

BEHAVIORAL ACTIVATION AS AN ALTERNATIVE TREATMENT APPROACH FOR LATINOS WITH DEPRESSION

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Depression is one of the most commonly diagnosed psychological health problems and a major cause of disability in this country. Very little attention, however, has been given to depression among Latinos. To address this issue, the authors provide a review of the literature on psychosocial factors that contribute to depression within the Latino adult population. In addition, the authors argue that Behavioral Activation (BA), as an alternative treatment approach, may be as effective as, if not more effective than, Cognitive Behavioral Therapy because of BA's focus on environmental conditions and behavior change rather than beliefs and underlying attitudes. More importantly, components of BA can be easily adapted to accommodate specific Latino cultural values. Its application is illustrated in a case example.

Keywords: Latinos, depression, psychosocial stressors, behavioral activation

Current census reports indicate that the Latino population in the United States has nearly doubled in size since 1990, reaching an all time high

of 40 million which represents about 14% of the total population (U.S. Census, 2007). Moreover, census projections indicate that Latinos will become the largest ethnic group by 2050, and immigration continues to be the major source of population growth (Camarota, 2005).

As the Latino population continues to grow it is becoming more evident that they face many challenges, such as underemployment or unemployment, inadequate housing, limited financial resources, and limited English language proficiency. It is well recognized that negative attitudes toward and stereotypes of Latinos are widespread, such that unfair and prejudicial treatment in employment, education, housing, and other human services makes it extremely difficult for Latinos to successfully integrate into mainstream society (Berry, 1997, 2001; Smart & Smart, 1995). In addition, migration can be a stressful process for Latinos, especially those who enter the country undocumented. Undocumented immigrants do not have full access to jobs, education, and health benefits, and may be hyper-vigilant about being discovered.

These life circumstances, which may be compounded by previous negative experiences during the migration process to the U.S., are thought to be major sources of psychological distress (e.g., Black, Markides, & Miller, 1998; Cuellar, 2002; Cuellar, Bastida, & Braccio, 2004; Smart & Smart, 1995). Moreover, the process of adaptation, particularly for recent immigrants and their families, can have a significant impact because it is likely that they will experience major changes in gender role expectations, loss of social support, displacement, isolation, and disruption in family functioning (e.g., Hiott, Grzywacz, Arcury, & Quandt, 2006; Santiago-Rivera, 2003; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002; Santisteban & Mitrani, 2003). In essence, these life stressors, combined with low socioeconomic status, make Latinos especially vulnerable to psychological problems, such as depression

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(Munet-Vilaró, Folkman, & Gregorich, 1999). This is particularly troublesome because depression is one of the leading mental health problems and major causes of disability in this country (Dwight-Johnson, Sherbourne, Liao, & Wells, 2000; Schoenbaum, Miranda, Sherbourne, Duan, & Wells, 2004).

With respect to Latinos, most of the depression literature has focused on identifying psychosocial factors that are related to a variety of mental health problems including depression; however, less is known about the actual treatment of depression. Thus, the purpose of this paper is to provide an overview of the literature on psychosocial factors that specifically contribute to depression in the Latino adult population and may be particularly important to treatment. We describe recent research that has used Cognitive Behavioral Therapy (CBT) for the treatment of depression and propose an alternative model called *Behavioral Activation* (BA). We argue that BA may be an effective treatment approach because of its focus on identifying contextual factors that may be linked to depression, and its emphasis on behavior change rather than beliefs and underlying attitudes. We describe ways in which BA can be adapted to accommodate Latino-centered cultural values as part of treatment and apply the framework in a case illustration.

Psychosocial Factors in Latino Depression

Acculturation and Stress

The role of acculturation and its impact on the psychological well-being of Latinos living in the United States has received the most attention in the literature. Gerardo Marín (1992) conceptualizes acculturation as a process of change in attitudes, values, cognitions, and behaviors as a consequence of exposure to a new dominant cultural environment. According to Trimble (2003), acculturation is viewed as a bidirectional interaction between the individual and the new environment, and the process of change occurs over time. Thus, over time, individuals acquire new values, beliefs, and behaviors. In addition, acculturation is a multidimensional and multifaceted phenomenon in that individuals keep elements of their culture of origin and adopt aspects of not only the larger dominant culture, but also other cultures that are part of that society.

