

# ENGAGE

*Engage in Rewarding Activities:  
A Stepped Psychotherapy for Late-Life Depression*





# Overview

Welcome to the Engage Manual for late-life depression. Included in the Manual are:

- A guide for helping older adults engage in rewarding activities
- A set of strategies for managing behaviors that serve as barriers to engagement in rewarding activities
- Instructions on how to manage common problems interfering with ENGAGE treatment (e.g., pain, hospitalization, and sleep)
- Session Materials

## What is Engage?

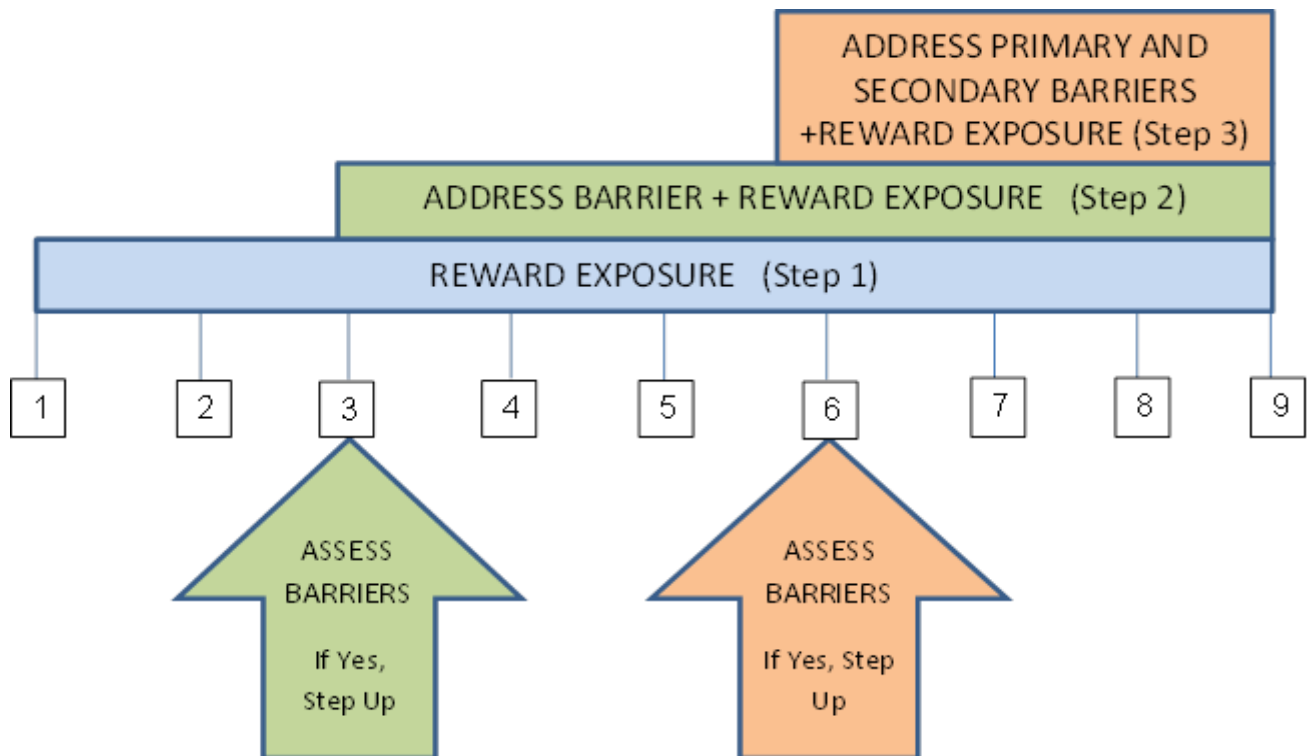
Depressed older adults wish to be treated with psychotherapy but few therapists in the community are trained and maintain their skills in evidence-based therapies. To address this need, we created “Engage”, a streamlined psychotherapy based on two domains of knowledge. First, “Engage” relies on neurobiology concepts of depression to identify core behavioral pathology of late-life depression. The neurobiology concepts on which Engage was based are discussed in the paper by *Alexopoulos GS and Arean PA, A Model for Streamlining Psychotherapy in the RDoC Era: The Example of “Engage”. Mol Psychiatry 2014; 19:14-9*. By focusing on core pathology, “Engage” limits its behavioral targets and reduces the number of decisions therapists must make. Second, “Engage” addresses core pathology with simple cognitive-behavioral interventions of known efficacy that have been found acceptable by therapists. As a result, “Engage” relies on a parsimonious set of efficacious strategies to address behaviors originating from core neurobiological dysfunctions of depression. We have demonstrated that Engage is easier to learn and retain and non-inferior than the evidence-based Problem Solving Therapy in late-life major depression. Please see *Alexopoulos GS, Raue PJ, Marino P, Renn BN, Solomonov N, Sirey JA, Hull TD, Kiosses DN, Mauer E, Arean PA. Comparing the Streamlined Psychotherapy “Engage” with Problem-Solving Therapy in Late-Life Major Depression. A Randomized Clinical Trial. Mol Psychiatry, 2020 Jul 1. doi: 10.1038/s41380-020-0832-3*.

“Engage” theorizes that impairment in reward network functions is a process central to late-life depression. This view is supported by animal models of depression and by human clinical and neuroimaging studies. The principal treatment vehicle of Engage is “reward exposure” consisting of reintroducing activities that patients once found rewarding and enjoyed, but have abandoned after they developed depression. Engage uses basic problem solving through which patients learn how to form “action plans” for pursuing rewarding activities of their choice. They are instructed to: 1) identify a goal, i.e., a rewarding and pleasurable activity; 2) develop a list of ideas of what to do in order to meet the goal; 3) select an idea; and 4) create an “action plan” that addresses obstacles that could interfere with successful plan implementation.

