of stuff we've been focusing on . . . I don't know. Is it really going to fix anything?

THERAPIST: Mark, I know it feels like this stuff isn't really getting at the real problem in terms of your thinking about Diana, and I agree that is really important to talk about. At the same time, I don't want us to lose sight of the fact that this other stuff makes a huge difference. It's important for you to re-

connect with ways to buoy up your mood before you start to tackle some of the past problems and those that still come up with Diana. Also, I think we will find that there are some similar patterns, so maybe the ways you have tended to pull away from other people since you've been down might have some connections with what happened with Diana.

MARK: That's true. I guess they are not totally separate.

THERAPIST: Are you saying that it's time now to start focusing our time more directly on those topics?

MARK: I think so. Maybe I'm more aware of it because I'm feeling a little better. I guess I'm asking more often, "Is this all there is now?" It just seems like a damn lonely life to be leading, if this is it.

The therapist and Mark end the session by reviewing the assignments. In addition, they agree on a plan to return to Mark's important questions in the next session.

Sessions 6–9

In this next series of sessions, the therapist and Mark return to Mark's question from Session 5. In repeated sessions, he reports improvements in mood related to making progress on projects at home, exercising, and becoming more socially connected in casual and friendship circles. These areas of progress are reflected consistently on his Activity Record forms, which now specifically target the areas of social engagement, reading, and swimming (see Figure 8.3). (This version of the Activity Record can be considered when the activation targets are clear and well developed, and the detailed information gained via hour-by-hour monitoring is not as necessary. It can also be used for clients who have difficulty with the more detailed Activity Record.)

Even with clear areas of improved activation and mood, Mark also reports that his mood is vulnerable to his tendency to ruminate frequently about his ex-wife. The therapist and Mark begin to explore the potential function of rumination about his ex-wife. As they did with respect to both TV watching and rumination during social interactions, they develop some initial hypotheses about the consequences of Mark's ruminating about his ex-wife.

Task	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Reading	✓	✓	✓	✓			✓
Reaching out to other people	✓	✓	✓			✓	✓
Swimming						✓	✓
Mood	5	5	5	6	8	3	3

FIGURE 8.3. Sample completed Activity Record (daily).

THERAPIST: Is it possible that ruminating might be a form of avoidance itself? It's like your mind gets stuck in a broken record format. You keep replaying what you did wrong, what you could have done, and one of the effects is that you are actually avoiding the painful emotions about the loss of the relationship, and maybe also avoiding exploring new relationships?

MARK: It feels like I can't stand the loss of it. That's what I can't accept—that it is lost. I keep thinking maybe there is a way to recapture it, even though I know there simply is not. We can't even communicate about the kids' health care without a lawyer.

THERAPIST: So, in a way, ruminating may be a way to avoid dealing with grief and sadness. I wonder if part of this comes from what you learned about how to cope with major loss after your dad left. It seems like no one talked about that and you got pretty caught up in thinking about how you might have been responsible. I wonder if it's hard to know what to do emotionally right now.

MARK: It's certainly true about what happened when I was a kid.

THERAPIST: So one possibility we could experiment with is taking time specifically to experience the sadness and loss.

MARK: I don't know. Thinking about her and what I've lost seems overwhelming. I just want to be done with it and move on.

THERAPIST: I know. Exactly! The problem is that ruminating seems to have the effect of keeping you from moving on. Instead of moving onto other relationships or pursuits

in your life, your mind keeps replaying what happened and didn't happen with Diana.

MARK: I just don't know if I'm ready for other relationships.

THERAPIST: So, if you weren't ruminating as much, do you think you might experience more fear?

MARK: When I think about getting into another relationship. . . . You know, I think that there is actually a person at work who is interested in dating, but that's been part of the reason that I've kind of held back from doing things with her. She's asked me to lunch a couple of times. I just don't want to be back in the same place again 2 years from now. I can't take this whole thing again, and I don't want to subject my kids to it either.

THERAPIST: So, it may be possible that ruminating has the effect of keeping at bay not only feelings of loss about Diana but also fears about future loss.

The therapist also emphasize the importance of continuing with activation plans developed in earlier sessions to maintain adaptive routines and improve mood. In particular, they highlight the need for consistent attention to social contact, exercise, and reading. In addition, the therapist and Mark begin to discuss his return to the writers' group in more detail, beginning to break down that larger task in manageable pieces. Work on these targets forms the majority of the middle of the course of treatment. As Mark begins to address feelings of loss more directly and continues his work on social connections, exercise, and limiting TV watching, he also begins to express interest in dating again.

Sessions 10–15

In this section of treatment, the therapist and Mark begin to address directly the prospect of his developing new intimate relationships in his life, specifically with a woman at work to whom he is attracted. They explore what is necessary to approach rather than avoid Mark's fear of starting a new relationship, and the therapist hypothesizes in particular that Mark's ruminative style may have functioned to avoid learning from patterns in past relationships. The therapist used the TRAP/TRAC acronym as a simple way to help Mark recognize the conditions under which he was likely to avoid (the TRAP), and to then engage in more adaptive coping behavior to get back on "TRAC." For example, Mark reported that he would see the woman at work (trigger) and begin to feel nervous (response) and either not talk with her or restrict his conversation to perfunctory work issues (the avoidance pattern). His alternative coping under the same conditions involved asking her if she would like to have coffee. Sessions then focus heavily on examining in detail what he might learn from his former marriage that would be instructive in future relationships. The following dialogue provides an example of the types of foci that these sessions target.

MARK: One of the things that happened a lot with Diana is I never felt like I was really present with her or the girls. It was like they were in this little world together and I was always on the outside somehow. I often thought that I should put myself more in the center, like say more of what I thought, but I just didn't. I never did.

THERAPIST: Did that cause conflict with her?

