DEVELOPMENT AND EVALUATION OF BEHAVIORAL ACTIVATION GUIDED SELF-HELP TREATMENT FOR MILD TO MODERATE DEPRESSION

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ABSTRACT

Background: Cognitive behavioral guided self-help (CBTgsh) programs are brief, cost-effective, and have been shown to be effective in the treatment of depression, anxiety, and eating disorders. **Aims:** The present study developed a novel guided self-help treatment based on Behavioral Activation (BA), an empirically supported treatment for depression and evaluated its acceptability and effectiveness among college students. **Methods:** Utilizing a train-the-trainer implementation strategy, an advanced graduate student in clinical psychology received expert-led training in BA, developed the guided self-help treatment (BAgsh) under supervision, and subsequently trained and supervised two junior graduate students to implement the treatment in an open clinical trial. Treatment comprised 10 sessions of BAgsh for 19 college students with mild to moderately severe depressive symptoms. Client outcomes were improvement in depressive symptoms on the Patient Health Questionnaire (PHQ-9) and the Behavioral Activation for Depression Scale (BADS). Implementation outcomes were acceptability and both therapist and client adherence. **Results:** Intent-to-treat analyses revealed that 31.6% of clients achieved reliable recovery, comparable to recovery rates from a large-scale clinical trial of CBTgsh. Clients also reported significant improvements on both measures with medium to very large effect sizes. Clients and counseling center staff reported high levels of satisfaction and therapists showed a 95% rate of adherence to the treatment protocol. **Conclusions:** The results of the current study provide "proof-of-concept" for the effectiveness and acceptability of BAgsh and support for the train-the-trainer model. These findings suggest that, given adequate training and supervision, specialized therapist credentials are not necessary for the effectiveness of BAgsh.

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Introduction

Close to 70% of people suffering with a mental disorder in the United States do not have access to psychological treatment, let alone evidence-based treatment (Kazdin & Rabbit, 2013). Commonly proposed solutions such as making treatments more widely available by increasing the number of therapists have been criticized as impractical. Instead, Kazdin and Blase (2011), suggest a shift in the model of treatment delivery. The proposed "reboot of psychotherapy" targets the increased use of non-professionals, or task-sharing, which could increase coverage without compromising quality of mental health care. The reboot also recommends the adoption of self-help treatments that are brief, cost-effective and have the potential to reach individuals in need and reduce many barriers associated with more traditional therapist-led treatments (Fairburn & Patel, 2014; Patel, 2009).

Self-help tools and techniques are often difficult to self-administer correctly and consistently and without a therapist involved, self-help treatments often show high attrition rates (Redding, Herbert, Forman, & Gaudiano, 2008). Across studies of self-help treatments, guided self-help outperforms pure self-help (Cuijpers, Donker, van Straten, Li, and Andersson, 2010; Newman, Szkodny, Llera, & Przeworski, 2011). Guided self-help (GSH) involves assistance from a therapist, typically for no more than 20–25 minutes often for 10 or fewer sessions (Zandberg & Wilson, 2012). Other advantages of GSH treatments include less complexity, brevity, and the minimal expertise required of the therapist. GSH treatments have been shown to be suitable for task-sharing, which allows them to be easily disseminated and implemented in areas where resources are scarce (Fairburn & Wilson, 2013; Zandberg & Wilson, 2012).

The current study focused on the treatment of depression, a leading cause of disability worldwide (World Health Organization, 2016). The most studied guided self-help treatments are based on Cognitive Behavioral Therapy (CBTgsh). CBTgsh treatments have been shown to produce large effect sizes and to be more effective than treatment-as-usual for depression in primary care settings (Gellatly et al., 2007; Williams, Wilson, Morrison, McMahon, & Andrew, 2013). Though guided self-help treatments have already been implemented for the treatment of depression, including as part of the Improving Access to Psychological Therapies (IAPT) program in the U.K., BA remains an under-explored option and has strong potential for adaptation to guided self-help (Lovell & Richards, 2008; Parkinson, 2014). BA has been evaluated across outpatient mental health settings and has a growing evidence base, even compared to "gold-standard" treatments like Cognitive Therapy and antidepressant medication (Dimidjian et al., 2006; Moradveisi, Huibers, Renner, Arasteh, & Arntz, 2013). BA is also recommended by the National Institute for Health and Clinical Excellence (NICE) guidelines (Clark, 2011; NICE, 2009).

Several small studies have investigated BA in a self-help group and for geriatric depression and found mixed results (Houghton, Curran, & Saxon, 2008; Moss, Scogin, Di Napoli, & Presnell, 2012). One study demonstrated that smartphone-delivered BA was effective and comparable to a mindfulness-based guided self-help treatment, but since the content of the BA treatment was derived from several manuals and written specifically for the study, the generalizability of the treatment is limited (Ly et al., 2014). Despite the limited research, BA is often cited as a viable option for future development into a guided self-help treatment. BA is a parsimonious treatment and has demonstrated acceptability,

feasibility and efficacy amongst non-specialists, suggesting BA is particularly well suited to task-sharing (Chowdhary et al., 2015; Ekers, Dawson, & Bailey, 2013; Ekers et al., 2014; Rhodes et al., 2014).

The current investigation had two main aims. The first was to develop a BA guided self-help (BAgsh) treatment and the second was to conduct an open-trial study for treatment-seeking college students with depressive symptoms. The self-help book, *Overcoming Depression One Step at a Time*, was not initially designed for a guided self-help treatment. Thus it was adapted with new supplemental materials with the goal that BAgsh could be feasibly implemented within a semester-schedule (Addis & Martell, 2004). Consistent with a conceptual model of implementation research, the study aimed to assess both implementation outcomes and client outcomes (Proctor et al., 2009). BAgsh was also developed so that non-professional therapists could deliver the treatment. Zandberg and Wilson (2012) previously demonstrated that graduate students could effectively deliver CBTgsh for eating disorders using the train-the-trainer (TTT) model, in which an expert trains a specific practitioner to both implement and train and supervise others. The initial therapist then becomes the trainer and supervisor for other less experienced therapists (Zandberg & Wilson, 2012). The current study used the same TTT model to demonstrate that for BAgsh, non-experts could deliver the training and supervision necessary for adherence without requiring the ongoing involvement of an expert therapist.