The acculturation process for Latinos can be

quite challenging. The demands on adjusting to different customs and social norms, learning a new language, and becoming familiar with new laws and rules can create considerable stress and strain (Organista, Organista, & Kurasaki, 2003). Consequently, these circumstances can lead to acculturative stress. Acculturative stress is considered one of the most important risk factors in the development of psychological problems among Latinos (Kouyoumdjian, Zamboanga, & Hansen, 2003). Acculturative stress may be pervasive and lifelong if not addressed but may peak during the early stages of the adaptation process (Smart & Smart, 1995). Specifically, the newly arrived immigrant first feels a sense of relief after the initial migration experience and hopes for a better future. After this initial optimism, the individual begins to encounter stressful barriers and negative experiences. The individual must deal with these stressors in order to successfully adapt to the new environment. As we discuss below, a treatment approach that targets these psychosocial stressors during this transition may be most beneficial.

Low acculturation and stress. Several studies have found that less acculturated Latinos experience more symptoms and higher rates of depression than more acculturated Latinos (Gonzalez, Haan, & Hinton, 2001; Munet-Vilaró et al., 1999; Ramos, 2005). Less research has examined the mechanisms behind this relationship; however, a plausible explanation is that less acculturated groups may experience more barriers and stress while undergoing the adaptation process. Essentially, when an individual has limited or no English language ability and does not have the appropriate personal (e.g., coping strategies), economic, or social (e.g., immediate and extended family and friends) resources, it is more probable that he or she will have difficulty navigating the new environment (Gonzalez et al., 2001).

High acculturation and stress. Individuals and families undergo change as they acculturate, which can lead to negative consequences. For instance, Chun and Akutsu (2003) describe a number of studies in which greater acculturation has been linked to lower levels of family cohesion and more parent-child conflicts. This may contribute to higher risk for drug use and deviant behaviors in Latino adolescents. Moreover, as married couples acculturate traditional gender roles may be challenged and marital relations may become strained (Negy & Snyder, 1997).

Similarly, Ramos (2005) found a subgroup of more highly acculturated Puerto Rican men (but not women) to be more depressed than less acculturated men. She speculated that these men may have experienced frustration, powerlessness, and disappointment as they acculturated because it did not lead to full integration into mainstream society. In several other studies, higher levels of acculturation have been associated with increased depression as well (e.g., Organista et al., 2003; Vega et al., 1998). In essence, acculturation is a complex, dynamic process that may lead to different stressors and psychological reactions that affect individuals as well as the entire family.

Sociodemographic Factors

It has been important to look beyond acculturation because research findings have been mixed. Thus, a number of sociodemographic factors have been examined that also help to contextualize the etiology of depression in Latinos. For instance, an important risk factor contributing to higher rates of depression is socioeconomic status. Specifically, in a sample of 1,519 Puerto Ricans residing in New York City, Canabal and Quiles (1995) examined the relationships among the demographic variables of age, gender, education, marital status, employment, acculturation, and poverty. They found that socioeconomic variables, such as poverty and unemployment, had significant and stronger relationships to depressive symptoms than did acculturation or other variables. A similar finding was reported by Cuellar & Roberts (1997).

Gender. Depression and depressive symptoms appear to be very high among Latinas (e.g., Cuellar & Roberts, 1997; Oquendo et al., 2001; Rickert, Wiemann, & Berenson, 2000), in comparison to both Latino men (Black et al., 1998) and Caucasian and other ethnic minority women (Bromberger, Harlow, Avis, Kravitz, & Cordal, 2004; Myers et al., 2002). A number of contextual factors have been linked to these higher rates in women, including low education (Cortes, 2003), gender role conflict in U.S. born Mexican Americans (Golding & Burman, 1990), high values placed on traditional roles (Munet-Vilaró et al., 1999), recent immigrant status (Black et al., 1998), and separation from children as a result of leaving them in the home country (Miranda, Siddique, Der-Martirosian, & Belin, 2005). Hiott et al. (2006) found that the stress associated with being separated from family was

related to greater depressive symptoms for Mexican American women, while stress associated with social marginalization was related to greater depressive symptoms for Mexican American men.

Age. Early studies revealed age differences in the prevalence of depression. Specifically, Kaplan and Marks (1990) found that younger Mexican Americans men and women ages 20 to 30 showed more symptoms of depression than older Mexican Americans and concluded that they may be encountering more stressors in their work and personal lives. With respect to older adults, who ranged from 50 to 95 years of age, Aranda, Lee, and Wilson (2001) reported that greater depressive symptoms were significantly related to low income and poor social functioning, defined as the inability to engage in activities with family or friends/neighbors because of poor physical and emotional well-being. These findings suggest that for Latinos spending time with family and friends provides an important source of support to offset some of the barriers that they face and is consonant with a cultural familistic orientation (e.g., Santiago-Rivera, 2003).

