CHAPTER 4
The Principles and Essentials of Behavioral Activation

The most important principle of BA is that the therapist should know the model and be able to discuss it with the client. For this reason, we will refer to the model frequently in this chapter, based on the underlying theories that were discussed in part I. There are four principles for therapists to keep in mind to guide them in conducting BA:

1. Individuals are vulnerable to depression for a variety of reasons.
2. Secondary coping behaviors play a significant role in depression.
3. BA is not simply about increasing pleasant activities.
4. Clients should pay close attention to the context they are in and the impact of behaviors on the context of mood.

Since this is an idiographic, functional approach, it is better for therapists to have principles in mind and a basic philosophical idea rather than just a set of techniques. As will be seen later, the techniques are quite common, but the application of these techniques takes skill and a clear understanding of where therapy is going for a particular client.

*Individuals are Vulnerable to Depression for a Variety of Reasons*

Precursors to a depressive episode are often difficult to determine. The onset of depression for many individuals can be traced to a sudden loss, such as losing a job or the dissolution of a relationship; to the lack of
attainment of a personal goal; or to difficulty coping with the daily hassles of life. There are others, however, who are not able to point to a particular life event that preceded the depression. In our contextual view of depression, the precipitants may have been present for many years and can still be found in the life of the individual even if the individual is not able to designate the particulars. One need not attribute the etiology of depression to a purely biochemical process even for those who cannot specify a life problem. Behavioral activation is based on the principle that individuals are vulnerable to depression for a variety of reasons. However, people who are depressed act in certain ways that maintain their depression. As was mentioned in part 1, many behaviors function as avoidance and keep the person stuck in a vicious cycle of depression. We have called these types of behaviors "secondary problems" because they appear to be manifestations of the individual's attempt to cope with the negative experiences that have led to depression.

Secondary Coping Behaviors Play a Significant Role in Depression

Focusing on the secondary problems can be useful even when an individual is unaware of precipitants or states that depression has been a chronic experience with no obvious beginning. Typical patterns of behavior observed in depressed individuals exacerbate the depression, prevent them from addressing problems in their lives that could ultimately have a positive effect on them, and maintain a passive approach to living that creates a vicious cycle. Depression is diagnosed in the DSM-IV when a constellation of symptoms, such as blue mood, loss of pleasure in many or all activities, hypo- or hypersomnia, changes in appetite, and/or ruminative negative thinking, are present. When BA therapists talk about the secondary problem behaviors seen in depression, we are often talking about the symptoms of depression. For heuristic reasons, in BA a separation is made between the feeling elements of depression (feeling the blues, loss of energy, etc.) and the action elements (e.g., decreased activity, sleeping long hours, anorexia or overeating). This distinction allows an easier approach to treatment and less complicated explanation provided to clients. Figure 3.2 (page 51) provided an example of the BA model in the context of depression. We can expand this figure as shown in figure 4.1, to show the model as it is presented to clients. Note that there is a distinction made between major life events or precursors to depression leading to a decreased or low level of positive reinforcement, the feeling components of depression that we simply label "depression"
Depression in Context

In many cases, depression can be managed through daily habits and lifestyle changes. However, it's important to point out that depression is not an isolated issue but rather a common experience in life. Many people have reported feeling depressed at some point in their lives, and it's often linked to specific events or experiences.

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FIGURE 4.1 A BA model of depression as presented to clients. Negative life events result in low levels of positive reinforcement and narrowing behavioral repertoires. The resulting symptoms trigger secondary maladaptive coping efforts, which maintain the depression. Much of BA is targeted at behavioral processes in the upper left and lower right boxes. The dashed arrow indicates that depressed behavior may exacerbate negative life events.

or “feeling depressed,” and the behavioral components of depression. The patterns of response to the environment are associated with either the development or maintenance of depression.