Methods

Clients and Recruitment

Clients were treatment-seeking undergraduate and graduate students at Rutgers University referred from the Rutgers Counseling, Alcohol and Other Drug Assistance Program, and Psychiatry Services (CAPS). Following a brief orientation to the treatment presented by the author, CAPS therapists used inclusion and exclusion guidelines to make referrals at their discretion. Subsequently, referred students were invited to attend a 60–90 minute intake interview with the author to determine eligibility. The intake interviews included pre-treatment questionnaires, an assessment of current and past depressive episodes, and an assessment of any other psychosocial stressors of comorbidities. Suicide risk was evaluated using the Columbia-Suicidal Severity Rating Scale to help assess for current and past suicidal ideation and behavior (Posner et al., 2011).

Inclusion criteria were mild to moderately severe depressive symptoms, defined as a PHQ-9 score of 5 to 20, based on the cutoffs scores for those severities (Kroenke, Spitzer, & Williams, 2001). As part of standard treatment at the counseling center, CAPS therapists regularly administer the PHQ-9 at intake and on a weekly basis, which provided an easy signal of possible eligibility for the study. Exclusion criteria were current suicidal ideation (defined as a "2" or above on question 9 of the PHQ-9) or evidence of another primary psychological disorder (i.e., bipolar disorder, eating disorders, or substance use disorders). These determinations were made by mutual decision between the trainer and expert therapist (GTW). Concurrent pharmacological or psychological treatments did not preclude participation, and information about other

treatment services was reported at pre- and post-treatment. All procedures were approved by the Rutgers University Human Subjects Institutional Review Board.

Treatment

The Behavioral Activation guided self-help (BAgsh) treatment utilizes the book *Overcoming Depression One Step at a Time (*Addis & Martell, 2004). The remaining elements were developed based on a CBTgsh treatment for eating disorders using the self-help book *Overcoming Binge Eating* (Fairburn, 2013). The Fairburn CBTgsh treatment is well-studied and has been shown to be effective even when delivered by clinically-inexperienced graduate students (Wilson & Zandberg, 2012; Zandberg & Wilson, 2012). The current treatment consisted of 10 sessions over 10 weeks and was provided free of cost at the Psychological Clinic at the Rutgers University Graduate School of Applied and Professional Psychology (GSAPP). Sessions 1 and 10 were 45–50 minutes with the remaining sessions, 20–30 minutes long, adding up to 5 total hours of treatment. Each session focused on reviewing the previous week's tasks with the aim of enhancing motivation, troubleshooting problems, and facilitating adherence to the self-help treatment. All sessions were scheduled weekly, though adjustments were made to accommodate illnesses and school breaks.

The content of the treatment was mainly derived from Addis and Martell (2004) and Table 1 outlines the topics covered in the treatment. The BAgsh treatment needed to maintain the essential content of BA while remaining brief enough to be delivered over 10 sessions. The Martell, Dimidjian, and Herman-Dunn (2010) manual was chosen to best represent the BA treatment, and the Addis and Martell book was assessed to determine the most important content. A supplemental module on values was developed,

consistent with a previous adaptation of BA (Houghton, Curran, & Saxon, 2008). A supplemental module on relapse prevention was also developed to be more consistent with the Martell et al. (2010) manual.

To increase client adherence and to assist both the clients and therapists with implementing treatment, a client manual ("User's Guide") was developed to make the self-help book better suited to guided self-help (Schwartz, 2016a). Modeled after the Fairburn (2013) book, the User's Guide breaks down the Addis and Martell (2004) book into sequential and additive steps with each step outlining the necessary components and instructions to complete all relevant homework. Each step also includes review checklists, a series of questions related to how well the client has done with the treatment thus far. The review checklists allow clients to monitor their own progress and provide the rubric for setting the treatment pace. Therapists recorded how compliant clients reported they were with major components of treatment (i.e., reading, self-monitoring) as an indirect measure of the treatment's feasibility. Appendix A contains a copy of the User's Guide.

Therapists and Training

Therapists were Rutgers University doctoral students in clinical psychology (Psy.D.) with limited or no previous experience in treating adults with depression. The study employed the train-the-trainer (TTT) model of training, and the trainer was a third-year doctoral student in clinical psychology with experience in delivering CBT as well as CBTgsh for eating disorders. The other two study therapists were second-year graduate students, self-selected based on expressed interest in treating depression.

Prior to the start of the study, the trainer independently reviewed and adapted a CBTgsh therapist manual (Carter & Fairburn, 1998) for the BAgsh manual. The trainer

then completed one training case with weekly individual supervision with an expert in CBT as well as in guided self-help treatments (GTW). Following completion of the training case, the trainer developed the materials for training others and provided all of the direct training and supervision during the study. Consistent with prior research on the value of checklists and prior studies of guided self-help, session-by-session therapist checklists (Schwartz, 2016b) were developed to promote therapists self-assessment of their adherence to the manual (Gawande, 2010; Zandberg & Wilson, 2012). The therapist checklists also provide a section for recording client adherence to the treatment. An example therapist checklist is included in Appendix B.