Psychotherapy for Depressed Latinos

As stated earlier, studies have shown that depression in the Latino population is characterized by multiple environmental stressors, including low income, acculturation, limited English language proficiency, stressful life experiences, and isolation, among many other issues. There is a tremendous need to develop treatments that are effective for this population. Moreover, with the exception of a few studies on Cognitive Behavioral Therapy (CBT) for Latinos, there is, in general, very little research on the efficacy of treatment approaches. In this section, we briefly review the research on CBT and introduce Behavioral Activation (BA) as an alternative approach. We argue that BA may be just as, or more effective than, cognitive-behavioral therapies based on recent studies demonstrating its utility.

Cognitive-Behavior Therapy

Most research on the treatment of Latino depression has focused on CBT, specifically using an adapted version of CBT developed by Muñoz and colleagues in both English (Muñoz & Miranda, 1986) and Spanish (Muñoz, Aguilar-Gaxiola, & Guzman, 1986). Research suggests that this approach is effective, but there is considerable room

for improvement. One of the largest evaluations of this approach was the Partners in Care study, which enrolled 398 Latino patients (of 1,356 total patients) in a randomized controlled trial of a quality improvement intervention in primary care that included either psychotherapy, using the Muñoz's adapted CBT, or medication (Wells et al., 2000). Results at 6-months for Latinos have been reported in two publications (Miranda, Duan, et al., 2003; Miranda, Schoenbaum, Sherbourne, Duan, & Wells, 2004), neither of which reported results separately for psychotherapy versus medication; thus, we do not know the effectiveness of the actual CBT treatment approach, per se, at this point. Nonetheless, results indicate that Latino patients receiving the quality improvement intervention increased rates of appropriate care, decreased rates of depression, and increased employment rates compared to Latino controls. However, it is important to note that the results are somewhat difficult to interpret because actual baseline depression was reported differently than depression at 6 months. Specifically, it appears that the depression results for Latinos were due more to an actual *increase* in scores for the control group than to a *decrease* in scores for the clients in the intervention group. Essentially, the rate of "Major Depression" at baseline was 41% (not reported separately for control and intervention clients) and the rate of "probable depression" at 6 months was 47% for intervention patients and 64% for control patients. Thus, rates of depression did not decrease for intervention patients and they increased for control patients. In contrast, the baseline rate of depression of 47% for White clients decreased to 37% for intervention patients and 41% for control clients.

An important finding from the Partners in Care study is that only Whites improved their likelihood of obtaining employment (Miranda et al., 2003). Treatment did not affect employment status for minorities, creating a potential risk factor for relapse. Specifically, for Latino patients, 60% were employed at baseline and 61% were employed at six months. Based on these findings, one could argue that important contextual factors have not been adequately addressed in the CBT treatment approach, such as educational and job preparedness differences, as well as external environmental factors (e.g., experiences with racism and discrimination).

Five-year outcomes of the Partners in Care study have also been reported, and these were reported separately for CBT versus medication

(Wells et al., 2004). Results suggest that CBT was successful in reducing disparities in care, in that usual care for Whites was much more successful (36% depressed) than for Latinos (57% depressed), but CBT succeeded in decreasing rates of depression for Latinos (43% depressed after five years) but not for Whites (34%). Thus, CBT was successful but there were still more Latinos treated with CBT who did not respond to treatment and were still depressed (43%) than there were Whites treated with usual care (36%).

Likewise, naturalistic studies of CBT also suggest considerable room for improvement, as well as a significant problem of drop out. Organista, Muñoz, and Gonzalez (1994) found a 58% dropout rate in a naturalistic study of the Muñoz CBT treatment in a low-income sample that was 44% Latino. It is interesting to note that when excluding dropouts, treatment improved depression for those who completed treatment. The mean Beck Depression Inventory (BDI) score at pretreatment of 27.5 dropped significantly to 18 at posttreatment, but this mean posttreatment score was still quite high and indicates that a large number of patients were still depressed after receiving the treatment.

Miranda, Duan, et al. (2003) found evidence that CBT was effective for a sample of mostly low-income, young, Latino women. To address the high drop out rate, educational sessions were provided before treatment started to teach women about depression treatment. In addition, transportation to care visits and childcare funds were provided to women in the intervention conditions. Despite these efforts, drop out from psychotherapy still was a considerable problem. Only 53% of patients received four or more sessions of therapy. However, those who stayed in treatment showed a significant reduction in depression scores. Thus, while research on CBT in treating Latino depression suggests that it is effective, there remains a relatively high drop out rate among Latinos who do seek treatment.

