

# Implementing Behavioral Activation in Geriatric Depression: A Primer

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Behavioral activation (BA) is a psychosocial treatment for depression designed to help patients increase contact with positive and rewarding aspects of daily life. The majority of BA research has focused on general adults and adolescents. While emerging data suggests that behavioral treatment is efficacious for depressed, elderly patients, there is little published guidance on how to adapt behavioral principles to meet the unique needs of an aging patient population. This article is designed as a primer to move from the empirically supported treatment to working as an evidence-based practitioner when treating geriatric patients with depression, providing suggestions for adapting the principles of behavioral activation to a depressed elderly population. We highlight prototypical situations and stressors that can present in older age patients who meet the criteria for late-life depression. We start with general suggestions for case conceptualization in behavioral activation. We then place a specific emphasis on case conceptualization and treatment planning for four prototypical psychosocial stressors: retirement, bereavement, physical pain/medical comorbidities, and caregiver stress. In each section, we emphasize how to anticipate and intervene around difficulties with activity scheduling and activity enjoyment.

**Keywords:** Behavioral activation, geriatric depression, depressed elderly, retirement, bereavement, chronic pain, caregiver stress.

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# Реализация поведенческой активации при гериатрической депрессии: руководство

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Поведенческая активация (ПА) — это вид психосоциальной терапии депрессии, предназначенный для того, чтобы помочь пациентам увеличить контакт с позитивными и полезными аспектами повседневной жизни. Большинство исследований ПА были в целом сосредоточены на взрослых и подростках. Хотя новые данные свидетельствуют о том, что поведенческое лечение эффективно для пожилых пациентов с депрессией, существует мало опубликованных рекомендаций о том, как адаптировать поведенческие принципы для удовлетворения уникальных потребностей пожилых пациентов. Эта статья является руководством для перехода от эмпирически обоснованного лечения к практической работе психолога при работе с пожилыми пациентами с депрессией. В статье также приводятся предложения по адаптации принципов поведенческой активации для работы с пожилыми людьми с депрессией. Мы описываем типичные ситуации и стрессоры, которые могут присутствовать у пациентов старшего возраста, отвечающих критериям депрессии в пожилом возрасте. В начале статьи мы приводим общие рекомендации по концептуализации кейса в поведенческой активации. Затем мы уделяем особое внимание концептуализации кейса и планированию лечения для четырех типичных психосоциальных стрессоров: выход на пенсию, тяжелая утрата, физическая боль, сопутствующие заболевания и стресс опекуна. В каждом разделе мы описываем как предвидеть и устранять трудности с планированием занятий и получением удовольствия от занятий.

**Ключевые слова:** поведенческая активация, гериатрическая депрессия, пожилые люди с депрессией, выход на пенсию, тяжелая утрата, хроническая боль, стресс опекуна.

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The behavioral theory of depression posits that environmental influences and avoidant behaviors can perpetuate and intensify depressed mood [4]. Behavioral activation (BA) seeks to help patients increase contact with positive and rewarding aspects of their daily life. As an empirically supported treatment, BA focuses on identifying contexts that are reinforcing and, as needed, problem solving barriers to either scheduling or enjoying activities [23]. Activity scheduling is a cornerstone of behavioral activation and cognitive behavioral therapy [14].

Though a vast majority of BA research has focused on general adults and, to a lesser extent, adolescents, examining the applicability of existing behavioral treatments in elderly patients struggling with depression has been a growing area of focus. In the past several decades, accumulating research has demonstrated that behavioral activation is efficacious in treating geriatric depression [7; 14]. Substance Abuse and Mental Health Services Administration (SAMSHA) has also concluded that behavioral therapy for depressed elderly patients is an empirically supported treatment [5].