Table 2 provides a summary of trainer and therapist training. Prior to the training, all therapists received the therapist manual and a copy of the Addis and Martell (2004) book. Therapist training consisted of three components: 1) Therapists were provided the BAgsh therapist manual for independent review; 2) Therapists attended two separate three-hour workshops, conducted by the trainer, on the application of guided self-help; and 3) Therapists received one hour of weekly supervision for the duration of the study. Sessions were audio-recorded and reviewed by the trainer to assist in providing weekly supervision. The trainer additionally rated therapist adherence for 30% of all supervised sessions, chosen randomly, as a check to the self-reported adherence rates from each of the less-experienced therapists. The expert psychologist listened to approximately one third of the audio recordings alongside the trainer in order to provide supervision of the trainer's supervision of the less-experienced therapists.

Measures

All clients were assessed at baseline and immediately post-treatment using the questionnaire assessments described below. As noted by Proctor et al. (2009), brief and feasible outcome measures are integral to implementation research in routine settings. Given this objective, measures and assessment procedures were abbreviated to decrease client burden. Pre-treatment and post-treatment assessments took place in the clinic waiting room.

Client outcomes of interest were reduction in depressive symptoms and improvements in behaviors related to depression. Open-trial, effectiveness studies frequently benchmark results from naturalistic settings against the findings of larger studies (Merrill, Tolbert, & Wade, 2003; Wade, Treat, & Stuart, 1998). Therefore, the results of this study were benchmarked to a study of CBTgsh in the IAPT program and a large-scale randomized-controlled trial of individual BA (Dimidjian et al., 2006; Gyani, Shafran, Layard, & Clark, 2013).

Patient Health Questionnaire (PHQ-9). Clients were given the PHQ-9 each session from baseline through post-treatment. The PHQ-9 is the nine-item depression questionnaire often used to monitor the severity of depression and response to treatment and has been shown to have high internal reliability (Kroenke, Spitzer, & Williams, 2001). Scores over 10 had a sensitivity of 88% and a specificity of 88% for Major Depressive Disorder and a score of 10 on the PHQ-9 is the most commonly used cut-off point to suggest a diagnosis of depression (Kroenke, Spitzer, & Williams, 2001).

Behavioral Activation for Depression Scale (BADS). The BADS is a 25-item questionnaire used to track weekly changes in behaviors hypothesized by BA to underlie depression (Kanter, Mulick, Busch, Berlin, & Martell, 2007). The subscales examine

changes in the following areas: activation, avoidance/rumination, work/school impairment, and social impairment. Kanter et al. (2007) demonstrated that the BADS has good reliability across two studies (Cronbach $\alpha = .79$ and .87).

Columbia – Suicide Severity Rating Scale (C-SSRS): Clients were assessed using the Columbia – Suicide Severity Rating Scale (C-SSRS) during the intake interview regardless of risk level. The C-SSRS allows practitioners to gauge the full spectrum of suicidal ideation and suicidal behavior, both past and present, and the psychometric properties have demonstrated moderate to strong internal reliability (Posner et al. 2011).

Acceptability Measures. Treatment satisfaction was assessed immediately post-treatment using satisfaction questionnaires previously used in a CBTgsh study (Zandberg & Wilson, 2012). Treatment completers were asked to rate their satisfaction with the overall treatment, self-help book, and therapist on a 5-point Likert scale and also asked to provide brief answers to four open-ended questions. At an institutional level, referring therapists from CAPS were also asked to rate their satisfaction with the treatment and referral process through a similar brief questionnaire (Zandberg & Wilson, 2012). A copy of both the client and CAPS satisfaction measures can be found in Appendix C.

Data Analysis

Data were analyzed using baseline-carried-forward, intent-to-treat (ITT) analyses. Primary outcome variables were depressive symptoms assessed with the PHQ-9. Secondary outcomes were additional depressive behaviors (avoidance, activation, withdrawal, rumination) assessed with the BADS. Paired sample t-tests were performed to compare pre- to post-treatment outcomes overall. Independent t-tests were used to test

whether specific subgroups (i.e., completers and non-completers, those with or without concurrent medication) differed significantly on pre-treatment variables. All tests were two-tailed and p value of .05 was used to indicate statistical significance. Cohen's *d* effect sizes (1988) were calculated as the mean difference between pre- and post-treatment scores divided by the standard deviation. Effect sizes were defined as .20 = small effect, .50 = medium effect, and .80 = large effect (Cohen, 1988). Cohen's Kappa statistic (κ) was used to determine the strength of agreement on adherence between the judgment of the designated trainer and each of the junior therapists (Cohen, 1960; Landis & Koch, 1977). Missing data were minimal with only one PHQ-9 score missing out of 182 attended sessions. Data analyses were conducted with SPSS for Windows, version 23.0.

Results

Clients

Figure 1 shows client recruitment and flow throughout the study. CAPS therapists referred 21 clients between January 2015 and October 2015. Two students were deemed ineligible following baseline assessment and referred back to CAPS. 100% (n = 19) of those who were offered participation consented to treatment. Table 3 details client characteristics at baseline. Eligible clients were 12 female and 7 male students with a mean age of 20.42 years (SD = 1.62). No differences were found between those taking concurrent psychiatric medication and those without on baseline levels of depression as assessed by either outcome measure (all p-values > .05). Mean pre-treatment score on the PHQ-9 was 12.32 (SD = 3.09) and 84.3% (n = 16) of clients began treatment with a

PHQ-9 score at 10 or above, the clinical cutoff for probable diagnosis of Major Depressive Disorder (Kroenke, Spitzer, & Williams, 2001). There were no significant differences between the three therapists on average baseline levels of depression as assessed by either outcome measure (all p-values > .05).

Feasibility and Acceptability

Treatment retention was high, with 73.7% of the sample completing all ten sessions. Four clients (21.1%) dropped out of treatment, and one client (5.2%) was withdrawn after eight sessions due to increased substance abuse. Treatment completers and non-completers did not differ on baseline levels of depression as assessed by either outcome measure (all p-values > .05). Treatment completers finished treatment in an average of 74.2 days, or 10.6 weeks (SD = 10.8 days) and 100% of treatment completers finished all 10 sessions within the same semester that treatment started.