Behavioral Activation

Background. The Muñoz CBT approach described above was an adaptation of Lewinsohn's "Coping with Depression," a group cognitive-behavioral treatment that includes relaxation training, pleasant activities monitoring and scheduling, social skills training, and cognitive restructuring (Lewinsohn, Antonuc-

cio, Breckenridge, & Teri, 1984; Lewinsohn, Muñoz, Youngren, & Zeiss, 1986). The history of “Coping with Depression” is important to consider, as it evolved from pure behavioral approaches that predate Behavioral Activation—the focus of this paper. Specifically, the early behavioral treatment of depression first proposed by Lewinsohn and colleagues (e.g., Lewinsohn & Graf, 1973; Lewinsohn & Libet, 1972) involved *activity scheduling*: Helping clients increase the rates of positive reinforcement in their lives through scheduling self-defined “pleasant events.” Lewinsohn’s treatment was seen as limited by other behaviorists (reviewed in Kanter, Callaghan, Landes, Busch, & Brown, 2004) and not expansive enough to account for cognitive phenomena seen as important to depression by cognitive-behaviorists (e.g., Dobson & Block, 1988). Research on it at the time was mixed (reviewed in Blaney, 1981). As a result, Lewinsohn’s early behavioral model did not endure and cognitive interventions were integrated into it over time.

Two major CBT approaches to depression resulted. First, Lewinsohn himself developed an integrative theory that combined behavioral and cognitive factors (Lewinsohn, Hoberman, Teri, & Hautzinger, 1985) and he modified his treatment into “Coping with Depression,” on which the Muñoz CBT approach was based. Second, Beck advanced his version of CBT (Beck, Rush, Shaw, & Emery, 1979), which—with the exception of relaxation training—included all of the same components as “Coping with Depression.” Specifically, Beck’s CBT recommended beginning treatment with activity scheduling (in general and for more severely depressed patients in particular) followed by cognitive restructuring and core belief modification. In other words, Lewinsohn’s and Beck’s treatments are largely equivalent in terms of treatment components.

Interest in activity scheduling alone was revived with Jacobson and colleague’s component analysis (Gortner, Gollan, Dobson, & Jacobson, 1998; Jacobson et al., 1996), which compared Beck’s CBT approach to activity scheduling alone. Jacobson termed this activity scheduling condition “Behavioral Activation” (BA). For the component analysis, BA therapists were taught to ignore cognition and focus simply on activating clients as per Lewinsohn’s original model. The goal of treatment was simply activating new and more rewarding behaviors, rather than feeling good or thinking differently.

It was assumed that activation alone would lead to reduced depression. To the surprise of many in the CBT community, this study found no evidence that complete CBT produced better outcomes over BA, despite a large sample, multiple outcome measures, excellent adherence and competence by therapists in all conditions, and a clear bias favoring CBT as a theoretical orientation by study therapists. Both treatments performed well and equivalently to typical treatments in depression trials. Also, CBT was no more effective than BA in preventing relapse at a 2-year follow-up (Gortner et al., 1998).

The results of the component analysis sparked a major effort by the Jacobson research group to reformulate and expand Behavioral Activation (Jacobson, Martell, & Dimidjian, 2001), resulting in the current version of BA (Martell, Addis, & Jacobson, 2001). Like earlier versions of BA, current BA maintains that environmental factors rather than internal factors, such as cognitions, are a more efficient explanation for depression and more effective intervention targets. However, unlike earlier BA, current BA adds an idiographic, functional approach that explores both the clients’ needs and goals and the environmental contingencies that support depressive behaviors and moods. This assessment leads to activation strategies and assignments to target inertia and avoidance, improve quality of life, address the environmental factors that caused depression, and increase pleasant events. BA therapists assist clients in breaking down activities into small, achievable tasks so the client is able to feel a sense of accomplishment and more immediate success. Clients are encouraged to activate regardless of their aversive thoughts and mood states they may experience. In other words, there is no direct attempt to control and change thoughts and moods, but rather the focus is on getting the client active.

Current BA was recently evaluated in a large, randomized trial (Dimidjian et al., 2006). In this study, 241 depressed adults were randomly assigned to one of four treatment conditions: BA, CBT, antidepressant medication (Paroxetine), or a medication placebo. Differential acute treatment outcomes were observed for the moderately to severely depressed patients but not for less severely depressed patients. For moderately to severely depressed patients, BA and Paroxetine significantly outperformed CBT on measures of depression. Dimidjian and colleagues speculated that targeting patterns of avoidance behavior and

focusing on *consequences* rather than on negative thought processes, as espoused in CBT, may be reasons why BA did well in this study. Similarly, Coffman, Martell, Dimidjian, Gallop, and Hollon (2007) determined that the severely depressed patients in this study who did poorly in CBT were equally likely to have been randomized to BA and suggested that BA may simply be a more effective treatment for these individuals. Moreover, BA demonstrated additional advantages with respect to bringing a greater percentage of patients to full recovery and retaining a greater percentage of patients in treatment compared to Paroxetine. Thus, BA shows promise as an alternative to CBT.