The restriction of daily activities may be a final pathway toward depression in elderly patients [8]. Some of the most common stressors that elderly patients present with can impact daily habits and previously engaged in activities. This can be the result of retirement, changes in physical functioning, becoming a caregiver to a spouse, and/or bereavement. These life events change the landscape of daily life and may contribute to a significant level of stress. Fiske and colleagues [8] present a comprehensive model that weighs different factors that contribute to depression in older adults. Consistent with the behavioral model, a final common pathway includes a decreased engagement in activities. The reduction in activities is thought to increase the risk for self-critical cognitions and avoidance-type behavior. Together, these factors are thought to escalate an individual's susceptibility to depressive symptoms [8]. Moreover, evidence suggests that older depressed patients are more likely to complain of anhedonia than overt sadness [8; 9; 19]. Thus, strategies aimed at improving access to natural sources of joy [18], discovering meaning [11; 12], and promoting motivated behavior to pursue rewards [4] may be a recipe for counteracting behavioral and certain environmental factors of depression.

Understanding how to help a patient re-engage with their environment may be a potent target of intervention, either as a stand-alone intervention or in combination with pharmacotherapy. Accordingly, psychologists, psychiatrists, and other clinical mental health workers who treat elderly depressed patients may benefit from understanding the principles of behavioral activation and how to promote it.

***From empirically supported treatment to evidence-based practice.*** Evidence based practice considers the research evidence in concert with the therapeutic relationship. It also takes into consideration the patients' individual differences, such as their values and preferences. The elderly patient's experience, circumstance, and psychosocial and medical stressors can vary in numerous ways compared to younger patients. Compared to younger adults, older age individuals are more likely to experience certain types of stressors. This can include loss of resources related to job loss, changes in relationships, and changes in physical functioning [10; 15]. The goal of this primer is to encourage the clinician to consider behavioral activation as a principle of change that can be adapted to the needs of a variety of depressed elderly patients. To assist the clinician in feeling more comfortable

with implementing behavioral activation, we provide suggestions about the case formulation and treatment planning strategies that geriatric depressed patients may be more likely to experience. We place emphasis on patients who: are having difficulty adjusting to retirement; have had changes to their interpersonal functioning due to bereavement or becoming a caregiver; and/or who struggle with chronic pain or other chronic health conditions. These four categories were chosen as highly representative of the lived experience of the young-old and the oldest-old [10].

**Assessment.** Adapting the principles of BA is appropriate for patients who are experiencing an initial episode of late-life depression or who have long histories of recurrent or chronic depression.

In addition to symptom-based information collected from the semi-structured interview and self-report scales, a method of collecting a plethora of relevant information from your patient is to ask them to walk you through a typical day. You might ask them to share the mundane details of when they wake up, whether they eat breakfast, who they see, and whether they leave the house. As they walk you through their weekday and weekend activities, take note of the following (see Table for a summary).

Table

**Quick reference, assessing your patient’s current functioning and preferences**

Structured time	Is there any predictability to their days? Is there an established social rhythm?
Social support	Do they see others in a typical day? Are they avoiding time or self-disclosure in existing relationships? Do new relationships need to be formed?
Level of independence	Will your patient be able to schedule BA activities outside of their residence independently? What type of assistance will be needed, and what level of physicality is appropriate and safe?
Comfort with technology	How will you teach your patients to self-monitor the relationship between their mood and activities? Do they have access to/are they comfortable with a Smartphone, or will it easier to use a traditional calendar or therapy journal?
Comfort with social distancing (pandemic specific)	How comfortable does your patient feel going to public places, and how can you increase their time spent away from their residence or with other people in a way that feels safe?

**Structured time.** Is there any predictability to their days? Do they use a calendar or plan activities in advance? Take note if there are any type of predictable social rhythms, such as when waking from sleep, eating meals, exercising, socializing, and leaving the house. Is it highly regimented or, on the opposite end of the spectrum, highly unstructured? Keep in mind that the retiree and widow(er) will likely present with a lack of structure and

may need help building more structure; the chronic pain patient will likely need flexibility regarding when to adapt the structure and plans; and the caregiver will need to work within the confines of a highly structured and busy schedule.