Treatment completers reported high ratings of satisfaction with the treatment at post-treatment assessment (M = 4.57; SD = 0.51), the self-help book (M = 4.14; SD = 0.53), and therapists (M = 4.79; SD = 0.43). At the conclusion of the study, referring CAPS therapists rated high levels of satisfaction with the overall project (M = 4.3; SD = 0.8) and the referral process (M = 4.6; SD = 0.8). 100% of referring CAPS therapists also expressed strong or very strong interest in training in the treatment upon completion of the study.

Clients were not required to advance through all seven steps to be designated as treatment completers since they use the treatment at their own pace. Nonetheless, 100% (n = 14) of treatment completers advanced at least through the fifth step on rumination and 71.4% (n = 10) advanced through the entire seven-step treatment within the 10 weeks.

Treatment completers finished treatment in an average of 74.2 days, or 10.6 weeks (SD = 10.8 days) and 100% of treatment completers finished all 10 sessions within the same semester that treatment started.

Client Outcomes

Primary client outcomes were assessed using the reliable recovery index, which requires an initial score above the clinical cut-off, a post-treatment score below the clinical cut-off and reliable improvement, which for the PHQ-9, is a pre- to post-treatment improvement of 6 points or greater (Gyani et al., 2013; Jacobson and Truax, 1991). Secondary client outcomes were significant improvements in total score from pre- to post-treatment on the BADS.

Table 4 presents the primary client outcome data. At post-treatment, 31.6% (n = 6) of the ITT sample showed reliable recovery and 42.1% (n = 8) of the ITT sample showed reliable improvement. Of those clients who completed treatment, reliable recovery and reliable improvement rates were 42.9% and 57.1% respectively. No clients in the ITT sample showed reliable deterioration in symptoms during treatment.

Table 5 presents the results of paired sample t-tests (ITT) performed to compare overall pre- to post- treatment outcomes on both the PHQ-9 and the BADS. Tests revealed statistically significant reductions in depressive symptoms according to the PHQ-9 with a large effect size (d = .80). On the BADS, all paired sample t-tests showed statistically significant improvement with effect sizes on the subscales ranging from d = .69 to .82 and a large effect size (d = 1.09) for the change in total score. A two-way repeated-measures ANOVA showed that the trainer and two trainees did not differ significantly in treatment outcome on either the PHQ-9 or BADS.

Therapist Adherence

Therapist adherence was high with therapists self-reporting 95.57% adherence to the session-by-session therapist checklists with no differences across study therapists. Additionally, there was substantial agreement between the designated trainer and the two therapists' judgments, $\kappa = .798$, $p < .0005$; $\kappa = .805$, $p < .0005$ (Landis & Koch, 1977). Therapists were also largely adherent to the recommended session lengths with 87% of sessions (n = 141) being completed within 5 minutes of the recommended session length.

Client Adherence

Table 6 outlines client adherence rates for both the ITT analyses as well as rates for treatment completers. Using the adherence rates for the review checklists as a proxy for overall client adherence, clients (ITT) self-reported 70.3% overall adherence to the treatment and among treatment completers, clients reported 84.5% adherence.

Discussion

BAgsh proved acceptable to clients and referring therapists. Clients were satisfied-to-extremely satisfied with the treatment and no eligible student refused treatment after being oriented to the guided self-help format. Though therapist satisfaction was not formally assessed, anecdotal evidence suggests both junior graduate students were highly satisfied with the treatment and training process. Institutional satisfaction was also high and all referring therapists reported interest in possible future training in BAgsh. Additionally, BAgsh was feasibly implemented within the semester schedule and the average total client-therapist contact was just over 5 hours. Together, the feasibility and acceptability outcomes suggest the potential suitability of this

treatment for the young adult sample within a college counseling center setting.

BAgsh was developed so that non-professional therapists could deliver the treatment, training, and supervision. All three therapists self-reported adherence rates above 93% with an average across therapists of over 95%. This study also found that 87% of sessions were completed within acceptable session length limits, a rarely studied factor that may impact whether a treatment can be delivered under institutional constraints in dissemination or implementation efforts. The implications demonstrate that with adequate training and continuing supervision, BAgsh can be implemented effectively by relatively inexperienced practitioners lacking formal professional credentials. Furthermore, the study provides further evidence for the TTT model, particularly in guided self-help treatments, which supports the assertion for a significant expansion of therapists who can deliver evidence-based treatment for underserved populations (Kazdin & Blase, 2011; Patel, 2009).

This study encouraged consistent application of therapist tasks through the use of session-by-session adherence checklists. Anecdotally, therapists reported high satisfaction with the checklists, not only for monitoring client progress and helping pace the sessions but also for reminding therapists of specific tasks. Though this study is exploratory, it highlights the possible value of session-by-session therapist checklists to promote adherent and consistent delivery of manualized treatment. More accurate self-reported adherence could serve as immediate feedback for therapist to make adjustments, which could reduce, though not eliminate, the burden on supervisors.

Implementation efforts require not only that therapists are adherent to the manual, but also that clients adhere to the treatment. Few guided self-help studies have assessed in

thorough detail which components of treatment clients report completing, which is concerning given the increased importance in program-led treatments (Newman et al., 2011). In the current study, client adherence rates were promising, especially for treatment completers, suggesting that BAgsh is not unduly burdensome and that college students can feasibly complete the treatment. Future studies should continue to thoroughly measure client adherence to determine which components clients are completing and identify further ways improve overall client adherence to manualized treatments.