Behavioral Activation or CBT for Latino Depression?

The superiority of current BA over CBT for moderate-to-severe depression in the Dimidjian et al. (2006) study demonstrates BA's potential for Latinos diagnosed with depression. The research comparing BA to CBT poses another important question: To what degree should treatment for Latino depression focus on behavioral or cognitive variables? First and foremost, the above review suggests that depression in the Latino population is characterized by multiple environmental stressors, including low income, acculturation, limited English language proficiency, stressful life experiences, and isolation among many other issues. Therefore, it is logical to assume that these environmental issues should be the primary targets of treatment, and a behavioral approach that directly activates clients to address these issues may be suggested rather than a cognitive approach.

Early researchers and theorists who have written about and studied Latino depression often recommended a behavioral approach for this very reason. For example, Miranda (1976) emphasized that Latino patients expect immediate symptom relief, guidance and advice, and a problem-centered approach. Similarly, Organista and Muñoz (1996) suggested that "short-term, directive, problem-solving therapies are more consistent with the expectations of low-income groups whose pressing life circumstances frequently demand immediate attention and interfere with long-term treatment" (p. 259). Rosado (1980) argued that "the behavioral component [of a treatment that also included humanistic components] would be congruent with the clients'

present-time orientation, extrospective manner of conceptualizing psychological problems, and their expectations for a concrete tangible approach to treatment" (p. 224). Similar sentiments have been expressed by several others (e.g., Acosta, 1982; Franklin & Kaufman, 1982; Herrera & Sanchez, 1976; Stumphauzer & Davis, 1983). It is interesting to note that even though these sentiments were expressed many years ago, research confirming them is still lacking (Rosenthal, 2000).

Only one study has directly compared behavior therapy to CBT for Latino depression, and this was several decades ago. A small, randomized trial (Comas-Diaz, 1981) provided either behavioral or cognitive group therapy to Puerto Rican women. In this study, behavior therapy was based on Lewinsohn's (1974) model, and CBT was based on Beck and colleague's (1979) model. Comas-Diaz found that both behavioral and CBT patients improved compared to waiting list control patients, but behavior therapy patients continued to improve over 6-month follow-up while CBT patients deteriorated. Comas-Diaz interpreted this result as offering a note of caution when using CBT on Latino patients. Specifically, she noted:

The cognitive therapy focused on the idea that depression is caused by distorted negative cognitions/expectancies, and clients were taught to challenge and modify them. The therapist also emphasized the importance of control over many important outcomes. However, minority individuals might face situations where they have no real power. For instance, . . . in this society, poverty, racism, and other social variables act as an inescapable barrier, not allowing the minority individual's personal responsibility for important life events. Analogously, . . . behavioral approaches are more relevant for minority clients, because these enable them to learn the real relationship of behaviors and rewards in a society that might be racist. (pp. 631)

Although this early study was very small, it nonetheless reinforces the notion that BA may be a useful intervention for Latino depression.

It is noted that CBT in general is short-term, directive, and focused on problem solving. However, the behavioral components of CBT are the most direct, short-term, and focused on problem solving of the CBT components. This is specifically why activation strategies are called for early in CBT treatment with more severely depressed patients. Furthermore, BA may be an easier framework to teach compared to CBT (Hollon, 2000).

Adapting BA for Latinos

We believe that an effective treatment approach for depressed Latinos is one that targets multiple stressors in the context of Latino-specific values and beliefs; provides a pragmatic conceptualization that matches client expectations; makes use of available family, social, and community resources; focuses on contextualizing client problems in terms of environmental factors; and proposes concrete strategies to change specific behaviors correlated with depression. Below we discuss these and several additional considerations in modifying BA for Latinos. A primary implication of BA for Latino clients is that it addresses depressive symptoms immediately through a variety of strategies, which is particularly important for clients who do not remain in long-term treatment (e.g., Sue & Sue, 2003). It focuses directly on the environmental problems and stressors faced by Latinos and how to change these life circumstances. Thus, it is practical, pragmatic, and action-oriented. It places no emphasis on changing thought patterns, although these patterns certainly may change as clients become more activated over the course of therapy.