**Social support.** Are they socially isolated? Do they feel lonely? Who are their sources of social support? Have close friends and family passed away? Do they keep their level of distress private? All four prototypical patients may need to focus on building social activities. This might involve opening up to existing relationships (e.g., the widower who does not tell his children how much he is hurting) or creating new relationships (e.g., the retiree who lost social connectedness when the job ended).

**Level of independence.** Can your patient independently complete activities of daily living? Can they drive? Do they live independently or in a care facility? Understanding functionality will help you keep in mind how to realistically brainstorm and choose activities to schedule, such as inside and/or outside of their residence.

**Comfort with technology.** Activity scheduling is the heart of BA. You will want to be flexible about how to adapt planning and tracking of activities based on what is most obtainable for them. Will you use pen and paper schedules, a daily to-do list, or an online calendar? Do they own, and are they comfortable with a smartphone? Work with what feels most comfortable for them, and do not be afraid to restructure the schedule with a new format in subsequent weeks. Collaboration is key. Additionally, would they use applications that might facilitate activation goals, such as ride-sharing company like Lyft, or access relaxation exercises using the Insight Timer app?

**Comfort with social distancing during and after the pandemic.** Even with a vaccine, your older age patient may continue to express hesitation to go to populated places such as gyms or museums. Validating the patient's concern and setting goals that respect their comfort level will be important. For example, you might help your patient to find a personal trainer via Zoom rather than at a rehabilitation center. Addressing cognitive distortions, such as catastrophizing, may result in improved social interactions with close ones who have already been vaccinated. Patients might slowly grow more comfortable with repeated exposures outside the home, and you can help them with the pacing. Over time the patient may begin to feel more comfortable with gradually increasing the social gathering number.

Assessing these broad domains of structured time, social support, level of independence, comfort with technology, and COVID-19 precautions will inform your conceptualization. This conceptualization ties into the overarching principle of change: *the identification of the barriers that inhibit your patient from coming into contact with positive and rewarding aspects of their daily lives*. Feedback and suggestions for personalizing treatment are reviewed in the sections that follow for each of the four prototypical presentations. More specifically, we will first review critical points tied to case formulation. Following, we address common barriers that interfere with activity scheduling and activity enjoyment, with strategies to address those barriers. To appreciate sensitivity to individuals who are gender-neutral, we will alternate between pronoun identifiers throughout the article.

## Retirement

**Case formulation.** Your patient may have fallen into a typical pattern where the lack of structure was enjoyed initially but eventually became a cause of depression. In that case, it is important to validate how haphazard days make sense but are also problematic. For example: “When you first retired, you may have reveled in the lack of structured time. Most people go through a honeymoon period after retirement. The ability to leisurely choose what to do and to have laid back days was probably quite enjoyable at first. But you may have noticed that, while you’ve continued with this lack of structure, your mood has simultaneously started to plummet, which brought you to see me. Now, if I’m hearing you right, time passes by during the day, and you find yourself aimlessly shifting from one activity to another. You don’t have routine opportunities to experience feelings of being excited or really engaged in things; and perhaps most importantly, you don’t have many moments of feeling productive or meaningful. Do you know what I mean? You may have also noticed that the longer you’ve fallen into this lack of routine, the more your mood has dropped, and the harder it has become to be more active and get out of that rut. Does that fit with what you’ve experienced?”

As you explain the purpose of the intervention, you will want to simultaneously promote predictable social rhythms as well as the identification of new activities to fill up free time. You may also want to anticipate that thinking of what to do may feel overwhelming for the patient or that they simply draw a blank when thinking about what they would like to do. For example: “The heart of what I want to help you do is, counterintuitively, bring back structure to your days. It’s probably counterintuitive because part of you likes that you don’t “have” to show up to things now that you are no longer wedded to a workday. What I want to hone in on is that your days right now are set up to keep perpetuating low energy and lack of engagement. This, of course, just worsens your other symptoms, such as feeling like you’re useless, feeling hopeless about your remaining years, feeling disengaged from those around you, and so on. I want to spend session time helping you build back a predictable daily rhythm and give you activities to look forward to each day so you will have an easier time getting out of bed. Even if you have to coach yourself to show up at first, it usually ends up being better than expected, and it opens up new opportunities for connection and excitement. And then it becomes easier and easier to keep showing up. If you’re thinking that you have no idea what to do or what you might have an interest in — that’s completely ok. In fact, that’s part of our work together. How does that sound to you?”