The Engage therapist guides patients to select among activities related to social engagement, intellectual exchange, physical exercise, volunteerism, etc. Some patients, however, do not respond to direct “reward exposure.” Common “barriers” to engaging in or deriving pleasure from rewarding activities are:

1. Emotional dysregulation;
2. Negativity bias; and
3. Apathy leading to inertia and inactivity.

The behaviors related to these barriers are the clinical expression of dysfunction in three different brain networks. Engage uses specific strategies to address each of these “barriers” so that they do not interfere with the development and implementation of “action plans.” However, a good number of depressed older adults can work directly with their “action plans” and engage in rewarding activities without requiring additional strategies. For this reason, Engage follows a stepped approach. It starts with “reward exposure,” a direct attempt to reengage patients in rewarding and pleasurable activities and utilizes additional strategies later, and only if needed following the timetable of the Figure below.



In Step 1, all patients are instructed to identify and engage in rewarding social and physical activities and are taught the “action planning” process. Throughout the first three sessions, Engage therapists assess whether patients: 1) have learned how to form “action plans” pertinent to their needs; 2) have been engaging in rewarding activities as planned; and 3) have begun to show improvement of depression. If all conditions are met, patients continue with Step 1 (“reward exposure”) until the end of treatment.

If the above conditions are not met, therapists review their experience with patients to identify the most prominent “barrier” before the end of session 3. A similar assessment is made between session 3 and the end of session 6. Patients who are doing well with the Step 2 approach (e.g., reward exposure plus strategies for negativity bias) should continue with the Step 2 strategies until the end of treatment. For those who still experience difficulties, the therapist should identify if another barrier exists and add a strategy to counteract it (Step 3). For example, a patient is not engaging in rewarding activities despite the fact that a strategy for his/her “negativity bias” has been used. In this case, during Step 3, the therapist may either use an alternative approach to address “negativity bias” or determine that another barrier (e.g. apathy leading to inertia) is operative and targets this barrier with an appropriate strategy. Strategies for each of the three

“barriers” are discussed later in this Manual. Some of the Engage interventions are implemented *during sessions*. Others are applied *between sessions* and are used to facilitate the implementation of “action plans” leading to “reward exposure.”

## Why Stepped Care?

“Reward exposure” through engagement in rewarding social and physical activities can improve depressive symptoms and signs and disability. Moreover, it is a relatively simple intervention for therapists to deliver and makes sense to many older adults.

Engagement in rewarding activities may not help all patients with late-life depression. Negativity bias, apathy, and emotional dysregulation may inhibit pursuit of action plans and engagement in rewarding activities. These problems may be apparent in the initial assessment of a patient, but emerge most reliably after unsuccessful attempts to engage patients in the “action planning” process.

Diversity in barriers to engagement in rewarding activities requires a targeted approach. Having the ability to add strategies based on patient presentation and response to the initial Engage intervention (reward exposure) personalizes treatment, and can increase the number of depressed patients who can benefit from treatment.

## Why Not Use All Strategies at Once?

A stepped approach to treatment enables older patients to socialize into psychotherapy, become comfortable discussing their problems, and develop trust in the therapist. Many depressed older adults respond to re-engagement in rewarding activities alone and require no additional interventions. Others have difficulties with multi-component interventions. While it is possible to treat some older people with all available options, a “full-tilt” approach to treatment may not be feasible or acceptable for many depressed older adults, and a stepped approach allows for better treatment personalization.

## Step 1 – Reward Exposure



Step 1 consists of three weekly sessions. The goal of the first three sessions is to socialize patients to the treatment and help them engage in rewarding activities using the “action planning” process. Engagement in treatment includes education about depression. Beyond destigmatization of depression and its treatment, the therapist has the opportunity to explain how depression can lead to social isolation and lack of interest in once rewarding activities. Patients are made aware that engaging in activities can improve mood, and as a result help one feel energized and able to take on bigger problems. The therapist also engages the patient in a discussion about goals for change and problems that may emerge.

***Creating a supportive environment.*** Engage therapists create and maintain warm, trusting, and supportive relationships with patients. They convey concern for patients and their lives and approach their experiences and feelings with empathy. As in other psychotherapies, the therapeutic relationship in Engage is seen as a condition necessary for therapy to proceed. For this reason, therapists must be attuned to the patients’ point of view and be aware of the degree to which patients agree on the goals and tasks of Engage. If problems emerge or if patients express disagreement on the proposed approach, therapists should address their concerns and attempt to resolve disagreements.

**Session Structure.** Engage is a semi-structured intervention. Early sessions cover a good deal of material, while later sessions will be less content heavy and focus mostly on helping patients implement the agreed upon activities. Regardless of content, the therapist should structure each session in the following way:

- Set an agenda: Let the patient know what you need to cover, and then ask the patient if there are other items to add to the agenda. Structure the agenda in this way:
  - Administer the PHQ-9 (a depression rating scale)
  - Develop or review the patient’s “action plan”
  - Create a new “action plan”
- Order and prioritize the session content, except during crises. If the patient is in a crisis (e.g., an upsetting event), devote the first part of the session to addressing the crisis.
- Redirect patients when needed. Some patients are easily distracted. Let those patients know that you will try to help them follow the agenda and remind them to do so when needed.
- Use the Action Planner in the session.
- Summarize the session at the end and ensure that patients are clear about their goals and understand how to use their “action plan.” Give patients a copy of their “action plan” as a reminder of what they decided to do during the week.

### *Session 1*

Session 1 has three aims:

1. Socialize the patient to *ENGAGE*;
2. Work with the patient to make a list of rewarding social and physical engagement goals;
3. Develop an “action plan” with the patient consisting of 2-3 activities that the patient would like to pursue between sessions.

To socialize the patient to Engage, the therapist first explains the structure of treatment, specifically that they will meet together for 9 sessions lasting 40-50 minutes each. The therapist briefly reviews the patient’s initial PHQ-9 score, most distressing symptoms, and duration of depression. The therapist discusses the importance of weekly PHQ-9 ratings as way to monitor symptoms and the patient’s response to treatment.



The therapist then educates the patient about the connection between social and physical activities and mood, and how it is important to remain active and positive. The therapist explains how the patient and therapist work together in Engage to set weekly social and physical goals by creating action plans in session. The therapist highlights the importance of the patient following through with these action plans out of session, and creating new action plans on the his or her own. The therapist explains that they will review the patient's success or difficulties in completing their actions plans every session. They will identify any barriers to re-engagement the patient experiences so that the therapist and patient can work together to develop strategies to overcome these barriers. The therapist then reviews expectations the patient has about treatment and addresses any concerns about treatment.