Culturally sensitive activation targets. Current BA contains standard activity scheduling interventions including monitoring and scheduling daily activities, rating the degree of pleasure and accomplishment experienced during specific daily activities, assigning increasingly difficult tasks related to client goals, rehearsing planned activities and tasks, and coaching clients to address specific avoidance behaviors that are related to depression. BA does not specify what behaviors to activate in advance; instead the client and therapist together develop a set of activation targets. Thus, a context of Latino-specific values and beliefs to guide the conceptualization of activation targets can be easily incorporated into the treatment. In addition, BA can directly target the primary environmental stressors faced by many Latinos, especially those who have limited financial resources. For example, the targets of activation may include scheduling simple pleasant events that are free or low-cost, such as going for walks, gardening, listening to music, going to a weekend street fair (e.g., community fiesta), or attending enjoyable church-related activities.

Activation also may address specific losses that occurred during the immigration process. For example, individuals would be encouraged to build social networks in their new communities,

attend church or church-related activities, find an ethnic grocery store and prepare traditional meals for the family, and reconnect with family and friends who remain in the country of origin (through whatever sources are possible—phone calls, letters, or emails). Goals and values around acculturation and the adaptation process would be explored and clients would be activated to work toward these goals as defined by them. For example, a client may be activated to become more proficient in English language if this is valued by the client. It is important to note that activation would directly target educational, job preparedness, and employment problems; for example, by scheduling and activating a visit to a community-based agency that assists with job placement or English language courses. Thus, BA can incorporate strategies that may be effective in addressing employment problems—an area where CBT specifically has been weak (e.g., Miranda, Cheng et al., 2003; Miranda, Duan, et al., 2003).

Focusing on stress and avoidance. It is important to consider that many of these activation assignments will be stressful, anxiety provoking, or evoke hopelessness in depressed clients. Unlike earlier forms of activity scheduling, current BA specifically targets these problems that may interfere with simple activation attempts, by teaching clients to identify avoidance patterns and develop alternate responses to avoidance. In standard BA, clients specifically are taught to use the acronym TRAP: Assess the situational Trigger (e.g., unemployment), identify one's own aversive private Response to the situation (e.g., anxiety, stress, hopelessness) and finally recognize the Avoidance-Pattern that follows (e.g., give up on job search, stay in bed all day). Activation targets are then generated that directly address the original triggers and function as alternate, active coping rather than avoidance. Although the acronym TRAP may not translate well into Spanish, the distinctions between triggers, responses, and avoidance patterns are still emphasized in BA adapted for Latinos.

For example, consider a client who had to go to the Department of Motor Vehicles (DMV) to get a driver's license (the trigger), was overwhelmed and anxious about this task because of English language difficulties and a general fear of mistreatment by authorities (the response), and had been avoiding the task (the avoidance pattern). The BA therapist would help the client to break

the task down by first calling the DMV to inquire about Spanish speaking employees, discussing the experience of visiting the DMV with her friends who had done so in the past, specifically scheduling the trip to the DMV at a particular time and date, and troubleshooting obstacles to completing the tasks that might arise. In this way, BA may be quite sensitive to the relationship between environmental stress and depression in Latinos and help empower them to overcome such barriers.

Addressing treatment engagement and retention. BA provides useful interventions quickly for clients who do not remain in long-term treatment as therapists are encouraged to develop a list of activation targets and schedule activities in the first session, if possible. Furthermore, BA's straightforward rationale, which focuses on environmental causes of depression and "action steps" (Spanish: "*Pasos de acción*") to address these factors rather than internal (e.g., biological or cognitive) causes and solutions, may be helpful in minimizing the stigma associated with seeking mental health treatment that often contributes to premature termination (Alegria et al., 2004; Bein, Torres, & Kurilla, 2000). Thus, BA emphasizes this nonblaming rationale in the first session. Furthermore, therapists specifically discuss concerns about treatment drop out with their clients in the first session. In fact, dropping out of treatment can usually be conceptualized as an example of an avoidance pattern targeted by the treatment. Thus, in the first session the therapist can emphasize coming to treatment as one of the activation targets and discuss obstacles that might get in the way of coming to the second session and problem solve these obstacles with the client. In this way, BA addresses treatment engagement and depressive symptoms immediately.

Incorporating family, social and community resources into treatment. In standard BA, family involvement is possible and encouraged; but in adapting BA for depressed Latinos, family involvement becomes a central issue that we recommend should be addressed in the first session. Family involvement may be a delicate issue for some clients in that, on the one hand, some family members may discourage seeking outside help for personal problems, but on the other hand, the family can be an extremely powerful agent of change. In the first session, therapists may tell their clients they can decide how much family can be involved, but the therapist would like

family to be involved to help the client take action. Family members are then invited into the session and the family is enlisted to help the client complete activation assignments.