**Issue that may interfere with activity scheduling: “What do I do?”** The prototypical depressed retiree may agree with the conceptualization and agree with building in more structure but is unclear about what to do.

A patient may have tried one or two things that they tell you did not go well, or they may tell you that their spouse and kids told them they just need to do X or Y. In response to this, they have a long list of “yes, but...” Critically, it is important not to fall into the role of telling your patient what to do or to generate the list for them, which can perpetuate reactance. Instead, you can gently guide the patient into the realm of increased curiosity and use elements of their life that they signify as valuable in a brainstorming roadmap. To

that end, one main strategy to counteract this issue is to begin with values exploration using a Values Inventory and use *values* as the roadmap of your therapy.

Begin by explaining what values are and how values are different than goals. For example: “Values are your overarching principles for how you want to be as a person, whereas goals are the items you check off a to-do list. For example, up until retirement, a top value may have been to be a trustworthy and hardworking employee. The actions you did to live consistent with that value were to show up to work on time, to communicate with your co-workers, and so on.”

A critical point is that the top values you focus on naturally shift and change throughout the lifespan. “For the past four decades, your top priorities were work and raising a family. And now your kids are older, and you are retired. That’s a really big shift, which may have brought with it a sense of loss. There is also opportunity inherent in this change. In addition to having a space to discuss the sense of loss you feel, I want us to spend time figuring out what you want your life to be about in the remaining years of your life. We can honor the loss while also seeing the change as an opportunity.” The language of values thus provides a context to address this role change. After encouraging the patient to work on a values inventory at home, the next session can be spent reviewing the areas that used to be focal, what was meaningful about that to them (i.e., honoring the accomplishment and sense of loss), and what areas have long been neglected. Additionally, it will be useful to identify the areas they imagine themselves focusing on that might be part of the well-being recipe. For example, physical health, emotional health, relationships with grandchildren, spirituality, community, or lifelong learning may be areas that would benefit from more investment.

A second critical point is not to make assumptions about what would be good for the patient. Patients will often be told by family and friends that they should engage in “volunteer work” and often have very different agendas for their own retirement. You may likewise be tempted to say — “why don’t you do volunteer work?” or your patient may vocalize what he thinks he “should” be doing with his time. Research shows that there is a relationship between *personal engagement* in volunteering and well-being [16]. Therefore, if your patient is only showing up because it is a “should,” data suggests the benefit will be undermined. “I also want to be clear I don’t want to focus on the “shoulds.” This inventory is a chance to look at yourself and say, ‘What are the areas that actually matter to me? What would give me a reason to get out of bed in the morning? What will be my guiding principles for how to spend my time?’”

In sum, a values inventory is an exercise that can produce rich conversation. Generate what matters to your patient and what areas have long been neglected. For the areas that matter, determine how much time they are actually spending engaged in values that they consider priorities. Try to pick up to three top areas for goal setting, which serves as your guide for helping them pick concrete activities to schedule into their daily life, which will increase structure and accountability.

***Issue that may interfere with enjoying the activity: Relying on previous expectations of accomplishment.*** The prototypical depressed retiree may set goals that seem realistic at first glance. But when you review progress in subsequent sessions, she

may be maintaining a dysphoric mood when you hear that she is engaging in self-critical thinking for not getting as much done as she wanted. It may be noticed that he is focusing on all that he still has to do rather than what he did do; or she may be fixating on her low levels of energy that interfere with what she planned to accomplish.