The second aim of Session 1 consists of asking the patient about changes in activities due to changes in health, life circumstances (e.g., new caregiving responsibilities), and mood. This discussion is meant to answer the following questions:

1. What activities has the patient dropped and would like to resume?
2. Are there any health concerns or goals the patient has?
3. Are there activities the patient hoped to be pursuing at this stage in life but has not?
4. Are there barriers to achieving the patient's goals?

Based on this discussion, the therapist creates a list of activities that the patient might find rewarding or pleasurable (see Session Materials). The therapist asks the patient to rate how easy or hard they are to pursue, and gives the patient a copy of this list.

After this discussion, the therapist introduces the *Action Planner* and uses this tool to help the patient create a plan for pursuing one or more activities during the ensuing week. For these first three weeks, the selected activities should be simple and easy to achieve.

*Creating Action Plans.*

<u>Action Planning</u>	
1. Select a goal	5. How did it go?
2. Develop ideas for meeting the goal	6. Identify barriers
3. Choose an idea	
4. List steps of action plan	

Completing the

Action Planner involves the following steps:

1. Select a goal. The goal for the week should focus on a social activity, a physical activity, or some other activity that the patient would like to pursue, but has been unable to do so. Examples of goals are:

<u>Social Goals</u>	
Spending more time with family/friends	Volunteering
Meeting new people	Working
Traveling	Resolving a conflict

<u>Physical Activity Goals</u>	
Exercising more (specific exercise)	Losing weight
Gardening	Sports
Finding a Hobby	Managing an illness

<u>Other Activity Goals</u>	
Financial	Spiritual
Legal	Educational
Hoarding/Clutter	

The goal should be clear and succinctly defined, so that the discussion about ways for reaching that goal does not go too far afield. We suggest that in the first three sessions, the focus be on social and physical goals, as the discussion around other goals can be challenging while the patient is still feeling depressed.

2. Develop ideas for meeting the goal. Once the goal has been set, the therapist helps the patient generate ideas to reach the goal. Depressed people often have a difficult time generating ideas, partly because they are discounting the value and effectiveness of their

ideas before adequately defining them. Teaching individuals to creatively think of a range of possible ideas is based on the premise that the availability of many alternatives increases the chances of identifying effective ideas. In other words, the *first idea* that comes to mind is not always the *best idea*. Therefore, it should be emphasized to patients that they should try to generate as many ideas as possible via *brainstorming* techniques. Additionally, ideas should be clear and concise. For instance, if the goal is to socialize with friends more, ideas should be along the lines of “Go to the movies this week with a specific friend,” “Go to a church social,” or “Talk to a friend on the phone.”

It is important that the ideas come from the patient. Sometimes this is difficult for depressed patients to do. If patients cannot generate ideas:

- Ask patients if they are having trouble because they cannot think of ideas or because the ideas that are coming to them are not appealing. If the latter, tell them to write down the ideas, as they can be adjusted to seem more attractive if discussed. You may also ask them what they would recommend to a friend, or what others might recommend to them.
- If patients still have difficulties generating ideas and solutions, you may offer to give them a set of ideas other people have proposed.

3. Choose an idea. Once you have a list of ideas, have patients evaluate them by asking the following questions:

- Is the idea achievable with a reasonable amount of effort and time?
- Could the patient see him/herself pursuing this idea?
- Does it cause other problems?
- Will it meet the patient’s goal?

Based on how the patient answers these questions, the most sound idea will emerge. Sometimes, all ideas are sound and it will be up to the patient to make a judgment about which idea to try first. The session then should focus on planning for its implementation. If the patient’s ideas are unrealistic, you may either have the patient propose more ideas or pick the most sound idea and discuss with the patient how to improve it.

4. List steps of action plan. Once an idea is chosen, the next step is to talk with the patient about specific steps necessary to implement it. This is an important part of the “action plan,” because many people can generate good ideas on how to meet a goal, but have problems implementing them. This is because once the time comes to implement the idea,

patients feel overwhelmed and may even be unclear where to start. Therefore, it is useful to ask patients to describe how they envision implementing their plan. It can be helpful to ask patients to close their eyes and picture themselves engaging in a step-by-step implementation of the plan they selected. Have them then consider:

- Who would be involved?
- Where will the activity take place?
- Is there anything they will need to prepare for the activity?
- When is the best time to start?

Once patients have considered all they need to implement their idea, help the patient list specific steps of the “action plan”. As an example, going to the movies with a friend involves the following steps:

- Calling friends to see when they are available
- Picking a movie and movie time
- Arranging transportation to the movie
- Making sure they have money for the movie.

5. How did it go? After patients implement the plan, they will need to assess how it went and how they felt after they implemented the plan. We provide a visual method for rating the plan, but patients can record their success however they see fit, as long as they evaluate how the plan went.

6. Identify Barriers. Forewarn patients that sometimes plans may not work out at first. Reassure them by indicating that understanding barriers to the plan’s implementation can help modify the plan so that it addresses their own needs. Have them record any barriers; these could be time constraints, feelings of resignation, lack of motivation, or other medical illnesses or disabilities. Discuss these barriers in session and help patients make more effective plans.

## *Session 2*

The purpose of Session 2 is to continue helping patients develop “action plans” and guide them in seeing the connection between re-engagement in rewarding activities and improvement in depressive symptoms. The therapist uses the Action Planner and the PHQ-9 scale, but also keeps a careful eye out for three common “barriers” to successful implementation of planned rewarding activities:

- Emotional dysregulation
- Negativity bias
- Apathy leading to inertia

It is useful to distinguish whether failure to engage in a planned rewarding activity is due to unexpected events or originates from one of the above three “barriers.” See Step 2 for more details on how to recognize these “barriers.” In the initial phases of Engage (session 1 and 2), it may not be necessary to intervene. In addition to identifying and evaluating barriers, it is important to review changes in PHQ-9 depressive symptoms.