The model is more complicated than it appears in this figure. Context includes all aspects of the individual's environment, which is not easy to demonstrate in pictorial form since drawings tend to imply arbitrary distinctions between feelings, behaviors, life events, etc. In essence, the model states that given the context of the person's life, he or she has developed a particular pattern of responding to environmental events. These environmental events may be external, as in the loss of a lover. The environmental events may also be private experiences. For example, thinking "I am a bad salesperson" is occasioned by the individual's experience of having been turned down by a customer. This thinking is a cue for acting less aggressively toward the customer that has, in the past, led to retaliation and complaints made to a supervisor. Understanding this theory is a crucial aspect of the treatment. It comes alive in the therapeutic process because it guides the way the therapist interprets the client's behavior, and the way the therapist talks about the client's experiences. When doing BA the fundamental concept to keep in mind is that all behavior serves a particular function, whether those behaviors are observable to the therapist or are private events known only to the client and reported to the therapist.
BA is Not Simply About Increasing Pleasant Activities

Many people engage in positive activity on a regular basis (e.g., they may exercise, go to movies, socialize with friends) and they are still depressed. Others have successful careers and have fulfilled life goals, and yet they report feeling like failures. Cognitive theory suggests that core beliefs or schemas are at work preventing the individual from accurately perceiving his or her world. Behavioral theory would suggest that the function of the positive activity or the successful career is not sufficient to affect the depression. A person who excels at her career but does not confront interpersonal relationship conflicts or fears may be subtly avoiding the very thing that will improve her life and/or mood. According to behavioral theory, “all that glitters is not gold” and pleasant events cannot be assumed to be antidepressive. If daily exercise continues, we can say that there is reinforcement involved in maintaining the behavior. We cannot say that the reinforcement is positive, however, unless we know the function of the behavior. If daily exercise decreases a morbid fear of obesity, then it is likely that it is being maintained via negative reinforcement (i.e., the function of exercise is to avoid anxiety and depression associated with gaining weight).

Behavioral activation treatment of depression is not about simple maneuvers that increase positive activity in a person’s life. It is about trying to discover, through a functional analysis, what contingencies are maintaining the depression, and teaching the client about the functional aspects of behavior. We view the therapist as a consultant who helps the client to become an expert observer of the various relationships between different actions and different consequences in day-to-day life. If the metaphor seems appropriate, we sometimes tell clients that this treatment is designed to help them become scientific experts on their daily lives. The notion is similar to the idea of collaborative empiricism developed by Aaron Beck in the context of cognitive therapy (Beck et al., 1979). What’s different is that we help clients observe how their behavior is or is not working for them, rather than focusing on how their thoughts affect their mood.

That BA is not about increasing positive or pleasant activities cannot be overstressed, as this is the mistake that is most likely to be made by therapists who are new to the approach. Recall from previous chapters that behaviors occur in a certain context, and that the BA therapist needs to be concerned more with the function than with the form of the behavior. From this perspective, it is difficult to name any behavior a

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Acceptance and tolerance of the client to make attention to sadness, low motivation work from the "context"
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“pleasant behavior” out of context. Eating chocolate cake is a very pleasant behavior in certain contexts, primarily when there has been some amount of deprivation from sweets or other foods. However, after the fifth cookie or the second glass of milk, eating a piece of chocolate cake may actually be an aversive experience. The behavior looks the same, and the piece of chocolate cake may look just as moist and chewy under both conditions, but whether the activity is pleasant depends on the context.

Clients Should Pay Close Attention to the Context They Are In and the Impact of Behaviors on the Context of Mood

A BA therapist continually questions the consequences of the client’s behavior, and he or she accepts without judgment behaviors that the client describes as useful or mood enhancing that on the surface may seem rather dull or mundane. For example, one woman stated that she would like to increase the amount of time that she spent reading about stocks and investing. Her therapist would not have engaged in this activity to improve his mood; however, if functioned in this fashion for the client, and the therapist simply accepted that this was a behavior for the client to schedule during her week. Clients frequently ask, “Why do I feel this way?” BA therapists teach clients to observe their own lives so that they begin to answer this question and recognize the context of their moods.

DEPRESSION IN CONTEXT

It is necessary to understand the context and conditions that may have preceded the depressive episode and that are found to exacerbate the depression. Furthermore, from a contextualist perspective, it is important to assist the individual in freeing him- or herself from the tyranny of moods and the struggle against negative affect (Hayes, 1994). As Hayes noted:

Often simply opening up the option of feeling what one feels, thinking what one thinks, and putting one foot in front of the other so as to do what needs to be done is a revelation to clients. Clients come in thinking that they have to win the war with their own psychology. (p. 31)

Acceptance and tolerance are implied in BA as the therapist coaches the client to make attempts at engaging in activities despite feelings of fear, sadness, low motivation, etc. The BA therapist encourages the client to work from the “outside-in,” by changing behavior without waiting for
any internal change. Clients often believe that they would improve if only they could feel motivated or empowered to act. From the perspective of BA, action can be independent of feeling. A client can choose to act despite motivation to do so, and by taking small steps that are scheduled to occur at specific times during the week, the likelihood of acting increases. Unlike other therapies involving acceptance, however, BA considers the experiences of people who are depressed as experiences worth changing, and it is hoped that mood will indeed improve as the client begins to act in ways that will prove to be antidepressant in nature.