The Application of Behavioral Activation With a Latino Client¹

Background, Presenting Problems and Cultural Context

Juan is a 46 year-old monolingual Spanish speaking Latino male. Juan is originally from Mexico and has been living in the United States for about 10 years. He was a butcher in Mexico and completed 2 years of high school. At present, Juan is a cook at a restaurant and works approximately 30 hours a week. Juan has been married for over 20 years and has five children, three boys ages 17, 12, and 8, and two girls ages 22 and 17. Currently he is not living with his family but with two Latino coworkers. Juan has an older brother who lives nearby and who he sees on a regular basis. He visits his family in Mexico about once a year.

Juan reported multiple interpersonal problems with his family related to the acculturation process. Having been raised in a traditional Mexican culture where male gender role socialization involves providing for and protecting the family and taking a position of authority within the home as a father and husband, Juan believed that his daughters and wife wanted more freedom and privileges since moving to the United States. He reported that he had helped his wife attain documented status in this country, but since then her attitude toward him had changed and he believed she did not respect him anymore. He also believed that she was being unfaithful to him, resulting in increased anger and threats of physical violence. These threats resulted in three days in jail and a restraining order, which required him to move out of the house.

He became increasingly angry and depressed. Juan believed that it was his role to set the rules in the home, but could not do so due to the restraining order. He believed his family—especially his daughters who had very little contact with him after he moved out—was happier without him. He felt strongly that it was his daughters'

¹ The case illustration is based on a real client whose name and demographic background have been modified to ensure anonymity.

responsibility to seek out and talk to him, and their *falta de respeto* ("lack of respect") increased his anger and agitation. He maintained more contact with his sons and spoke to or saw them regularly even though there were occasional arguments with them as well. Juan began to have suicidal thoughts, including a plan to jump into a lake, and was hospitalized for two days. He began treatment one week after his hospitalization.

Several culturally specific values and issues were important in the conceptualization of Juan's case. First, Juan very much valued *familismo* (the importance of family connectedness) and *machismo* (male role to be loyal, responsible and provide for the family) and felt that he deserved *respeto* (respect) from his children. His children did not share these values and were much more acculturated than was he; in general, he felt that his children had been raised too "Americanized" and felt unable to control the situation. These conflicts resulted in considerable stress, anger, hopelessness, and depression.

Course of Treatment

Juan was seen at a mental health clinic located in a comprehensive community-based health center in a Latino community. His therapist was a 28 year-old Latino male who was an advanced doctoral graduate student in Counseling Psychology. The therapist received training in BA and weekly supervision from the second author. All therapy was conducted in Spanish. Juan received a total of 45 sessions of behavioral activation.

At the start of treatment, Juan reported continued thoughts of hurting himself and his wife. Other depressive symptoms included lack of energy, loss of appetite, excessive sleeping, and difficulty concentrating. He reported having very low self-esteem and he wanted to feel better about himself. He reported frequent anger at his wife and daughters. He was overweight and reported a desire to get into better physical shape. In addition, he was having problems engaging in social situations and frequently isolated himself.

Juan's therapist presented the behavioral activation model to him in terms of negative life events (triggers), aversive feelings that result from those events (responses), and avoidance patterns that in turn are a response to the aversive feelings. Negative life events for Juan included situations in which he felt *falta de respeto* from his wife and daughters, including

his wife's potential infidelity and his daughters' alienation from him. Broadly speaking, these negative life events were framed in terms of difficulties with the acculturation process, leading to problems with his wife and children and considerable stress. His aversive feelings included anger, irritability, agitation, and sadness. Juan's avoidance patterns were quite diverse and included isolating himself, ruminating, yelling at his wife, gaining weight, as well as excessive sleeping and watching TV.

In order to activate Juan to address avoidance patterns, activity logs were used to schedule meaningful activities. Activating Juan to proactively address the difficulties with his daughters was tricky because he was unwilling to take the first step with his daughters and it was important to the therapist to respect his desire to maintain cultural traditions including the importance of *machismo* and *respeto*. The therapist educated Juan about differences between how he was raised in Mexico and how his daughters had been raised and influenced by the American culture, helped him to focus on how much he cared for his daughters, and stressed the importance of active communication in relationships rather than avoidance. Over time, Juan began to spend more time with his children by meeting them on Sundays, which is traditionally a day that the entire family gets together for dinner and socializing. This slowly increased to spending time with them several times a week.