### *Session 3: Decision-making*

Before the end of Session 3 (but in some cases in Session 2), the therapist decides if the patient would benefit by continuing to work on Step 1 or needs to move to Step 2. This decision is based on a combination of factors including:

- Engagement in selected rewarding activities
- Ability to complete “action plans”
- Ability to retain focus during sessions
- Changes in PHQ-9 scores
- Subjective patient report of improvement
- Clinical judgment

Criteria for continuing with Step 1 are: a) engagement in selected rewarding activities; b) ability to complete “action plans” despite difficulties with emotion management, negativity bias, and apathy leading to inertia; and c) improvement in mood and functioning ( $\geq 30\%$  reduction in session 1 PHQ-9 score). Patients continuing with Step 1 should be re-evaluated in another three weeks. Patients who are struggling with “action plans” because of emotional dysregulation, negativity bias, or apathy should move to Step 2.

Use the Barrier Rating Scale (see Session Materials) to identify primary barrier.

### *Step 1: Sessions 4-9 (For patients without barriers to “action plans”)*

Continue to work on one to two additional goals for engagement in rewarding activities,

and look for the following cues to identify whether the patient is improving:

1. Use of Engage: Optimally, patients should begin to effectively use the action planning process on their own.
2. Improvement of depression: Use the PHQ-9 to assess improvement of depression. A good number of patients may have 50% reduction in their PHQ-9 scores by week 6 or 7. Some patients may report noticeable improvements in mood and function not reflected in the PHQ-9.

Patients who do not continue to show improvement between Sessions 3 and 6 may move to Step 2 by Session 6.

Use the Barrier Rating Scale (see Session Materials) to identify additional barrier.

***Preparing for termination:*** By Session 8, the therapist should begin discussing treatment termination. Start Session 8 by reviewing progress made in functioning and social and physical activation since the beginning of treatment. Use the Relapse Prevention Planner (see Session Materials) to develop a prevention plan. The relapse prevention plan includes:

1. Early warning signs of an emerging depression;
2. Activities having positive impact on mood;
3. Education on symptoms and signs of depression requiring medical attention.

### ***Step 1: Last Session***

In this session:

1. Review the relapse prevention plan;
2. Provide additional copies of the PHQ-9 mood tracker and Action Planner;
3. Congratulate the patient on completing the Engage program.

## Step 2 – Adding Strategies



This section covers strategies for overcoming depression-related barriers to successful treatment. Specifically, it covers how to decide on which barrier to focus, strategies you can use in-session, and strategies to teach Step 2 patients for managing negativity bias, apathy leading to inertia, and emotional dysregulation.

### Deciding to Move to Step 2

The decision to move to Step 2 should be personalized based on three indicators:

1. *Improvement of depression:* Although 3 weeks may seem too early to make a judgment about treatment response, many patients begin to show some improvements in mood and other symptoms by that time. Move to Step 2 for patients who do not show  $\geq 30\%$  reduction in session 1 PHQ-9 score at session 3.
2. *Ability to complete “action plans” and engage in rewarding activities:* Ability to create and implement “action plans” is a good sign even when improvement of depression is lagging. Examine whether patients can select reasonable goals, identify feasible strategies to meet them, and implement their “action plans.”

Patients who do not fully complete them should be considered for Step 2, even if their PHQ-9 trajectory indicates some improvement in depression. The rationale is that improved mood in the absence of behavioral change is a risk for relapse.

3. *Behavior in session:* Even though a patient may understand the action planning process and their depression score is improving, the therapist may notice that implementation of “action plans” lags because of excessive emotionality. Another patient may understand the first step of Engage and formulate “action plans,” but find them irrelevant to their problems because of a “negativity bias.”

## Deciding on Which Barrier to Focus

As discussed above, there are three common barriers to engagement in rewarding and pleasurable activities: negativity bias, apathy leading to inertia, and emotional dysregulation. The *Barriers Rating Scale* (see Session Materials) is designed to help determine the barriers a patient is experiencing, and should be completed at the end of Session 3 and again at the end of Session 6. If there is more than one barrier, the Scale will guide the therapist on where to focus during Step 2. Be aware that behaviors associated with these barriers often overlap, and it may not always be easy to identify the barrier interfering with treatment.

### *Emotional Dysregulation*

Emotional dysregulation results from inadequate capacity to regulate emotions, and as a result emotions spiral out of control, change rapidly, and overwhelm reasoning. Patients with this presentation will often describe themselves as intense or emotional people, and may be tearful or excessively anxious during sessions. They will have difficulty focusing on discussions of problems or engagement in activities and will often begin talking about past injustices and painful memories. Such patients may benefit from strategies for controlling the impact of their emotions on goal-directed behavior. What follows are signs that the therapist should look for to determine whether emotion management difficulties are barriers to treatment success.

#### *In-session signs:*

- Does the patient become emotionally overwhelmed to the point that you cannot



maintain a treatment focus?

- Does the patient become easily anxious, angry, or sad while talking about problems or activities?
- Does the patient recall memories from the past that become emotionally overwhelming?

### *Between-session signs:*

- Are “action plans” not initiated or completed because the patient becomes too anxious or upset while pursuing them?
- Does the patient report continued problems with controlling emotions even when engaged in activities?

### *Negativity Bias*

Negativity bias refers to selective attention to negative rather than positive information and experiences. On a behavioral level, negativity bias is evident:

- When given positive information and negative information about another person, the patient’s net judgment about this person is negative, rather than balanced.
- If a patient has a good experience and a bad experience close together, he/she will feel upset and will discard the good experience.
- Negative information has greater impact and attracts more attention than positive information of similar weight. A positive event receives less attention than a negative event.
- When put in a novel environment, a person immediately notices the threats instead of the opportunities.

### *In-session signs*

- Does the patient only focus on negative aspects of a situation and seem unable to consider an alternative perspective?
- Does the patient’s negativity interfere with his/her ability to keep treatment focus?
- Is the patient unable to consider or independently generate positive approaches to meeting his/her goals?