**Working with Thinking in BA**

Behavioral activation is not psychotherapy from the neck down, however. In all aspects of the treatment, client thinking is acknowledged and assessed. No one would question that people think, and there is certainly mention occurring at all parts of therapy. In some or many cases the client may change attributions and this may account for therapeutic effectiveness, but it need not necessarily occur in all cases. What can be observed is that assisting a client to approach rather than avoid, or to find better ways of coping, is therapeutically effective. Behavior analysts have begun to look at thinking and verbal behavior to try to explain how listeners understand rules (Hayes & Hayes, 1989), and what makes the listener follow or act upon the rule (Hayes, Zettle, & Rosenfarb, 1989). Detailing these theories is beyond the scope of this book; the main point, however, is that our understanding of what goes on inside the mind is still incomplete. Theorists and therapists from purely biological, cognitive, or behavioral camps see the same mountain from different sides.

The behavioral activation therapist accepts her clients’ thinking, but encourages clients to look at the context of thinking rather than at the content of the thoughts. So, when clients present ruminative thinking about their depression or bad life circumstances, the BA therapist will help them look at the antecedents and consequences of this kind of thinking. The topics are not refuted, or addressed, but the process of ruminating is. It is important that the therapist not give the impression that the client’s thoughts are unimportant, but that there are consequences to his thinking. Ruminating does not lead to constructive activity, so the client would be encouraged to do something different that would actually be constructive. This would also be true for thinking that was not ruminative. If a client said he thought that “everyone at work hates me,” the therapist would ask what he does when he is thinking this way. If the consequence of the thinking is that he avoids his coworkers, the therapist would ask him if his goal is example, “No, I want them to like me.”

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**Essential Elements**

There are several essential elements. The primary question if environmental factors are involved, how is the client responding to maintain negative feelings. The second essential concept is that it be active in a goal or plan rather than another one of our clients expressed a hard time “believing in” her not respect” her. She was as Rather than addressing her in her goals for work. This list is own office, rather than a co with coworkers; I want to make a lot of money.” Obviously, An important aspect of BA is toward goals even when those the distress the client experiences priorities, and in trying approach which competing goals are mine. Also, clients can be encouraged and that some of those goals go unmet.

BA is a therapy that works in fashion and when client said were to state that she “just ask her to concretize that statement as “Are there specific things you
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would ask him if his goal is to avoid them. If he were then to say, for example, "No, I want them to like me," the therapist would say, "Well, how would you act if that was the goal?" The client would then be helped to describe actions that could lead to approaching coworkers, and the specific thought "everyone hates me" would not be directly addressed. The truth of that thought would not be evaluated, but rather the impact of the behavior "thinking that people hate me" would be assessed, and the client would be coached to act differently.

Essential Elements of Behavioral Activation

There are several essential elements to BA. First, client behaviors and the environmental context in which the behaviors occur are the primary focus. The primary question for the therapist to consider should be "What environmental factors are involved in how the client is feeling right now, and how is the client responding to these environmental factors that may be maintaining negative feelings?" (University of Washington, 1999).

The second essential element has been discussed earlier. The client is taught to become active in spite of feeling states—to act according to a goal or plan rather than according to an internal state. For example, one of our clients expressed dissatisfaction at work and said that she had a hard time "believing in" herself and thought that "others at work did not respect" her. She was asking herself if she should take a new job. Rather than addressing her internal state, the therapist asked her to list her goals for work. This list included things like "I'd like to work in my own office, rather than a cubicle; I want to have frequent interaction with coworkers; I want to be able to leave the office at 5:00; I want to make a lot of money." Obviously, some of these goals were incompatible.

An important aspect of BA is that clients can be shown how to work toward goals even when those goals are incompatible and may occasion the distress the client experiences. Clients may need coaching in setting priorities, and in trying approaches to goals that may help them clarify which competing goals are most important to their emotional well-being. Also, clients can be encouraged to accept that they have competing goals and that some of those goals will be met at certain times while others go unmet.

BA is a therapy that works best when it is presented in a concrete fashion and when client problems are operationalized. So, if a client were to state that she "just feels unhappy," the BA therapist would help her to concretize that statement. The therapist may ask questions such as "Are there specific things that you are unhappy with?" "What do you
think your life would look like if you were happy?” “What do you think leads to a happy life for others?”