Another aim of the study was to evaluate the preliminary efficacy of BAgsh. Reliable recovery rates from mild to moderately severe depressive symptoms at 10-week post-treatment were 31.6% and overall clients showed statistically significant improvements on the PHQ-9 and BADS from pre- to post-treatment with medium to very large effect sizes. Additionally, treatment outcomes did not differ significantly between therapists, even though the trainer was more expert than the two trainees.

The results were benchmarked against those found in the Gyani et al. (2013) study, which found reliable recovery rates of 38.4% for clients (n = 408) who received CBTgsh. Since the current study excluded high-severity clients, the results were benchmarked against those in low-severity subgroup in the Dimidjian et al. (2006) study, which reported response and remission rates, analogous to reliable improvement and reliable recovery rates used in the current study. Among the less severely depressed, who received up to twenty-four 50-minute sessions of individual BA over 16 weeks (n = 18), response and remission rates based on the Beck Depression Inventory (BDI-II) were 50% and 44% respectively (Beck, Steer, & Brown, 1996; Dimidjian et al., 2006).

Though the 38.4% reliable recovery rate achieved by Gyani and colleagues (2013) is larger than the 31.6% rate achieved in the current study, the current findings suggest that BAgsh can be implemented by non-professionals without significantly compromising clinical outcomes. Furthermore, outcomes in the current study approach the rates achieved in the Dimidjian et al. (2006) study despite it being a lower-intensity treatment with significantly less therapist contact time.

The attrition rate of 26.3% in the current study was higher than the 16.3% found in the Dimidjian et al. (2006) study, but still comparable to the 21.7% rate of a similar naturalistic study of guided self-help treatment in a college population (Zandberg & Wilson, 2012). Despite the elevated attrition rate, the brevity, cost, and ease of training, and client outcomes suggest that for a significant subset of clients, BAgsh can be an effective and efficient treatment for depressive symptoms and may be an appropriate primary treatment option.

Limitations

The current study had limitations, most notably the small sample size and the absence of a control condition. Without a control condition the possibility that factors independent of the treatment were responsible for clinical change cannot be ruled out. Due to the low sample size, the study was unable to detect any differences in outcome based on initial severity, though qualitative evidence suggests initial severity did not affect response to treatment. In addition, clients were permitted to access additional treatments, including psychiatric medications, to address comorbid concerns, and CAPS therapists made these referrals as they deemed appropriate. However, two clients reported participating in concurrent psychological treatment during the study, and neither received

it on a weekly basis. Though almost one-third of clients received psychiatric medication, those who did performed no better than those without medication. Additionally, several key stakeholders among the counseling center staff stated that the ability to prescribe additional treatments at their discretion contributed to their willingness to refer students. Finally, since all three therapists were graduate students, they had flexibility in their schedules to accommodate scheduling changes that may not be possible for college counseling center therapist.

Conclusions and Future Directions

This study presents promising initial findings for a guided self-help adaptation of Behavioral Activation (BAgsh), using the Fairburn (2013) treatment as a model. The results suggest that BAgsh is acceptable to college students and can be feasibly implemented within the semester schedule. The supplemental materials used in the BAgsh treatment, particularly the client manual, may hold promise as an adjunct to any self-help program. The results also suggest that given adequate training and supervision, specialized credentials are not necessary for successful implementation of BAgsh and the use of therapist checklists represents a promising option in sustaining therapist adherence. Finally, the results of the study provide promising initial evidence on the efficacy of BAgsh in the treatment of mild to moderately-severe depressive symptoms.

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Table 1

Summary of content in BAgsh treatment

Step	Content
1	Introduction, Self-monitoring
2	Activity Scheduling
3	Values*
4	Avoidance (TRAP/TRAC)**
5	Rumination**
6	Mood Dependence, Short-Term Goal Planning
7	Relapse Prevention*

* Supplemental Module
** Step designed to span 2 sessions

Table 2

Summary of trainer and therapist training

Personnel	Training and Supervision
Trainer	Development of therapist manual One BAgsh case with weekly expert-led supervision Weekly expert consultation on training and supervision tasks
Therapists	Independent review of therapist manual Two, three-hour clinical workshops Weekly individual supervision

Note: All therapist training and supervision was conducted by the trainer. Trainer also acted as therapist. Trainer received weekly supervision on his cases from expert.

Table 3

Baseline client characteristics

Characteristics	Clients (N=19)	
	N	%
Gender		
Female	12	63.2
Male	7	36.8
Ethnicity		
Caucasian	7	36.8
East Asian	4	21.1
Latino/Hispanic	1	5.3
African American	4	21.1
Indian American	3	15.8
Education		
Freshman Undergraduate	2	10.5
Sophomore Undergraduate	6	31.6
Junior Undergraduate	4	21.1
Senior Undergraduate	5	26.3
Transfer Undergraduate	1	5.3
Graduate Student	1	5.3
Prior inpatient depression treatment	1	5.3
Other prior inpatient hospitalization	2	10.5
Current psychotropic medication	6	31.6
Concurrent psychological treatment (at least 1x/month)	2	10.5
Continued in treatment post-study	3	15.8
	Mean	SD
Age	20.5	1.62
Initial PHQ-9	12.32	3.09
Initial BADS Total Score	66.16	16.39

Table 4

Treatment outcome in total (intent-to-treat) sample and treatment completers

	Intent-to-Treat Analyses (N = 19)	Completer Analyses (N = 14)
	Post-Treatment	Post-Treatment
Reliable Recovery	31.6%	42.9%
Reliable Improvement	42.1%	57.1%

Note: Reliable recovery - defined as an initial Patient Health Questionnaire (PHQ-9) ≥ 10, improvement of at least 6 points, and post-treatment PHQ-9 score < 10. Reliable improvement - defined as improvement of at least 6 points on the PHQ-9.