A theme related to these topics that can be discussed with the patient are the expectations he has for himself. What are normative changes related to aging that he may need to accommodate? You may help him realize that his speed is different than it used to be, he may be less able to multi-task, or he may need to give himself permission to challenge his work ethic and prioritize activities that provide enjoyment. If there is a particular time of day the patient gets more fatigued, you may want to help him incorporate that into his overall scheduling strategy. For example, if there is typically a 2:00 PM dip in energy, this may not be the best time for him to complete his taxes. However, it may be a good time to take a neighborhood stroll or listen to a meditation exercise. Plan around diurnal variation in mood; for example, if mornings are the hardest, try to schedule in an activity where there is social accountability for late mornings so that he gets out of bed and dressed at an appropriate time. Finally, keep in mind how your patient is defining his metric of success. If he compares himself to what he used to be capable of, or if he is focusing on all that he still wants or needs to do, then he will be caught in a negative vicious cycle. Help him frame success based on *what choice* he made and his level of engagement in whatever task he set out to do. Making progress on a values-consistent area will be more sustainable and reinforcing.

In summary, the retired patient may be caught in a habit of haphazard days that fuel depression. She may resist the idea of structure at first because she spent decades looking forward to a lack of structure. Stabilizing her social rhythms will help to counteract biological components of depression. Helping her have accountability to show up to things that matter will help counteract psychological components of depression. It will also increase her self-confidence, motivation, and pleasure while decreasing rumination. Encourage her to be in the driver's seat, metaphorically speaking, of what to do. Acknowledging loss that is part of this new life stage is important. Defining success in terms of the active choice *to do* — rather than how much was done — can be an element that leads to improved mood.

### **Bereavement of the Spouse/Long-Term Romantic Partner**

**Case formulation.** Bereavement, including persistent complex bereavement disorder (PCBD), may occur when individuals suffer from prolonged grief that continues to cause dysfunction and distress in their own lives [3]. If your patient does not meet the criteria for a complicated bereavement, there may still be subtle patterns of avoidance that undermine their confidence, which contributes to the ongoing dysphoric and anxious mood.

One productive exercise in treatment, prior to activity scheduling, may be to review the 15-item Grief-Related Questionnaire (GRAQ) [20]. Reviewing the items can be a practical and interactive way to ask your patient if she avoids some of the most common stimuli, such as talking about the loved one, specific activities inside or outside the home, and/or looking at photographs. Sharing the list with her and asking which items are relevant may identify behaviors that contribute to her sense of distress. This conversation



can then be used as a guide for activity scheduling. Indeed, in addition to helping the patient identify activities that would bring her a sense of joy, peace, accomplishment, or other positive emotions, you may consider working with her to identify grief-related activities that have been avoided [1]. The avoidance behavior may be directly linked to a sense of fear that she would not be able to cope with the distress arising from the activity.

***Issue that may interfere with activity scheduling: Avoiding because it feels too painful.*** After having your patient generate a list of what they avoid, have them use their past experiences as a guide. *Have there been small steps you have already taken that you feel good about or that went better than expected?* There are usually several “firsts” that they have already done that were a successful experience, such as: the first time back at their place of worship, the first birthday of the loved one, or the first closet they cleaned out. With a calm and open-ended style, ask them what was helpful when engaging in that challenging activity. Also, try to see if you can elicit some grief-related activities that have become easier to face over time.

Consider a rating scale as you apply that rationale to the new activities they generated. Even if you do not use numerical ratings (e.g., 0–10 or 0–100), it could be helpful to conceptualize and appreciate the fact that some activities will feel more daunting than others. Consider having the patient generate what they want to try first and the pace at which they would like to attempt it. Ideally, the patient should be setting the goal. The therapist should be able to provide genuine confidence that they will be able to cope with their feelings when confronted with it.

You may learn that your patient avoids sitting still or being home alone. In this situation, the patient will benefit from the therapist’s assistance with scheduling time to sit still. Ask her if she is afraid of the quiet and if she has lost the willingness to sit with herself. You may want to have her do an imaginal rehearsal in session in which she talks through and imagines herself in her house alone, where urges to distract are noticed. She can learn to coach herself through this therapeutic target and hopefully gain an increased sense of peace.