The third essential element of BA is that therapists need to trace patterns of responding that may be maintaining depression. This is done by carefully reviewing the client’s activities on a daily basis, using some form of activity log maintained by the client. In chapter 3 we explained that the BA therapist looks at broad classes of behaviors or that it is a molar rather than a molecular approach, but that she must also look at specifics. Patterns of responding are often difficult to recognize, so many examples of behavior must be discussed with the client. Since the therapist cannot follow the client around with a videotape recorder, it is important to help clients to be as detailed as they possibly can when discussing their behavior. The details of completing activity charts and looking at client behaviors will be examined in later chapters, but, basically the therapist wants to see what the client is doing, or not doing, during the day. This is achieved by simply having the client record general behaviors on an hourly basis. The next step is to look at the relationship between client activity and mood. Ultimately, the client and therapist will discuss specific situations that occurred, what the client desired to accomplish, what she actually did, the result, and other possibilities for behaving differently in the future if necessary.

Finally, it is essential that clients are taught how to do a functional analysis, by looking at antecedents and consequences to their behavior. This is not always easy to do, and most clients are certainly not used to thinking about their behavior in these terms. For most people behavior is attributed to internal causes. Although the antecedents can be “internal” or private, it is usually more helpful to look for public, observable antecedents in the environment. A person may say that he went to a horror movie because he “felt like having a good scare,” attributing his behavior to a feeling or a desire. Another individual may say that she made a lewd gesture to another driver because he “made” her “angry,” thus attributing her behavior both to an external cause, the other driver, and to an internal one, her anger.

Behavioral activation therapists need not be overly philosophical with clients or argue points of view. In other words, a BA therapist would be unwise to say, “Well, we need to look at other reasons for your going to that horror movie because we know that feelings do not cause behaviors.” Likewise, the woman described above would most likely not respond well to being told that “nobody else can make you angry; that is not really what caused you to flip him off. Who cares if you were angry anyway?” Anger is on the chain but the therapist wants the client to look further back to environment link to behavior, however, b of flipping the bird is nega is better to just accept the terms and help the client t situations and to be awan attributed much of her dis not argue with this concepts things by that term, and I Could you tell me what if you have low self-esteem? A self-esteem is high? I'd be c the therapist and client ha possible function of the be of “low self-esteem,” they c in a way that will create, c

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further back to environmental cues—anger may be the most proximal link to behavior, however, but anger may be aversive and then the behavior of flipping the bird is negatively reinforced by the reduction in anger. It is better to just accept the language of the client and to operationalize terms and help the client to see that behaviors are occasioned by certain situations and to be aware of the consequences. Leslie, for example, attributed much of her distress to “low self-esteem.” The therapist did not argue with this concept other than to say “Well, people mean many things by that term, and I want to really know what you mean by it. Could you tell me what kinds of things are going on when you feel like you have low self-esteem? Are there times when you would say that your self-esteem is high? I'd be curious to know what is going on then.” Once the therapist and client have workable terms with which to discuss the possible function of the behaviors that may maintain the vague feeling of “low self-esteem,” they can begin to strategize how to activate Leslie in a way that will create, change, and improve her situation.

TREATMENT TARGETS

We have discussed theory, organizing principles, and essential elements of BA. We also stated that it is important for the therapist to keep the organizing principles in mind. It is equally important that therapists conduct a good case formulation (Persons, 1989; Turkat, 1985) and develop treatment goals with clients. We have found that there are several targets of treatment that are specific to BA. In this chapter we consider four specific targets: avoidance behavior, the context of client problems (both outside of therapy and within the therapeutic relationship), routine disruptions, and passive coping.

Avoidance Patterns: The Foremost Target for Intervention

BA targets avoidance as a primary problem in depression. This is another difference between standard behavior therapy and BA as it has currently developed. The emphasis on avoidance has occurred in behavior therapy for other disorders, but not for depression. In fact, depression itself may be a form of avoidance. The individual does not have to deal directly with problems in life if social withdrawal, spending more time in bed, pushing people away with chronic negativity, etc., are used as a means of coping with painful feelings. Avoidance is like giving a man who is stranded in a desert, dying of thirst, a bottle of vodka. He may
gratefully and greedily drink the vodka to escape from the aversive thirst, but the immediate solution ultimately keeps him avoiding the long-term solution. If he has an immediate decrease in thirst due to a substance that ultimately dehydrates him further, and he becomes intoxicated and neglects a further search for water, he will ultimately die. Depressed individuals are trying to resolve problems and to get themselves out of aversive situations. The short-term solutions often make the long-term consequences worse and maintain the depression. These avoidance patterns or secondary problems are the primary targets of BA treatment.