Juan responded more immediately and positively to other areas of activation, particularly related to physical exercise and weight loss. He removed his bike from the back of his garage, fixed it, and gradually increased his physical exercise to 4 times a week by riding his bike and jogging. To increase his social activities, he began to attend church services; spend more time with his brother, such as eating out more often with him; and shop and run errands in his neighborhood.

To address problems with anger, Juan worked with the therapist to identify the triggers and appropriate alternative behaviors other than isolation, yelling, or physical threats. For example, one trigger was ruminating about how miserable he was that his daughters did not take the initiative to contact him. This led to a response of getting angry and an avoidance pattern of isolation. Juan was encouraged instead to take deep breaths in the heat of the moment and to exercise,

which had the added benefit of weight loss. Another trigger included ruminating about his strained relationship with his wife. This caused him to become sad and an avoidance pattern of excessive sleeping. He was encouraged to call his brother or another family member to talk about different things instead of ruminating. In addition, he was advised to take walks or to run errands rather than ruminate about his wife.

Outcome of Treatment

Juan did not miss any sessions and was very engaged in therapy, evidenced by continued use of activity logs and endorsement of the behavioral activation framework. At the end of therapy, the client was no longer depressed and was no longer having thoughts of hurting himself or others. Depression was measured by the Patient Health Questionnaire-9 (PHQ-9; Kroenke & Spitzer, 2002), a 9-item self-report questionnaire based on the diagnostic criteria for Major Depressive Disorder that measures depression severity on a scale from 0 to 27. Juan's PHQ-9 score at the start of therapy was above 20, indicating severe depression. After 30 sessions, Juan's score was a 9, indicating mild depression, and during the final two months of therapy and at the final session, his PHQ score was 0, indicating no depression. At termination, Juan had reestablished a relationship with his daughters and sons and planned to spend more time with them. In fact, Juan planned to take a trip to his native country to visit his family with his children. In addition, Juan reported that as a result of therapy his wife and family wanted him to move back home. Juan continues to work at the restaurant and engages in meaningful activities with friends and family.

Therapist's Observations

A Latino-centered approach encourages the involvement of the family in treatment; however, this was not the case for Juan. Although he was motivated to include his family in the process, particularly his daughters, they did not attend any sessions. Furthermore, Juan was not able to involve his wife in the therapy because of a court restraining order. Perhaps Juan's progress might have been accelerated if his family members had attended specific treatment sessions. Nonetheless,

his life dramatically improved during the time he was engaged in psychotherapy.

Conclusions

It is well recognized that there is a great need to adapt psychotherapeutic treatment approaches to better serve the ethnically and culturally diverse population of the United States (Sue & Sue, 2003). It is even more important to develop interventions that are tailored to specific ethnic groups (e.g., Comas- Díaz, 2006). In fact, recent research findings support this view. For instance, in a meta-analysis study Griner and Smith (2006) found that treatment approaches targeted to a specific ethnic group were four times more effective than approaches that were adapted across ethnic/cultural groups. While some progress has been made in treating depression in the Latino population, there is considerable room for improvement and the development of alternative approaches. As such, an adapted version of BA for Latino clients may be a step in this direction.

Although the theoretical rationale of BA for Latino depression appears to be a good fit and the current case study is promising, research in this area is needed. Specifically, randomized trials comparing BA to either treatment as usual or other active treatment conditions, such as CT, are necessary, as well as research to help understand under what conditions it might not work, work less well, or be contraindicated. For example, some depressed clients appear quite active at the start of treatment or are in situations for which there are no apparent solutions; modifications to BA or alternate treatments may be more appropriate in these situations. Furthermore, the importance of nonspecific factors, such as expectancies and the therapeutic alliance, is highlighted by the fact that many clients report improvements in depression before the implementation of any specific techniques, such as those in BA (Busch, Kanter, Landes, & Kohlenberg, 2006; Hopko, Lejuez, Ruggiero, & Eifert, 2003; Ilardi & Craighead, 1994). These factors may be very important to treatment.

A final issue is that acute depression is treated relatively easily, but preventing relapse and recurrence of symptoms after acute treatment is more difficult. This is undoubtedly the case for depression in Latinos, as well. Thus, a true test of BA for this population would assess for relapse prevention one to two years after acute treatment.

In fact, CT has recently shown some strength in relapse prevention in comparison to medication (DeRubeis et al., 2005; Fava, Rafanelli, Grandi, Conti, & Belluardo, 1998; Paykel et al., 1999), notwithstanding the recent BA study (Dimidjian et al., 2006). Thus, BA has considerable work to do if it aims to make a lasting contribution to the field in this area.

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