Take note of the extent to which the patient has or draws upon sources of social support. For example, your patient may not want to discuss how much she misses her husband to her children because she is afraid it will upset them too much. A consequence of keeping her grief private is that it contributes to further withdrawal and a sense of alienation, which further exacerbates symptoms of depression. It can be helpful to think of reminiscing as an activity scheduling goal. Sharing fond memories of a loved one with others who also loved the person may be an appropriate therapeutic target. You may even give them permission to externalize the rationale, e.g., *Blame it on me — tell your kids Dr. X thought it would be good for you to talk about your dad.* The patient might be encouraged to take out old photo albums and tell stories or to ask her friends or family members to tell her some of their favorite stories with the deceased. Multiple forms of communication are encouraged, including in person, by phone, and, if relevant, by e-mail or chat.

***Issue that may interfere with enjoying the activity: too busy worrying.*** There are generally new responsibilities that fall on the surviving spouse. If his partner was the one to generally manage the finances, then paying monthly bills may become a source of stress.

If his partner was the one to generally manage the home, then cooking, doing laundry, or grocery shopping may be a source of stress. Learning to take on new roles in the grieving process may become overwhelming due to a general sense of loss of control as well as potential skills deficits.

Worries can undermine BA. For example, imagine that your patient is driving on a sunny day to go shopping, but all he can think of is whether he forgot to pay the credit card bill. Accordingly, strategies to identify sources of worry can be beneficial.

For example, “worry time” may be incorporated into your patient’s schedule. Have your patient dedicate 20 minutes per day to writing about her feelings, particularly her stressors and concerns. When she brings the worry time journal to session, you can teach her to identify action items, which are topics she can do something about to decrease the likelihood of the feared outcome from happening. Action items become new items to schedule, consistent with the BA model. As weeks progress, worry time can transition into more broadly conceptualized journal time. In addition to the action items, this time allocation can be used to acknowledge a vulnerability of what feels distressing and uncertain, which is often tied to a sense of losing control.

The bereaved spouse may engage in subtle forms of cognitive, behavioral, or emotional avoidance that, if left undetected, can undermine the benefit of increasing pleasurable and values-driven activities. For example, despite getting out to the gym or going to a movie with a friend, they may be returning home every night to their husband’s office that looks like it did the day he passed; or they may be sleeping in a separate bedroom, afraid to return to the marital bed. These are avoidance behaviors that are not likely to come up in session unless directly probed for by the therapist. Opening a compassionate discussion about ways in which they may be avoiding certain reminders of the loved one can help to identify new “firsts,” which may occur while working on other activities that promote mastery. Providing additional strategies to manage worry, such as mindfulness, can help the patient feel more comfortable in the present moment when stressful *or* pleasurable experiences arise [2]. This may eventually allow for an improved sense of control.

### **Dealing with Medical Comorbidities**

**Case formulation.** Your patient may feel helpless in regard to his physical health condition. “It sounds like you are afraid of when [the condition] will flare up, or you know if you work too hard it will flare up, so you’ve found it’s easiest to stay in that recliner. You may be embarrassed of symptoms acting up or embarrassed of the new support you need. So it’s easier to stay home than explain yourself. You may think it is also easier to just suffer instead of having people feel sorry for you. But as you know, when you are home, you lose the opportunity to have fun and to feel engaged. Over time, your illness has started to define you. The more time you are home in that chair, the more you fuel false beliefs about how useless you are and how unlikely things are to change. Does that sound like it fits what you’ve been going through?”

This patient may have a black and white mentality of “do nothing” or “do everything,” which has led him to learn that inactivity decreases physical discomfort even if the cost has

been increased depression. In behavioral terms, inactivity is negatively reinforced because it removes physical pain in the short-term. Consistent with a CBT framework for chronic pain [6], the heart of BA with this patient will be to *flexibly* choose how to implement their goal activities.

***Issue that may interfere with activity scheduling: Rigidity in scheduling.*** The major task of helping a patient with his BA goals is to encourage him to listen to his body and find a middle path between complete inactivity (e.g., sitting on the recliner and watching TV) and completing the initial goal 100%.