It is not always apparent that a client's behavior is avoidance or escape behavior. The client is doing what feels natural. It is only by looking at the consequences of the behavior that we can begin to understand its function.

Steve entered therapy after a series of life events had left him feeling depressed, suicidal, and discouraged. His depression had been intensifying over the past six months as he began to have increasing arguments at home with his girlfriend, to miss more days of work, and to get further behind financially. Steve described a sequence of events on days when he felt particularly despondent: He would awaken in a blue mood. Although he always felt better when he would keep busy at work and accomplish things, on these days he would stay in bed long after the alarm rang. As he would lay awake in bed he would begin to think about his children who lived with his ex-wife. He would then begin to ruminate about the losses in his life. As he began to sink deeper into the depression of the day, he would also have thoughts about his failures as a husband, a father, and now as an employee — after all, here he was staying at home when he was perfectly healthy, letting his employer down. He also would wonder whether his girlfriend was really committed to him. Although he was sullen and distant from her, and usually responded to her with irritation, he thought that she was behaving less affectionately toward him because she "no longer loved him."

The protocol for a cognitive therapist would be to address the faulty thinking in this client. In fact the thinking errors are quite obvious. Steve demonstrates several cognitive distortions, such as maximization, arbitrary inference, and overgeneralizations. A psychodynamic or interpersonal therapist might focus on his repressed anger, or the similar dynamics in various relationships in his life. What is interesting is that the behavior of staying in bed is typically assumed to be a consequence of some more fundamental cause, be it cognitive, dynamic, or even biological. In BA, however, the focus of treatment makes it clear that Steve's problem begins with staying in bed. Steve's responses to dysphoria are what we call secondary avoidance behavior — stay in bed because he feels world or be productive at of contact with possible re Steve is not necessarily it is really not an issue for the function of various activities the function or experience behavior. Steve's painful feeling is the consequence is that the is decreased. Another conse creased likelihood of experienced pleasure or accomplishment does not experience himself views his behavior as imbecile or is a therapist focuses on the con sort of internal cue. Steve is with anxiety or other distress loving, concerned manner. Steve responds in short, in Likewise, his response to h not wish to be with him. It the belief that she does not necessary to change his own client hypothesize that it is girlfriend's distance.

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secondary avoidance behaviors. Although Steve’s stated intention is to stay in bed because he feels so badly and thinks that he cannot face the world or be productive at work, the end result is that it keeps him out of contact with possible reinforcers in his environment.

Steve is not necessarily intentionally avoiding anything. Intentionality is really not an issue for the BA therapist. Instead, we’re interested in the function of various activities—regardless of whether clients are aware of the function or experience themselves as consciously controlling their behavior. Steve’s painful feelings are a trigger for his staying in bed and the consequence is that the intensity of the experience of those feelings is decreased. Another consequence of this behavior is an additional decreased likelihood of experiencing situations that might bring a sense of pleasure or accomplishment to Steve’s life. While recognizing that Steve does not experience himself as choosing to stay in bed, the therapist views his behavior as imbedded in an entire context of avoidance. The therapist focuses on the consequences of Steve’s activity rather than some sort of internal cue. Steve also avoids situations that may be associated with anxiety or other distress. Instead of approaching his girlfriend in a loving, concerned manner, which may result in rejection of his affections, Steve responds in short, irritated sentences or ignores her altogether. Likewise, her response to his behavior confirms his belief that she does not wish to be with him. It is not necessary, however, to change or test the belief that she does not wish to stay in the relationship; it is simply necessary to change his own rejecting behavior. In BA the therapist and client hypothesize that it is Steve’s rejecting actions that lead to his girlfriend’s distance.