MARK: Yes, absolutely. It was one of things that she said when she ended things. Being on the outside is a big thing for me.

THERAPIST: What does being on the outside involve specifically? How would I know if you were doing that?

MARK: It's just not being willing to speak up about things. She always said it was like I wasn't really in or out on anything, just kind of on the fence the whole time.

THERAPIST: Can you think of a specific example when that was an issue?

MARK: Well, my mother and brothers never re-

ally liked Diana very much, but I didn't do much to stand up for her with them. I just kind of let things unfold. . . .

THERAPIST: So, that might have been a TRAP with her? Was it a trigger that you thought she wanted something from you in terms of your commitment?

MARK: Yes, it was, because I ended up feeling really overwhelmed by that.

THERAPIST: And the avoidance pattern was withdrawing.

MARK: I did. I just backed off, and she had to handle the whole scene with my family.

THERAPIST: So with your coworker, if you were to take a stand with her now, what would that look like? What would alternative coping be?

MARK: I have no idea.

THERAPIST: Do you think there is a similar trigger?

MARK: Maybe, because I think she is wondering what's up with me? Like am I interested or not?

THERAPIST: Have you been clear with her about being interested in dating her?

MARK: Not really. We talk often at work, but I can't say that I've really said much about it.

THERAPIST: Would you like to ask her out?

MARK: Yes, I guess I would.

THERAPIST: Why don't we think of some specific things you could say as alternatives to withdrawing and practice with some of them?

In these sessions, the therapist and Mark define, in very specific and concrete terms, the types of behaviors associated with decreased satisfaction and quality in his former marriage. For instance, the therapist's following question to Mark is a central question asked repeatedly over the course of BA: "What does being on the outside involve specifically? What does it look like? How would I know if you were doing that?" The therapist emphasizes identifying clear, specific, and observable behaviors when analyzing behaviors and defining goals. Then, the therapist and Mark work to identify specific strategies that he can use to practice alternative behaviors in pursuing a future relationship. They continue to use the TRAP/TRAC

framework to examine situations that arise and Mark's response, and to guide him toward a more engaged approach to intimate interpersonal relationships. As Mark begins dating, they have ample opportunity to revise and refine strategies through activation assignments that target being direct and present in intimate interactions.

Sessions 16–19

By Session 16, the therapist and Mark agree that the bulk of the work of understanding and problem-solving Mark's depression in terms of his unique life context and avoidant response patterns that maintain his depression has been completed. Mark has been successfully activated both in terms of his secondary problem behaviors (e.g., increased reading, exercise, social contacts, and projects around the house; decreased TV watching). He has also been activated toward solving his primary problem (avoidance of intimacy) via initiating a new relationship.

Thus, the final sessions of treatment focused on reviewing and consolidating primary themes and methods used in therapy. Specifically, the therapist and Mark identified the importance of continuing to practice his new skills of blocking rumination by attending to immediate goals and to his direct and immediate experience, and being more direct and expressive with his new partner. In addition, the therapist carefully reviewed with Mark the ways he had learned to use the fundamentals of behavioral activation himself. Together they reviewed ways that Mark would know when he was starting to feel depressed or to engage in avoidance response patterns. They also reviewed specific steps he could take to begin self-monitoring his mood and activities, and to problem-solve alternative coping behaviors. They also specifically identified a number of alternative behaviors that were uniquely helpful in breaking the vicious cycle of depression, avoidance, and withdrawal. Mark reported that he felt well equipped with these tools and the opportunities he had had to practice them in therapy. He also reported feeling encouraged about the positive changes he had already made in his life. He ended treatment expressing optimism about his future and warmly thanked the therapist for all of their work together. Over time, Mark continued to maintain the gains he made in treatment. He established a

new relationship with a woman, and they became engaged over the course of the following year. He continued to practice many of the skills he had learned in therapy in the context of this new relationship, with his children, and with his coworkers and friends.

Case Summary

The course of treatment with Mark provides an example of many of the core principles and strategies of BA. The treatment followed from careful and ongoing functional analysis of key problems that Mark presented, which in turn allowed the therapist to develop the organizing case conceptualization. This work was completed in collaboration with Mark during sessions and was also a focus of the ongoing clinical consultation team meetings, of which Mark's therapist was a key member. During treatment, the therapist used a range of specific strategies, including goal setting, self-monitoring, graded task assignment, problem solving, behavioral rehearsal, and attention to experience. She also addressed a number of important treatment targets frequently observed in BA, including interpersonal avoidance, rumination, and routine disruption. Overall, the therapist worked as a coach throughout therapy, helping Mark to problem-solve specific steps to overcome patterns of avoidance and to engage in activities. She also taught Mark to understand the pattern of antecedents to depressed mood and how his responses contributed to either maintaining or improving his mood. She skillfully balanced acknowledging the difficulty of change when depressed with emphasizing the importance of action, even when mood is low. She maintained a matter-of-fact, nonjudgmental, problem-solving approach to difficulties that arose during the course of Mark's therapy, and returned regularly and persistently to the selected targets of change.

CONCLUSION

This chapter provides the conceptual basics and the how-to specifics that are required to use BA with depressed clients. Evolving from the seminal foundation established by the work of Ferster, Lewinsohn, and Beck, BA highlights the power of direct and sustained attention to behavior change. BA aims to help clients be-

come active and engaged in their lives in ways that reduce current depression and help to prevent future episodes. BA therapists help depressed clients to increase activities that bring greater reward and to solve important problems. Clients are assisted in approaching important life goals and engaging directly and immediately with problematic aspects of their lives. Both outcome research and other converging lines of empirical inquiry suggest that BA holds promise as an efficacious treatment for depression. Future research will examine in greater detail the process of change in BA and the ease with which BA can be transported to applied community settings.

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