### *Between-session signs*

- Are “action plans” incomplete because the patient did not believe that they could be effective?
- Are “action plans” incomplete because the patient thought of reasons not to engage in the plan?
- Does the patient fail to value the implementation of an “action plan” because another problem occurred during the week and overshadowed the impact of his/her success?

### *Apathy Leading to Inertia*

Apathy refers to lack of motivation interfering with initiation of activities. Apathetic patients quickly lose interest and cannot maintain their focus on the task at hand.

### *In-session signs:*

- Is the patient easily distracted?
- Does the patient go off on tangents when talking about goals?
- Does the patient seem disorganized?

### *Between-session signs:*

- Are “action plans” incomplete because the patient did not start them?
- Are “action plans” incomplete because the patient was distracted during the week?
- Does the patient fail to use the Action Planner for activities other than those discussed in session?

## Strategies for Emotional Dysregulation

Provide the patient with the pamphlet “Coping with Feelings”.

Strategies for emotional dysregulation can be anything that helps calm emotions, redirect attention away from unpleasant feelings, and promote relaxation.

### Emotional Dysregulation Strategies

Meditation   Relaxation Exercises   Deep Breathing   Prayer   Imagery

Selection of an appropriate strategy should be based on previous experiences helpful to the individual patient. Therapist and patient should weigh the pros and cons of each strategy. The selected strategy should be practiced first in session and then between sessions so that patients master these techniques and can employ them when they begin to feel overwhelmed. To this end, we recommend that patients find a quiet time and place to practice the selected emotion management techniques for about 10-15 minutes a day. Patients should record their mood before and after practice. They should also be instructed to incorporate these strategies before each step of the “action plan”. Below is an example:

*Ms. M is a 75 year depressed woman who complains of being socially isolated. She has picked as her goal to call an old friend she is comfortable talking to and go out for coffee. When she tried to implement this plan, however, she became overwhelmed with doubt, anxiety, and sadness; these feelings prevented her from picking up the phone to call her friend. Ms. M and her therapist agreed to practice imagery exercises to help her through her intense emotions when she implements her plan. The Engage therapist instructed Ms. M to imagine a pleasant, relaxing scene (for her it was laying on a warm beach). Ms. M even brought in a picture of one of her favorite vacations to the beach to help her visualize the scene. Ms. M and the therapist used this imagery exercise to help Ms. M manage her excessive emotionality during Engage sessions. Below is Ms. M’s new action plan:*

**Plan: Who is involved? *Myself and my friend Jane.***

**Where will it happen? *I will call Jane on Monday at 2PM, and will set up a time to have coffee, e.g. on Tuesday in the morning, around 10-11 am.***

**When will you start? *I will get ready for the call by first thinking about the beach to help me relax.***

What do you need? *Jane’s phone number, a phone, my script, and my beach picture.*

Steps:

- Spend 5 minutes looking at my picture, then close my eyes and relax*
- Dial up Jane*
- Ask Jane right away for coffee*
- On Tuesday, before the coffee meeting, practice with beach picture to calm my nerves.*
- Meet Jane*

After you determine that non-response to treatment is due to emotion management difficulties, you will need to discuss your observations with the patient. The feedback should be structured using what is called “*The Feedback Sandwich*.” The feedback sandwich starts with positive observations, continues with discussion of challenges, and ends with positive “action plans.” This method of providing feedback has been found to be helpful in a various forms of communication, and therapy is no exception. For example:

*Ms. J, it is time for us to review your progress together. I want to start by saying that I see you really trying hard to overcome your depression, and you come up with creative ideas for doing so (positive feedback). I also notice that when we talk about your “action plan” you become overwhelmed when you are trying to think of ideas to get more engaged. I have also noticed the same when you try to make an “action plan.” Do you agree? Does that sound like the main problem to you (discussion of the challenge)? This is common in many people with depression. I think together, we can come up with a way to help you get a better handle on your feelings so that they do not get in the way of you feeling better and getting more connected with people. There are a number of strategies that are helpful, let’s talk about the pros and cons of each (ending with positive plan).*

The next step is to generate a set of strategies and select among them those that the patient feels most comfortable using. For some strategies, you may have to teach the patient how to use them in the initial session of Engage Step 2. A training guide for such strategies appears in the Session Materials section. Strategies requiring initial patient training are:

- Relaxation Exercises
- Mindfulness Meditation
- Deep Breathing

Prayer and imagery are relatively easy to do, but may still require practice. Patients will need to practice their chosen strategies between sessions (at least 10 minutes daily) and use them when they complete their “action plans.” See Step 2 session structure for how to incorporate these strategies into the session structure.

## Strategies for Negativity Bias

Provide the patient with the pamphlet “Coping with Pessimism”.

Strategies for coping with negativity bias help patients evaluate their situation in a balanced way, recognize when they are excessively focusing on negative information, and draw their attention to neutral or positive aspects of the situation. In Engage, we use modified cognitive-behavioral strategies to overcome this barrier. However, instead of applying these cognitive behavioral strategies in all situations, we ask patients to use them specifically when they encounter difficulties in their “action plans”.

Choice of one of the following 3 strategies depends on the patient’s preference and your clinical judgment.

### Negativity bias strategies

Devil’s Advocate

Weighing the Evidence

Practice Having a Positive Focus

***Devil’s Advocate:*** The Devil’s Advocate technique is one way to help patients counteract their negative thinking. The following are instructions to patients:

1. Write down the reasons for *not* using your “action plan”;
2. Think of the opposite view: What would you say to get someone else who is making the same negative argument about following through with the “action plan”?
3. Organize the positive arguments and refer to them whenever you feel like abandoning the “action plan.” You can also use the Argument Worksheet in the Session Materials section.

***Weighing the Evidence:*** Using the Weighing the Evidence worksheet in the Session Materials section, ask patients to:

1. Estimate the probability that their worst expectations will come true.

2. Think back of all the times they engaged in a similar activity and ask them to recall how often they actually experienced the expected negative outcome. Estimate if that was less or more than half the time.
3. Engage in the “action plan” and then document if the negative outcome actually occurred. Point out to the patient the difference between their expectations and the actual outcome.