Table 5

Pre- to post-treatment scores (ITT) on measures of depressive symptoms and behaviors

Measure	Baseline Mean (SD)	Post-Treatment Mean (SD)	p	*d*
PHQ-9	12.32 (3.09)	9.00 (5.22)	<.01	0.80
BADS-AC	16.79 (6.12)	21.79 (8.52)	<.01	0.69
BADS-AR	20.42 (8.24)	27.68 (10.02)	<.01	0.81
BADS-WS	11.95 (5.83)	16.58 (6.59)	.03	0.76
BADS-SI	18.05 (6.04)	22.79 (5.89)	<.01	0.82
BADS-T	66.16 (16.39)	88.32 (24.63)	<.01	1.09

Note: AC, activation; AR, avoidance/rumination; WS, work/school impairment; SI, social impairment; T, total. Cohen's *d* effect sizes (Cohen, 1988) were defined as 0.20 = small effect, 0.50 = medium effect, and 0.80 = large

Table 6

Client adherence rates in total (ITT) sample and treatment completers

	Intent-to-Treat Analyses (N = 19)	Completer Analyses (N = 14)
	Adherence	Adherence
Reading	76.0%	94.4%
Exercises	68.5%	88.7%
Self-monitoring	69.0%	84.1%
Homework	65.5%	81.0%
Review Checklists Use	45.6%	57.1%
Review Checklists Adherence	70.3%	84.5%

Note: Homework, any assignments other than self-monitoring (i.e. TRAP/TRAC forms, Rumination monitoring etc.); Review Checklists Use, how often clients report returning to the checklists between sessions; Review Checklists Adherence, how many checklist items client report completing between sessions

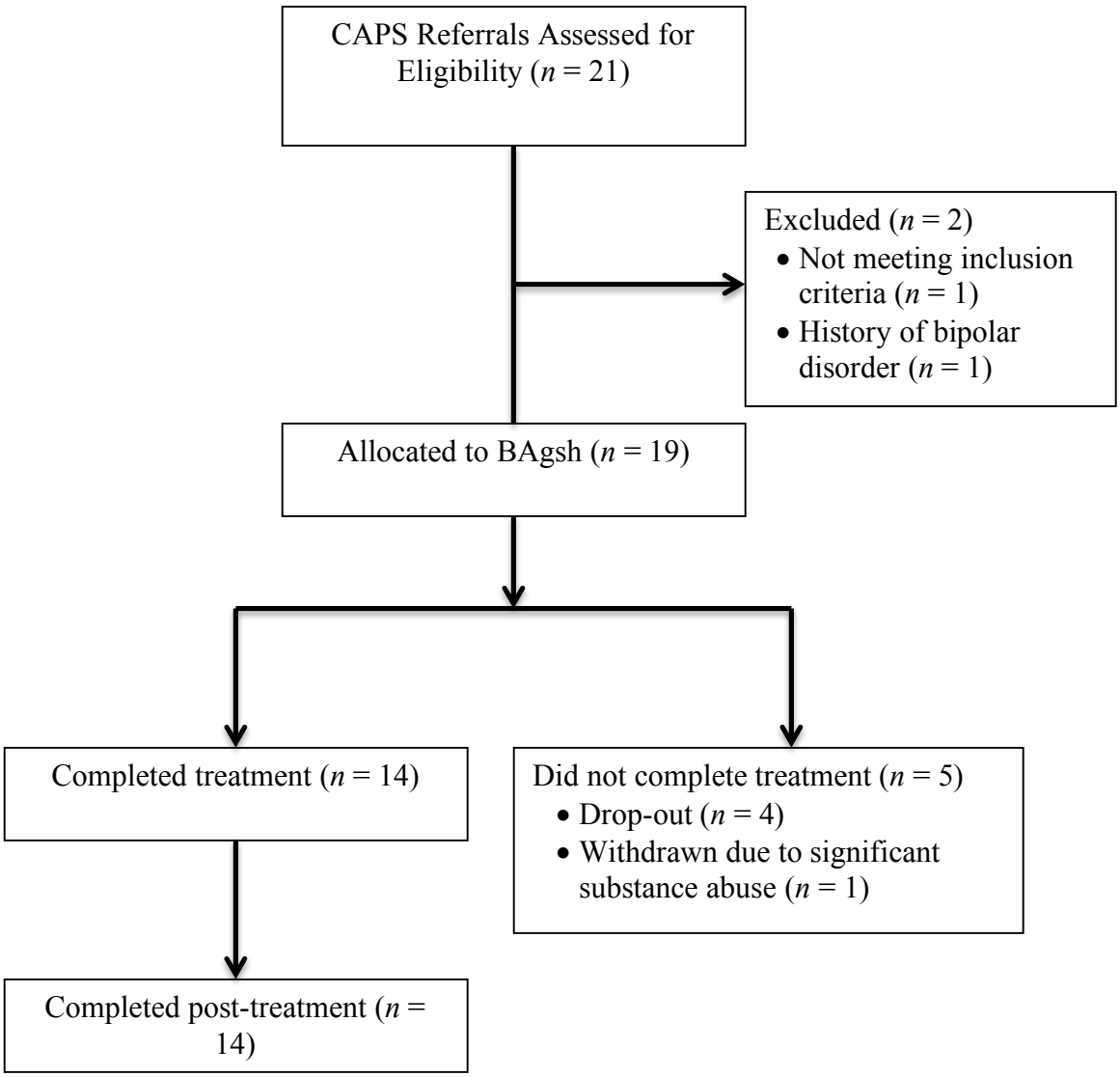

Figure 1. Schematic presentation of referral, enrollment, retention, and assessment completion

Appendix A - User Guide to *Overcoming Depression One Step at a Time*

Step 1

Reading: Page 1 to 35

Homework:

1. Self-Monitoring using the Activity Record
   - Monitor, but don't change your activities and mood
   - Use the example Activity Record as your guide
2. Complete exercises on pg. 4, 8, 9, 11, 12, 14, and 19-20
   - Skip exercises on pg. 26-27, 28, 31-32, and 34-35
     - Use the Activity Record instead (see below)

Forms:

1. Activity Record
   - Instructions
     - For each day, write down what you did in sufficient detail during the morning, afternoon and evening. Next to your activity, write how you felt at the time (i.e. sad, bored, relieved) as well as the intensity of that emotion on a 1-10 scale, with 1 being the least intense you've ever felt and 10 being the most intense you've ever felt. You can and are encouraged to write more than one emotion next to each activity should you feel more than one.
     - Since each cell covers a section of the day, please write multiple activities in each cell. Write your activities in chronological order so the connections between your activities and mood are clearer.