CONSIDERING THE CONTEXT

It is by now quite obvious that in BA the context is everything. This includes the context of the therapeutic encounter. The behavior of the client in therapy and the behavior of the therapist is very important. If the therapist is understanding, validating, and interested it is assumed that he or she will provide a relationship that will have some type of impact on the client. If somewhere in the client’s history important people have appeared understanding, validating, and interested and have also been cruel these characteristics in the therapist may potentially be aversive to the client. So, the client may have a pleasant encounter with the therapist, but might actually become less self-disclosing as the conditioned response to the therapist’s behavior is controlled by previous therapeutic encounters. It is important for the therapist to be vigilant to
subtle changes in the client's response to him or her. Frequently checking in with the client to make sure that he or she is comfortable with what is happening in the session is a good way for therapists to stay attuned to behaviors that may be subtly punishing client responses. So, as in all forms of therapy, forming a positive therapeutic relationship with the client is important. Even when working like a coach, the therapist must quickly learn the types of interactions that may either reinforce or inadvertently punish the client's self-disclosure, and commitment to try change strategies.

Many clients like to talk about their problems. Ferster (1973, 1981) referred to some client complaints as magical or superstitious behaviors. In other words, a complaint such as "I'm cold" may have at one time been reinforced by the response of a caregiver to either provide a sweater or turn up the heat. For people who become depressed, the complaint may be occasioned by the individual's deprivation, but without a response from anyone who could minister to the deprivation. Complaining behavior was at one time reinforced, but the individual continues the behavior even when it is no longer reinforced by anyone in the external environment. The complaint, therefore, takes on the nature of being magical, in that the person engages in complaining apart from the presence of someone who could minister to the complaint. The statement "I'm lonely" may serve such a function. In a therapy session the statement "I'm lonely" may be a complaint that is made to escape from discomfort or it may be made in the presence of the therapist as someone who can address the feeling of social deprivation experienced by the client. It is important for therapists to consider the function of client verbalizations. In general, it is better to encourage conversation about productive behaviors rather than to allow the client to engage in repeated complaining about life.

It is important to try to understand the context of a client's behavior outside of the therapy session. Along with helping clients to break avoidance patterns, this is an essential target of BA. It is accomplished by using activity schedules (Beck et al., 1979) to review the complexity of a person's daily life and attempting to make situation-activity-behavior relations. This is how clients are initially taught to think in terms of functional analyses. Activity schedules, or activity charts, are simple forms that break the days of the week into 24-hour blocks of time (see appendix A). Therapists can experiment with various activity charts available that allow clients ample room for detailed writing. Therapists may also choose to develop their own. We have found several computer literate clients to make up charts that they them to include specific in

Uses

While it makes sense to important part of therapy, I should present a good ratio chart, as in the following example:

"I'd like to get a good start difficult for me to do so well. Since I cannot accompany sense of what kinds of thin doing them, I'd like to have life. Your daily experience is that can be used to help build your life. It requires you possible."

When the client understands understanding behavior and the client's experience, resisting track of behaviors on an: Any documentation is ace only a few hours of docum would be encouraged to try two days, etc., until the cli the chart in a detailed fash several different goals in min that therapists will be creativ

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make up charts that they find more pleasing to the eye or that allow them to include specific information.

Uses for an Activity Chart

While it makes sense to BA therapists that charting behaviors is an important part of therapy, it is not always so clear to clients. Therapists should present a good rationale for tracking behaviors on the activity chart, as in the following example:

“I’d like to get a good sense of what your life is like, and it is very difficult for me to do so without following you around on a daily basis. Since I cannot accompany you throughout your life, and can’t get a sense of what kinds of things you do and how you feel when you are doing them, I’d like to have a visual presentation of the details of your life. Your daily experience is a rich source of information. I have a chart that can be used to help both of us to better understand all the intricacies of your life. It requires you to keep information as close to hourly as possible.”

When the client understands that the activity chart is a vital tool to understanding behavior and that it helps the therapist to really understand the client’s experience, resistance to using the chart is usually low. Keeping track of behaviors on an activity chart is a tedious endeavor, however. Any documentation is accepted as useful, even if a client returns with only a few hours of documentation from an entire week. The client would be encouraged to try to write something for an entire day, then two days, etc., until the client became more comfortable with keeping the charts in a detailed fashion. The therapist can use the charts with several different goals in mind. Here we discuss eight uses, but we assume that therapists will be creative and come up with additional uses.

Assessment of general activity level. In the very beginning of therapy it is important to gather an understanding of how active or inactive a client is. An activity chart should be the first and foremost self-monitoring tool that the BA client uses. At this point the chart is used in a very simple manner, and the client is asked to just write what they did during the hour blocks of time. Clients are encouraged to be as detailed as they can be, but they are also warned that they need not obsess over filling in every blank since any information they can give is better than none.