Here is an example:

*Ms. B is a 68 year old woman with chronic depression and clear negativity bias. Her “action plan” had been to go to her ballroom dancing classes on a regular basis, not just when she felt like it (she almost never went). She indicated that she was too depressed to go to ballroom dance, and told her therapist that she had a lousy time each time she felt like this. The therapist said, “So you believe that there is a 100% chance of you having a bad time if you went to class today?” to which Ms. B agreed. Then, the therapist said to Ms. B: “Think back of all the times you went to class despite feeling depressed. Did you always have a lousy time? Did you ever have a good time?” Ms. B said that she did not always have a bad time, sometimes dancing distracted her from her depressive thoughts and she did feel better after class. Ms. B and her therapist then agreed that if she went to class that day, she would have a 75% chance (but not 100% chance) of having a lousy time. Her “action plan” was to go to class and see how it went. Ms. B and her therapist agreed that she would stay in class for at least ten minutes, and if she was having a lousy time, she could tell her instructor that she had a headache and leave class. In the week after this session, Ms. B went to class, and reluctantly reported that she was able to enjoy it.*

***Practice Using a Positive Focus:*** Having a positive focus is the brain’s tendency to seek out and pay particular attention to pleasurable and positive cues. Positive thinking is muted during depression, and depressed patients need to work hard to restore it. Patients who chose to counteract their negativity bias by engaging in positively focused thinking may benefit from practicing the strategies listed below until they feel comfortable with them and are able to make them part of their “action plans.”

- **Think outside yourself.** Imagine trying to give other people reasons to pursue your “action plan.” Think about less negative statements that offer more realistic expectations about your “action plan’s success.
- **Keep a “negative thought log.”** Jot down in a notebook any negative thought that comes up while implementing an “action plan.” Review it from time to time and ask yourself if your negativity was truly warranted. Ask a friend or me to go over

your log with you so that you can have a second opinion.

- **Changing perspectives.** Review your negative thought log. Then, for each negative thought, write down something positive or find an alternative explanation. For instance, “My boss hates me. He gave me this impossible task to do.” could be replaced with “My boss must have a lot of faith in me to give me so much responsibility,” or “My boss has given me so much work because this is an important project with a short deadline.”
- **Socialize with positive people.** Notice how people who always look on the bright side deal with challenges, even minor ones. Then consider how you would react in the same situation. Even if you have to pretend, try to adopt their optimism and persistence when implementing your action plan.

## Strategies for Apathy Leading to Inertia

Provide the patient with the pamphlet “Improving Concentration and Disorganization”.

The very process of creating an “action plan” can help depressed patients with mild apathy. However, patients with significant apathy may need to add prompts for initiating their “action plans.” Examples of such prompts include:

- Checklists for complex “action plans”;
- Signs and equipment necessary for daily activities in full view in the patients’ homes;
- Labels and electronic devices to signify the time to initiate an “action plan”;
- Calling the patient during the week to prompt the “action plan”;
- Involving family and friends in the “action plan” as prompts to initiate it;
- Starting the “action plan” in session.

Apathetic patients often lose their focus soon after they start implementing an “action plan.” Most of the work for managing the loss of focus needs to happen in session. The therapist should work with the patient to create cues that can be used to redirect the patient back onto task. Strategies we have used effectively are:

- “Time out” signs to interrupt patients when they go off into tangents;
- Ask patients if what they are talking about is related to achieving their goal.

At home, patients who lose focus easily may benefit from the removal of distracting items from their environment, e.g., designating one place at home where they can review and complete their “action plans” and other between-session work.

## Step 2 Session Structure

Sessions 4-6 are similar to each other and use the same session structure detailed in Step 1, but also include:

1. Selecting and practicing the barrier strategies;
2. Including strategies for overcoming barriers in the “action plan.”

### *Step 2: Session 4 and 5*

Session 4 begins with a discussion of your observations about barriers interfering with implementation of “action plans.” Then identify strategies to address the barrier the patient and you believe interferes most with implementation of “action plans.” Some strategies (emotion management and negativity bias) require some practice. Leave 10 minutes at the end of session to add the selected strategy to an existing “action plan.” The new “action plan” will consist of:

- The goal and the plan for accomplishing it;
- The strategy to overcome the barrier to plan implementation;
- Time for the patient to practice those strategies.

Provide the patient with the appropriate Step 2 pamphlet.

Session 5 focuses on the implementation of the new strategies and “action plans.” You should continue to observe whether the patient now becomes able to better implement the “action plans” and shows improvement in mood.

### *Step 2: Session 6, Decision-Making*

By the end of this session, the therapist decides whether the patient can benefit by continuing Step 2 treatment or needs to move to Step 3.

*Criteria for Continuing in Step 2:* Engage offered according to Step 2 should continue unchanged, if the following conditions are fulfilled:

1. Has the patient begun to use “action plans” on his/her own?
2. Did the patient benefit from the Step 2 strategies to overcome his/her barrier to forming and implementing “action plans”?



3. Does the patient improve by  $\geq 30\%$  in his/her session 1 PHQ-9 score by week 6?
4. Does the patient report noticeable improvements in mood and functioning?

Patients who do not show such improvements should move to Step 3. Step 3 consists of techniques targeting barriers in addition to those used during Step 2. Step 3 techniques are selected from the same list of strategies for Step 2. However, they should be other than the strategy used in Step 2 that was unsuccessful.

### ***Step 2: Sessions 7-9, Continuing with Step 2 strategies to overcome barriers***

Continue to use the Action Planner in sessions 7 through 9, work on one to two additional goals each week using the selected technique for barrier mitigation during Step 2. By session 8, it is time to begin discussing termination and relapse prevention. Additional tasks for Session 8 and for the final 9<sup>th</sup> session are the same as those described above in Step 1 Section (under Preparing for Termination and the Last Session).

## Step 3 – Adding More Strategies



### Deciding to Add Strategies at Step 3

As discussed above, the decision to move to Step 3 is made by the end of Session 6. By this time, the therapist is in good position to judge what additional barriers the patient is facing when implementing or failing to benefit from “action plans.” If “action plans” are created thoughtfully and strategies to overcome behavioral barriers are mastered, patients should be able to implement and benefit from their “action plans” by six weeks. Patients who fail to complete them partially or fully should be considered for Step 3 strategies, even if their PHQ-9 score is dropping. The reason is that improved mood in the absence of behavioral change is likely to be temporary.