Step 1 Review Checklist:

1. **Have I been monitoring using the Activity Record?** ____
2. **Am I monitoring as well as I can?** ____
3. **Are any patterns becoming evident?** ____

Step 2

Reading: Page 36 to 44

Homework:

1. Self-Monitoring using the Activity Record
2. Activity Scheduling using the Activity Record
   - Schedule at least one alternative activity per day
     - Use example Activity Scheduling as your guide
   - Check off the activities as you complete them
   - Note if and why any scheduled activities were moved or cancelled
3. Complete exercises on pg. 38-39, 43
   - Skip exercise on pg. 42
     - Use the Activity Record to plan your activities

Forms:

1. Activity Record

Step 2 Review Checklist:

1. **Have I been monitoring using the Activity Record?** ____
2. **Am I monitoring as well as I can?** ____
3. **Am I identifying problematic situations/behaviors?** ____
4. **Am I trying to come up with alternatives for most of them?** ____
5. **Am I following through with my Activity Scheduling?** ____
6. **Am I comparing the results of my experiments** ____
7. **Am I trying to maintain a non-judgmental attitude?** ____
8. **Did I complete all the assigned exercises?** ____

Step 3

Reading: Values Module

Homework

1. Self-Monitoring using the Activity Record
2. Activity Scheduling using the Activity Record
   - Check off the activities as you complete them
3. Complete exercises in module
4. Coping Card
   - Begin building and adding to it

Forms:

1. Activity Record
2. Coping Card
   - Instructions: See Module

Step 3 Review Checklist:

1. **Have I been monitoring using the Activity Record?** ____
2. **Am I monitoring as well as I can?** ____
3. **Am I following through with my Activity Scheduling?** ____
4. **Am I trying to recognize and prioritize my values?** ____
5. **Am I able to identify activities that are consistent with my values?** ____
6. **Am I trying to incorporate my values into Activity Scheduling?** ____
7. **Am I adding to and using my Coping Card?** ____
8. **Did I complete all the assigned exercises?** ____

<u>Step 4</u> (2 sessions)

Reading: Page 47 to 69

Homework:

1. Self-Monitoring using the Activity Record
2. Activity Scheduling using the Activity Record
   - Check off the activities as you complete them
3. Complete exercises on pg. 51, 52, and 54, 69
   - Skip exercise on pg. 64-65
     - Use TRAP Worksheet
   - Skip exercise on pg. 67
     - Use TRAC Worksheet
4. Complete Exercise on pg. 69
   - Use TRAP Worksheet
     - Complete at least 5 worksheets
   - Use TRAC Worksheet
     - Complete at least 5 worksheets

Forms:

1. Activity Record
2. TRAP Worksheet
   - Instructions: See pg. 64 or Blank TRAP Worksheet
   - Note: On your worksheet you will list both the short and long-term consequences.
3. TRAC Worksheet
   - Instructions: See pg. 67 or Blank TRAC Worksheet
   - Note: On your worksheet you will list both the likely short and long-term consequences.

Step 4 Review Checklist:

1. **Have I been monitoring using the Activity Record?** ____
2. **Am I monitoring as well as I can?** ____
3. **Am I following through with my Activity Scheduling?** ____
4. **Am I becoming more aware of my avoidance patterns?** ____
5. **Am I trying to find and try alternatives to avoidance?** ____
6. **Did I use the TRAP and TRAC Worksheets?** ____
7. **Did I complete all the assigned exercises?** ____

Step 5 (2 sessions)

Reading: Page 88 to 103

Homework:

1. Self-Monitoring using the Activity Record
2. Activity Scheduling using the Activity Record
   - Check off the activities as you complete them
3. Complete exercises on pg. 90, 91, 93, 94, 95, 98, 100, 101, 102
4. Monitoring Rumination (pg. 98 or worksheet)
   - Use example form as your guide
5. Rumination Cues Action (pg. 100 or worksheet)
   - Use example form + Rumination Handout as your guide

Forms:

1. Activity Record
2. Monitoring Rumination
   - Instructions: See pg. 98
3. Rumination Cues Action
   - Instructions: See pg. 100

Step 5 Review Checklist:

1. **Have I been monitoring using the Activity Record?** ____
2. **Am I monitoring as well as I can?** ____
3. **Am I following through with my Activity Scheduling?** ____
4. **Am I becoming more aware of when I am ruminating?** ____
5. **Am I noticing trends/patterns/themes in my rumination?** ____
6. **Am I noticing more when I'm ruminating?** ____
7. **Am I trying to reduce my rumination when I can?** ____
8. **Am I trying to use Rumination Cues Action?** ____
9. **Did I complete all the assigned exercises?** ____

Step 6

Reading: Page 129 to 147

Homework:

1. Self-Monitoring using the Activity Record
2. Activity Scheduling using the Activity Record
   - Check off the activities as you complete them
3. Complete exercises on pg. 131, 133, 136, 138, 139-140, 143, 144, 145-146
   - Skip exercise on pg. 142
     - Use Short-Term Goal Plan
4. Short-Term Goal Plan
   - Complete at least 3 plans