You could try starting with a values inventory, as discussed above. Try to identify valued areas that range in level of physical activity. For example, taking care of physical health can mean going to a swimming class (highly physical), but it can also mean doing a relaxation exercise (less physical). Likewise, intellectual curiosity might be stimulated by attending a lifelong learning class (more active if in person, less active if via Zoom). It can also be met by listening to a book on tape or a podcast (less activity and interaction required). Having a wide understanding of how a value might become enacted will assist with flexibility in scheduling.

One straightforward strategy that fits well with BA is to help your patient develop decision trees. For example:

*If I wake up without pain (e.g., 4 or less on my 0–10 rating), plan A is to go to swimming class.*

*If I wake up in pain (e.g., higher than 5), plan B is to still focus on physical health, but I'll do a progressive muscle relaxation exercise instead. Or I can focus on my other valued area of relationships and call two of my friends and ask them how they are feeling.*

*As the day goes on, I will listen to my body and try to take a walk around the block (aim for 1 PM). I'll start with 5 minutes and either come back or walk a little further, depending on how I feel.*

Finally, it is generally helpful to teach and have your patient schedule in a range of relaxation techniques, including progressive muscle relaxation and deep breathing [22]. Not only can these strategies provide physical relief, but they can also help patients experience more control over their illness. Notably, engaging in active behaviors to improve physical health, such as self-compassion, is associated with reduced secretion of cortisol [13].

***Issue that may interfere with activity enjoyment: Viewing lack of follow through as a failure.*** Consistent with the idea of being flexible in what to do, a priority should be to encourage your patient with being flexible in how he evaluates that choice. Model to your patient in how to celebrate the process more than the outcome. For example, evaluate if and how he worked through a decision tree and if he made a decision that took care of his body and his mind. “Your status quo has been at 0% sitting in the recliner, arguably doing nothing. But to be a success, we don't need you to do 100% goal completion either. The reality is that, depending on the day, you are going to be at different places on that spectrum. From my vantage point, success means you worked through a decision tree,

made an intentional choice, and chose to spend your time doing something that was actively consistent with your values. Even if it wasn't highly physical in nature that is ok. Success is in the active choice, regardless of which activity on the spectrum it ends up being." He can get a positive affect boost from the lower energy activity by seeing that he is making choices on how to best take care of his body.

The patient facing chronic pain or illness may have learned that being too active makes the condition flair up, which, over time, has resulted in a passivity to the illness and a limited repertoire of behaviors. Like the retiree, you can help the patient identify core values she wants to live by. Action can be taken consistent with those values each day. Consider promoting inner awareness, where she listens to his body and then makes an active choice to do *something* while respecting her physical limitations. Defining success as being connected to the intentional choice, rather than what or how much was done, can be a contributing factor to an improved mood.

### Caregiver Burnout

**Case formulation.** For your patient whose primary role has become that of a caregiver, including, for example, for a spouse or a grown child, her time is likely pre-determined and highly structured. Days may be organized around giving medications, assisting with ADLs, and traveling to doctor's appointments. Therefore, you may quickly rupture a therapeutic alliance if you merely suggest that she needs to schedule in activities that bring her mastery and pleasure without nuance to the constraints she is working under, both psychological and practical.

"On the one hand, you love this person very much, and doing what you can to be there for them is clearly consistent with your values and brings meaning to your life. If I'm hearing you right, you wouldn't have it any other way. At the same time, you're human. It's natural to feel depleted. Your days may be all about completing tasks and none about pleasure — which was probably ok for a while but seems to be starting to take its toll. It sounds like that's what brought you through these doors to this visit. I wonder if you and I could work together to help figure out how best to take care of you — respecting completely that your number one job right now is supporting your loved one. How does that sound?"