Assessment of activity and mood connections. This stage of the game becomes a little trickier for some clients because they have difficulty identifying how they feel. It is not uncommon for depressed people to say that they feel “blah” or “numb” when asked to describe their mood.
Nevertheless, they should be asked to add to that activity chart not only what they have done during the hours, but also how they felt when they were doing it. It can also be helpful to ask them to rate the intensity of their mood on a scale of 0–10 with 10 being most intense, but this should be done only after they have become familiar with recording activities and feelings.

Range of feelings. The activity chart is an excellent tool for evaluating the range of the client’s feelings during the time between sessions. One of our clients completed an activity chart that was quite extensive. There were a wide variety of activities described and specifics about home and work activities. It was interesting to note that the client defined his mood as either “frustrated,” “anxious,” or “relieved.” The therapist noted this and asked the client if he was aware of this, he replied that he was not. The therapist then began to explore how the client could engage in activities that might actually make him feel “happy,” “calm,” “peaceful,” “content,” and so on.

Mastery and pleasure ratings. This is relatively standard in cognitive therapy. Clients are asked to record whether they had a sense of mastery or pleasure or both when engaged in an activity. They can then rate the intensity of the feeling on a scale of 0–10. Mastery is defined as an activity that provides a sense of having accomplished something, having done a task that may have been difficult or that simply needed to be done. Cleaning out a desk drawer may give a client a sense of mastery, for example. Eating ice cream may give a client a sense of pleasure, but not much accomplishment. For some clients, washing the car could provide both a sense of mastery and pleasure. It is good to help clients distinguish between the impact of certain behaviors on their feelings of having accomplished something, or just enjoyed the activity.

Observing the breadth or restriction of activity. The therapist can take a completed activity chart and begin to get a sense of the breadth of the client’s activity. When there is a narrow repertoire of behavior it is important for the therapist to discuss this with the client. For example, a therapist may, while reviewing an activity chart with a client, recognize that the client has spent many hours in a week playing solitaire. It would be important for the therapist to point this out to the client. The therapist could hand the activity chart to the client and ask if he sees any patterns in behavior. If the client doesn’t recognize the pattern, the therapist might simply ask, “Did you realize that you spent X hours playing solitaire? Do you think that is accurate?” If the client agrees that the total hours reflected in the chart is accurate, the therapist can then ask what impact he believes it had on his mood that week. If the client and therapist agree that this behavior was they would work on guide

In the opposite case, if engaging in many varied activities and analysis, because it is important that the client be not focus on simply “getting but on guiding his activity to improve his mood and help.

Guided activity. This is if have explored the overall plan are connected with positive increase activities that have often get stuck at this point. The therapist must continue from the “outside-in” and scheduling activities should be chosen and then be given homework.

Helping the client make the choice of what activities to do is a good way to help clients make the decision to move beyond this behavior. The therapist can ask the client to think about what activities he actually did during the week, then choose the behaviors that he actually engaged in and then rate them. The therapist can then begin to add positive activities to the client’s repertoire.
agree that this behavior may be contributing to the client's depression, they would work on guided activity (see below).

In the opposite case, the activity chart may reveal that the client is engaging in many varied behaviors. This is important for the functional analysis, because it is important to understand what is maintaining the depression if the client is, in fact, quite active. The therapist would acknowledge that the client seems to be very active and that therapy will not focus on simply "getting him moving" since he is already doing so, but on guiding his activity so that he will be engaging in activities that improve his mood and help him to attain life goals.

**Guided activity.** This is the heart of BA. Once the therapist and client have explored the overall activity level of the client, and what activities are connected with positive or negative feelings, they can begin to try to increase activities that have been associated with positive moods. Clients often get stuck at this point when they "don't feel like doing anything." The therapist must continue to coach and encourage the client to act from the "outside-in" and use the written chart to guide his behavior. Scheduling activities should initially be done in the session, with the client being given homework (see below) to add activities on his own.

**Helping the client monitor avoidance behaviors.** The difficulty that clients (and therapists) have in determining whether or not a behavior is avoidance will be discussed in greater detail below. However, it is useful to note that an excellent use of the activity chart is to help the client to monitor the function of various behaviors. The therapist can ask the client to take the activity chart and look back over the day, and ask himself if, given the specific goal at the time, he thinks what he actually did brought him closer or farther away from the goal. If the latter, then the behavior might have been avoidance. If the client knows he was actively avoiding an aversive event, he should mark that. He can also monitor when his behavior was an activation behavior, facing a situation he would typically avoid. This allows both the therapist and the client to begin to get a better idea of the functional analysis of the client's daily behaviors.