Forms:

1. Activity Record
2. Short-Term Goal Plan
   - Instructions: See pg. 139-141

Step 6 Review Checklist:

1. **Have I been monitoring using the Activity Record?** ____
2. **Am I monitoring as well as I can?** ____
3. **Am I following through with my Activity Scheduling?** ____
4. **Am I thinking about how to be more goal-dependent?** ____
5. **Am I trying to be proactive instead of reactive?** ____
6. **Am I trying to plan more short-term goals?** ____
7. **Am I able to outline my long-term goals?** ____
8. **Am I trying to choose goals in line with my values?** ____
9. **Did I complete all the assigned exercises?** ____

Step 7

Reading: Relapse Prevention and Next Steps Module

Homework:

1. Self-Monitoring using the Activity Record
2. Activity Scheduling using the Activity Record
   - Check off the activities as you complete them
3. Post-Therapy Plan
6. Use example Post-Therapy Plan as your guide
4. Complete exercises in module

Forms:

1. Activity Record
2. Post-Therapy Plan
   - Instructions:
     - *What makes me vulnerable to depression?:* Write down what aspects of the environment leave you prone to or trigger depression. You should stick to general themes over specific examples.
     - *Which behaviors maintain or worsen my depression?:* Write down the most important behavior patterns that maintain your depression. Again still to general themes over specific examples.
     - *Which behaviors help improve my mood or reduce my depression?:* Write down the general behavior patterns that break the depression cycle. Mark which behaviors you would like to maintain at their current level and which ones you want to increase.
     - *What can I do to follow through?:* Write down anything that you can do to continue to follow through on the helpful behaviors mentioned above. Use your past successes as your guide, but feel free to add new ideas to both overcome your depression and keep it away.

Step 7 Review Checklist:

1. **Have I been monitoring using the Activity Record?** ____
2. **Am I monitoring as well as I can?** ____
3. **Am I following through with my Activity Scheduling?** ____
4. **Did I summarize what makes me vulnerable to depression?** ____
5. **Did I summarize which behaviors worsen my depression?** ____
6. **Did I summarize which behaviors reduce my depression?** ____
7. **Did I summarize what I can do to follow through?** ____
8. **Did I complete the Post-Therapy Plan?** ____
9. **Did I complete all the assigned exercises?** ____

Appendix B - Example of BAgsh Therapist Checklist

Session Two (20-25 minutes)

Reading Completed: Y/N or N/A	Exercises Completed: ___ of ___ or N/A
Monitoring Completed: Y/N	
Used Checklists: Y/N	Checklist Adherence: ___ of ___
Moved on: Y/N or N/A	

Necessary Forms:

- Activity Record
- Example Activity Scheduling

Agenda

Before Session

____ Set up tape: Therapist name, Participant ID, Session #, Date
____ Get Activity Record and any additional forms

Check In (5-7 minutes)

____ Welcome. This is session 2. We have 8 sessions left after this one.
____ Review PHQ-9 & BADS-SF
____ Review and discuss any symptoms changes
____ Assess any suicidality noted on question #9 on PHQ-9

Review Client's Use of Treatment

____ How well were you able to follow the assignments and do the reading?
____ Praise client's effort and completion of exercises/assignments

Review Monitoring Forms (8-10 minutes)

_____ Review collaboratively client's Activity Record
_____ Positive comment on all signs of progress or attempts to change

*20 minutes into session → Must review checklists + Preview Next Step/Review Current Step

Review Step Checklist (3 minutes)

_____ Did you refer to the review checklist throughout the week?
_____ Go through any unanswered questions
_____ How well do you think you did on this step?
____ Discuss and decide whether or not to move on

Preview Next Step (3 minutes)

____ Read Step 2
____ Discuss Depression Loop
____ Introduce Activity Scheduling
____ Handout example form

or Review Current Step (3-5 minutes)

____ Reread current step
____ Troubleshoot difficulties
____ Review current forms
____ Encourage client despite pace

Appendix C - Satisfaction Questionnaires

Post Treatment Questionnaire

Please help us improve our treatment by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. We also welcome your comments and suggestions.

1) Rate your overall satisfaction with the guided self-help treatment:

Extremely Satisfied_____5
Satisfied_____4
Indifferent_____3
Dissatisfied_____2
Extremely Dissatisfied_____1

2) Rate your overall satisfaction with the guided self-help book:

Extremely Satisfied_____5
Satisfied_____4
Indifferent_____3
Dissatisfied_____2
Extremely Dissatisfied_____1

3) Rate your overall satisfaction with the guided self-help therapist:

Extremely Satisfied_____5
Satisfied_____4
Indifferent_____3
Dissatisfied_____2
Extremely Dissatisfied_____1

4) What parts/aspects of the treatment did you find the most helpful?

5) What parts/aspects of the treatment did you find least helpful?

6) Are there any changes that you would make to the treatment?

7) Other comments or suggestions?

CAPS SURVEY
Guided-Self Help for Depression

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1. Did you make a referral to the guided self-help study?

   Yes……1
   No……0

   If No → Skip to Item 4

2. Please rate your overall satisfaction with the referral process:

   Extremely Satisfied……5
   Satisfied……4
   Indifferent……..3
   Dissatisfied……...2
   Extremely Dissatisfied……1

3. Please rate your overall satisfaction with the guided self-help treatment:

   Extremely Satisfied……5
   Satisfied……4
   Indifferent……..3
   Dissatisfied……...2
   Extremely Dissatisfied……1

4. Please rate your interest in future training on how to use guided self-help treatment:

   Extremely Interested……..5
   Interested……,……4
   Indifferent……..3
   Uninterested……....2
   Extremely Uninterested……..1

5. (Optional) We aim to improve the referral process based on your feedback. Please use this space to provide comments and suggestions:

THANK YOU!