### Selecting a Barrier in Step 3

The process for selecting barriers to target in Step 3 and the selection of strategies to address them is the same as in Step 2. Use the Step 3 Action Planner to add strategies to the treatment plan and help the patient practice these strategies during each session.

## Step 3 Session Structure

### *Step 3: Sessions 7-9*

At the beginning of Session 7, the therapist discusses with the patient observations about additional barriers interfering with implementation of “action plans.” Together, therapist and patient decide on additional strategies and integrate them into the “action plans.” The new “action plan” now consists of:

- The goal and accompanying plan;
- The additional strategy targeting the most common barrier to implementation;
- Time for the patient to practice those strategies.

Provide the patient with the Step 3 pamphlet.

Continue to use the Action Planner in sessions 7 and 9. Work on one to two additional goals each week using the selected technique for barrier mitigation during Step 3. Additional tasks for Session 8 and for the final 9th Session are the same as those described above in Step 1 Section (under Preparing for Termination and the Last Session).

### **Does the Patient Need a Different Type of Care?**

This question should be asked throughout treatment and for all patients regardless of the Engage Step required. However, a definite decision should be made by session 8 and shared with the patient. Some patients will need a different type of care, be it antidepressants, a different kind of psychotherapy or other treatments. This way by session 9, the therapist will have a treatment plan and potential referrals to appropriate providers and services.

## Chronic pain, sleep, and hospitalization



This section briefly covers other barriers to successful treatment and how to address them. Pain, sleep and medical illnesses are all common in late life and may interfere with the success of any depression intervention. We briefly discuss each barrier below and their management during Engage.

***Chronic Pain:*** Patients who had no medical evaluation for chronic pain management should receive appropriate referrals. If a patient has been evaluated and treated but still experiences pain, the therapist may integrate chronic pain management strategies into the Engage treatment plan so that pain does not interfere with the implementation of “action plans.” If a patient avoids an “action plan” on the days in which the pain is most intense, the therapist should plan for “pain day” alternatives, i.e., activities that the patient can pursue despite being in pain.

***Insomnia:*** Sleep difficulty is another common problem in late-life depression. Like chronic pain, insomnia patients may benefit from a sleep evaluation, as some may have sleep problems in addition depression-induced insomnia (e.g., sleep apnea). If the insomnia is mainly related to depression, there are a few sleep hygiene strategies that can help (see Session Materials section). The therapist should encourage patients to use these strategies, as better sleep will give the patient more energy to pursue their “action plans.”

***Illness/hospitalization:*** Hospitalization can interrupt therapy. If the hospitalization is brief and does not require a lengthy post hospitalization recovery period, you should be able to pick up treatment where you left off. However, if the hospitalization or recovery period lasts more than three weeks, you may have to start Engage all over again. Remain in contact with the patient while they are in the hospital to maintain the therapeutic rapport; chances are, they will need your support.

## Session Materials



## Engage Therapist Session Note

Therapist: \_\_\_\_\_

Patient ID: \_\_\_\_\_

Date: \_\_\_\_\_

Step Number: \_\_\_\_\_ Session#: \_\_\_\_\_

**Materials Given:**

- Action Planner
- Step 1 educational materials
- Step 2 or 3 educational materials
  - Emotion management difficulties
  - Negativity bias
  - Apathy leading to inertia

**Severity Ratings:**

- PHQ-9 Total Score: \_\_\_\_\_ Sleep Score: \_\_\_\_\_ Suicide Score: \_\_\_\_\_

**“Action Plan” review:**

- N/A, session 1
- Primary action plan completed, additional plans created
- Primary action plan completed, no additional plans created
- Primary action plan partially completed
- Primary action plan not completed
  - Too sick
  - Too distressed
  - Didn't think it would help
  - Too many competing demands
  - Forgot

**New “Action Plan”:**

- Activity discussed and planned:  
\_\_\_\_\_
- Activity discussed but not planned:  
\_\_\_\_\_
- No Activity discussed or planned. Explain:  
\_\_\_\_\_
- Termination session; discussed goals and completed relapse prevention plan

**Barriers—only fill out if step 2 (one barrier) or step 3 (two or three barriers)**

Barrier 1: \_\_\_\_\_ Strategies used: \_\_\_\_\_

Barrier 2: \_\_\_\_\_ Strategies used: \_\_\_\_\_

Barrier 3: \_\_\_\_\_ Strategies used: \_\_\_\_\_

**Therapist Comments:**

**ENGAGE Activities List**

Please identify as many possible pleasurable/meaningful activities as you can, and rate them for difficulty (E=Easy, M=Medium, H=Hard).

1)

2)

3)

4)

5)

6)

7)

8)

9)

10)



**ENGAGE Action Planner**

1. My goal is: \_\_\_\_\_

2. Ideas for meeting my goal:

Idea 1: \_\_\_\_\_

Idea 2: \_\_\_\_\_

Idea 3: \_\_\_\_\_

3. Choose best idea (most feasible and most rewarding):

\_\_\_\_\_

4. List steps (What will you do? When? For how long? Who is involved? Where will it happen? What do you need?):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please complete the questions below *after* you have engaged in your activity.**

5. How did you do in achieving your goal?



6. If you couldn't do your plan, what got in the way? \_\_\_\_\_

\_\_\_\_\_

## Barriers Rating Scale

### *Emotional Dysregulation Barriers*

AR Score \_\_\_/6

When the patient tries to implement an “action plan,” does s/he:

- Become anxious?
- Become overwhelmed by the task?
- Worry about failure?

When the patient is in session, does s/he:

- Cry easily?
- Become anxious when talking about problems or goals?
- Become visibly upset by the idea of implementing an “action plan”?

### *Negativity Bias Barriers*

NB score: \_\_\_/6

When the patient tries to implement an “action plan,” does s/he:

- Become pessimistic about the plan?
- Come up with potential problems that were not discussed in session?
- Evaluate successful implementation negatively?