**Issue that may interfere with activity scheduling: Cannot find the time.** You might take a self-care approach with your patient. Self-care can be conceptualized as taking care of your body and mind in small moments throughout the day. Main areas include but are not limited to sleeping, eating, exercising, and replacing drugs and alcohol with relaxation. You might check in with your patient to see which of these areas she is doing well in, which feel out of balance, and which she feels are critical to helping her feel more emotionally balanced. Your patient may have gotten into a habit of drinking more than is typical to help her relax at night; she may have given up on exercising; or she may have gotten into the habit of picking up fast food on the way home from appointments.

These are areas that you can jointly conceptualize as the non-negotiables. In other words, there could be a short list of activities you encourage your patient to turn into daily habits that, consequently, are less likely to be procrastinated. Second, you can encourage

creativity in how those non-negotiables are scheduled in, keeping in mind that the total length of time may be much less important than making an intentional choice to nourish oneself for any length of time. For example, a daily practice of relaxation might be dedicating her first 10 minutes of the morning to a deep breathing exercise or mindful stretching, rather than ruminating about how tired she feels. The daily shower might become an opportunity to purchase some special bath products or for singing her heart out to the radio. The idea is to help your patient create nourishing rituals that tap into her own resilience. Secondary benefits include replacing mindless time, which typically fuels rumination or worry, with present-focused time that promotes positive emotions. It will also allow the patient to engage in strategies that are inherently anti-depressant, such as exercise or relaxation.

***Issue that may interfere with enjoying: Feeling guilty that you need “you” time in the first place.*** Your patient likely expresses ambivalence in the interview or seemingly engages in contradictory statements that are simply reflections of that ambivalence. She is starting to identify that she is overwhelmed, and the depressive symptoms are escalating. This patient may have a hard time acknowledging that she has limitations, and she may experience negative emotions by admitting to you (and to herself) that she has needs that are not being met. Thus, activities designed to bring her into the present moment, with a focus on improving the body and mind connection, may be undermined by further ruminations.

Encouraging your patient to seek social support can be a scheduled activity that serves as an antidote to the unrealistic expectations she is carrying about herself. One option is going to support groups. The National Institute of Aging recommends joining caregiver support groups, either in the community or online [17; 21], which can be a place to express what feels like socially undesirable thoughts and feelings. This simultaneously reduces isolation and provides an opportunity to exchange resources and other practical strategies. The cognitive restructuring takes place from the stories they hear and the exchanges they have. For some, this can be more compelling than having those thoughts reframed in an individual therapy session. Beyond support groups, generally encouraging the patient to maintain other meaningful relationships and scheduling time to catch up or participate in a shared activity can also provide critical relief. This should ultimately help the patient tap into other roles and aspects of themselves that they have not had a chance to focus on. These social activities are likely to be very potent in increasing momentary positive affect and decreasing feelings of loneliness. Reviewing the relationship between activities, behavior, and mood in session may be the data that the patient needs to see that they are indeed a better caregiver when more life balance is incorporated into the schedule.

The patient in the caregiver role may experience conflicting emotions. On the one hand, they are seeking treatment, so in part, they know that the situation, as is, is not tenable. At the same time, they may feel guilty acknowledging their needs and are frustrated with themselves for not being “stronger.” Work with the patient to pick *moments* throughout the day in which they nourish themselves. Encourage them to focus on areas of self-care that may be physiologically and psychologically anti-depressant. Encourage social interactions, either formally in a support group or informally with friends or other family, where they get to occupy other roles. This will allow the patient to tap into other aspects of

themselves that have been dormant. As they accumulate positive feedback from their experiences, ask them to explain how these activities impact their mood. Then inquire about how this may positively affect the caregiving relationship.

### Conclusion

Beyond its applicability as an empirically supported treatment, BA is a principle of change. This article was designed as a primer to move from the empirically supported treatment to working as an evidence-based practitioner when treating geriatric patients with depression. It can be challenging to encourage patients to experience positive and rewarding aspects of their daily life when there are barriers, life changes, and stressors. This article is meant to highlight prototypical situations and stressors that can present in older age patients who meet the criteria for late-life depression.

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