**Evaluating progress toward overall life goals.** Clients can also use their activity charts, once they have completed a week or more of them, to assess whether the activities they are engaging in are consistent with their overall life goals. Are the behaviors they see on the activity chart the kind of behaviors they want to engage in, given their goals in life? The therapist can ask, "As you look over this week's chart, do you get a sense that this is the life you want to be living? Do you feel content with most of the activities that you have engaged in?" If the answer is "yes," then
the therapist and client can focus on specific situations that may cause difficulty for the client. If the answer is “no,” then the therapist and client can focus on planning steps to help the client begin to reach desired goals or to engage in activities that would be more meaningful to the client.

It is hopefully clear that the activity chart should be carefully and thoroughly reviewed with the client every session. Sometimes therapists think that attending to this type of detail is obsessive or boring, but we believe that it is extremely important and that attending to the minute details of an activity chart helps the therapist to see into the complexities of the client’s life. Therefore, rather than being boring or tedious, it is the tool that truly allows the therapist to get to know his or her client.

**ROUTINE DISRUPTION AND DEPRESSION**

Avoidance patterns are important in the development and maintenance of depression. It is also important to look at the disruption in normal routines that may precede a depressive episode. Clients who experience major changes in their lives have had their routines disrupted. Many people actively establish new routines and get back on track after such a change. It is well known that changes in jobs, a move to a new home or new city, marriage or divorce, and the birth of a child are all major stressors in peoples’ lives. Most people cope with the stressors and learn to adjust without becoming depressed. For those individuals who develop passive coping styles, however, and are otherwise vulnerable to depression, such changes in routine can be precursors to a depressive episode. The depression is exacerbated by the secondary problem behaviors that may increase the disruption in routine. The frequently observed depressive behaviors of sleeping until late in the day, skipping meals, and refraining from calling friends throw off the person’s routine. The side effect of these behaviors is that negative moods are worsened.

Routine disruption has been recognized as an important component of bipolar disorders (Ehlers, Frank, & Kupfer, 1988). A German word that refers to contextual synchrony, *zeitgeber*, explains humans’ dependence on social/environmental routines to maintain emotional stability. Light is a primary zeitgeber, as are schedules for meals and sleep-wake cycles; certain individuals in life (parents, spouses, etc.) can become zeitgebers as well (Ehlers et al., 1988; Wirz-Justice, 1995). It is quite possible that there is a connection between the regulation of routine and depression. Ehlers and colleagues (1993) also refer to zeitstörers as time disrupters. Transmeridia loved one are examples of zeitgebers and zeitstör in depression, diurnal var (Wirz-Justice, 1995). In shot deal. Therefore, and helps the client to restal depression or a major life have been in place.

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Depression in Context

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as an important component fer, 1988). A German word ir, explains humans' depen-maintain emotional stability. es for meals and sleep-wake spouses, etc.) can become z-Justice, 1995). It is quite he regulation of routine and o refer to zeitstöre as time disupters. Transmeridian airflight, nightshift work, or the death of a loved one are examples of zeitstöre (Ehlers et al., 1993). The concept of zeitgeber and zeitstöre explains phenomena such as seasonal cycles in depression, diurnal variations in mood, and results of sleep deprivation (Wirz-Justice, 1995). In BA, change in behavior is not considered a one-shot deal. Therefore, another essential feature of BA is that the therapist helps the client to reestablish routines that may have been disrupted by depression or a major life change, or to establish routines that may never have been in place.

PASSIVE COPING

Needless to say, people who have developed a pattern of avoidance, trying to escape from aversive feelings or situations, becoming increasingly inactive and getting out of touch with their usual routines, often appear to be very passive. In fact, we have observed that many depressed people seem to simply react to life rather than act. In BA we coach clients to become proactive. This often begins to happen as they are breaking avoidance patterns, and trying to act according to goals rather than feel-ings. It is important that clients experience actively pursuing a goal so that they can begin to shift the patterns of passively waiting for life to happen to them. We want clients to make life happen as much as they can. Certainly, none of us have complete control over the joys or pains of our own or other's lives. Suffering is ubiquitous to human beings (cf. Hayes et al., 1999), but people who actively cope even during times of loss are more resilient to depression than those who react to suffering by giving up (Holahan et al., 1999).