When in session, does the patient:

- Seem overly focused on negative information?
- Have difficulty considering the potential for a positive outcome?
- Have trouble thinking of ideas to meet goals because s/he believes nothing will work?

### *Apathy Leading to Inertia Barriers*

CC Score: \_\_\_/6

When the patient tries to implement an “action plan,” does s/he:

- Have trouble starting the plan?
- Experience too many weekly distractions to focus on the plan?
- Seem to forget to do the plan?

When in session, does the patient:

- Seem disorganized and have trouble focusing on one thing at a time?
- Become easily distracted?
- Have trouble with structured tasks?

**ENGAGE Action Planner (Step 2)**

1. My goal is: \_\_\_\_\_

2. Ideas for meeting my goal:

Idea 1: \_\_\_\_\_

Idea 2: \_\_\_\_\_

Idea 3: \_\_\_\_\_

3. Choose best idea (most feasible and most rewarding):

\_\_\_\_\_

4. Barrier Strategy is: \_\_\_\_\_

5. List steps (What will you do? When? For how long? Who is involved? Where will it happen? What do you need?):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please complete the questions below *after* you have engaged in your activity.**

6. How did you do in achieving your goal?



7. If you couldn't do your plan, what got in the way? \_\_\_\_\_

\_\_\_\_\_

**ENGAGE Action Planner (Step 3)**

1. My goal is: \_\_\_\_\_

2. Ideas for meeting my goal:

Idea 1: \_\_\_\_\_

Idea 2: \_\_\_\_\_

Idea 3: \_\_\_\_\_

3. Choose best idea (most feasible and most rewarding):

\_\_\_\_\_

4. Barrier Strategy is: \_\_\_\_\_

5. List steps (What will you do? When? For how long? Who is involved? Where will it happen? What do you need?):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please complete the questions below *after* you have engaged in your activity.**

6. How did you do in achieving your goal?



7. If you couldn't do your plan, what got in the way? \_\_\_\_\_

\_\_\_\_\_

## Argument Worksheet

### Playing the Devil's Advocate

Write your reasons for not doing your “action plan” here:

---

---

Write down why your reasons are not good reasons here:

---

---

### Getting Your Arguments in Order

List three good arguments you can use to help you do your “action plan”:

(1)

(2)

(3)

Look at these arguments whenever you start to consider not doing your “action plan.”

**Weighing the Evidence**

Activity	Predicted likelihood of bad outcome (%)	Past experience	Actual experience

**Changing Perspectives**

- a. How can I view the situation from a different perspective?
- b. How might other family members or friends have thought about or reacted to a similar situation?
- c. Think of someone optimistic whose opinion you highly value. How would s/he perceive the situation?

# Cheat Sheet for Emotion Management

1. Set aside 10 minutes every day.
2. Find a quiet spot where you will not be bothered.
3. Record what your tension level is.
4. Close your eyes and take five slow and deep breaths.
5. Start your practice.
6. End your practice.
7. Record your tension level.

## My practice plan is:

Relaxation  Imagine  Meditation  Prayer

Tension	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Before							
After							

Tension	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Before							
After							



## RELAXATION TRAINING

Close your eyes and think of a beautiful picture that makes you relax.

Take a deep breath through your nose, like filling your stomach with air.

Hold your breath and count to 5.

Exhale slowly until all air is out (sometimes as you exhale, it may be helpful to whisper a word slowly, for example “relax”).

Wait for 15 seconds.

Repeat.

Please practice these exercises according to the therapist’s recommendations before you apply them in an anxiety provoking situation.

Write down your thoughts and feelings and rate the effectiveness of the exercises on a scale of 1-10 (1=not effective; 10=most effective) after each training session.

Please be aware that there may be an increase in anxiety in the beginning of the training sessions before the exercises are effective.

## SLEEP HYGIENE

- 1. Do not go to bed unless you are sleepy.** If you are not sleepy at bedtime, then do something else. Read a book, listen to soft music, or browse through a magazine. Find something relaxing, but not stimulating, to take your mind off of worries about sleep. This will relax your body and distract your mind.
- 2. If you are not asleep after 20 minutes, then get out of the bed.** Find something else to do that will make you feel relaxed. If you can, do this in another room. Your bedroom should be where you go to sleep. It is not a place to go when you are bored. Once you feel sleepy again, go back to bed.
- 3. Begin rituals that help you relax each night before bed.** This can include such things as a warm bath, light snack or a few minutes of reading.
- 4. Get up at the same time every morning.** Do this even on weekends and holidays.
- 5. Get a full night's sleep on a regular basis.** Get enough sleep so that you feel well-rested nearly every day.
- 6. Avoid taking naps if you can.** If you must take a nap, try to keep it short (less than one hour). Do not take a nap after 3 p.m.
- 7. Keep a regular schedule.** Regular times for meals, medications, chores, and other activities help keep the inner body clock running smoothly.
- 8. Do not read, write, eat, watch TV, talk on the phone, or play cards in bed.**

**9. Do not have any caffeine after lunch.**

**10. Do not have a beer, wine, or any other alcohol drink before bedtime.**

**11. Do not have a cigarette or any other source of nicotine before bedtime.**

**12. Do not go to bed hungry, but don't eat a big meal near before bedtime.**

**13. Avoid any exercise within six hours of your bedtime.**

You should exercise on a regular basis, but do it earlier in the day (talk to your doctor before you begin an exercise program).

**14. Avoid sleeping pills, or use them cautiously.** Most doctors do not prescribe sleeping pills for periods of more than three weeks. Do not drink alcohol while taking sleeping pills.

**15. Try to get rid of or deal with things that make you worry.** If you are unable to do this, then find a time during the day to get all of your worries out of your system. Your bed is a place to rest, not a place to worry.

**16. Make your bedroom quiet, dark, and a little bit cool.**

An easy way to remember this: It should remind you of a cave. While this may not sound romantic, it seems to work for bats. Bats are champion sleepers; they get about 16 hours of sleep each day. Maybe it's because they sleep in dark, cool caves.