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Applying a Process-Oriented Model of Cultural Competence to Behavioral Activation for Depression

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Abstract

Efforts to integrate cultural competence and evidence-based treatments (EBTs) typically take the form of cultural adaptations of EBTs, characterized by modifications to the existing treatment based on presumed cultural notions of a given race or ethnic group. Much less attention has been given to ways EBTs can integrate a process model of cultural competence, which focuses on what clinicians do in-session to identify and integrate key cultural factors for a given individual in the treatment. Our objective is to consider how a process model of cultural competence (Shifting Cultural Lenses) can be integrated with an EBT (Behavioral Activation). We present a theoretical rationale for integrating the SCL model with BA and illustrate this integration, which clinician provides an additional approach to bringing culture to treatments and shows promise for identifying clinicians' in-session behaviors that reflect cultural competence.

Keywords

cultural competence; Shifting Cultural Lenses Model; Behavioral Activation

Major mental health organizations have called for an increased focus on cultural factors as they relate to psychotherapy (American Psychological Association, 2017). Attention to these factors in the treatment of depression is needed as the disorder presents a significant public health burden globally (Marcus et al., 2012). Cultural adaptation of evidence-based treatments (EBTs) represents the dominant approach to integrating culture in the treatment of depression. Cultural adaptations are characterized by modifications to existing

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interventions that facilitate the use of cultural knowledge and intervention strategies that are especially useful in working with a given racial or ethnic group to increase the intervention's attention to cultural matters while protecting the intervention's core ingredient (Cardemil, 2010). The use of such culture-specific expertise is critical to cultural competence (Sue, 1998) and its application in cultural adaptations represents a major strength of this cultural competence strategy. Cultural adaptations effectively produce changes to behavioral health outcomes for ethnic minorities across a range of disorders and mental health problems (e.g., Hall et al., 2016), including depression symptoms (Chowdhary et al., 2014).

There are, however, four significant interrelated limitations to solely relying on a cultural adaptation approach to provide culturally competent care. First, the cultural adaptation approach tends to treat culture in a fixed group-based manner that may limit the flexibility of the intervention in adapting to the variability in clients' cultural perspectives (López et al., 2020). The focus on ethnic and racial groups as the basis of culture risks promoting stereotypical thinking about individuals from given groups. Second, cultural adaptations do not acknowledge and address the intersectionality of vast contexts, such as cultural, structural, historical, sociobiological, and social conditions, that give shape to individual identity/ies (Howard & Renfrow, 2014), in line with the most recent multicultural guidelines (American Psychological Association, 2017). In doing so, cultural adaptations can fall short of capturing the diverse ways social context can influence an individual and, by extension, the therapy process. Third, the cultural adaptation method is not well positioned to consider how social cultural processes play out for a given individual. It risks promoting what Kleinman and Kleinman (1991) refer to as caricatures of experience.

Another method for integrating culture within interventions is the process approach. Process-oriented models focus on the individual-level cultural meaning assigned to clinical matters (e.g., problem behaviors or treatment methods), with less attention to group-level components of culture and how they matter for different groups (see Huey et al., 2014). An advantage of the process approach is that it can flexibly accommodate cultural perspectives as defined by the individual, which may not be based on the individual's presumed ethnic and racial group. Moreover, the principles and skills of a process approach can be applied to persons from various sociocultural groups across multiple identities with an emphasis on intersectionality. There are, though, sparse data about process models' efficacy or effectiveness (Huey et al., 2014). A review of cultural competence models indicated that almost no process models have been tested in controlled trials with clinical samples. Moreover, data on whether clinicians can implement the skills outlined by the models is scarce. Very few studies have shown that a given process approach or its components distinctly accounts for observed outcomes (Huey et al., 2014).

Adopting a process-oriented approach can help circumvent the potential drawbacks of depending solely on group-based notions of culture to engage in culturally competent practice. Taking this path is consistent with Sue's (1998) conceptualization of essential ingredients for culturally competent psychotherapy and counseling. In addition to proficiency in working with specific sociocultural groups, a culturally competent clinician applies skills that are useful in working with diverse individuals. These include being scientifically minded and exercising skills in dynamic sizing. Scientific mindedness refers to

the clinician's formulation of hypotheses rather than premature conclusions about a client given his or her culture (e.g., Does the treatment's theoretical notion apply to this client?). Dynamic sizing refers to the clinician's skill in determining when to apply group-specific knowledge to a client who identifies with the group and when the knowledge does not apply (Sue, 1998). Process-oriented models and cultural adaptation approaches together support essential components of cultural competence.

We propose the novel integration of a process model of cultural competence,[1] the shifting cultural lenses (SCL) model (López, 1997; Lopez et al., 2002, 2020; Lakes et al., 2006), with EBT techniques that comprise behavioral activation (BA) for depression (Jacobson et al., 2001; Kanter et al., 2009; Lejuez et al., 2001). First, we review conceptualizations and clinician behaviors of both approaches. Second, we consider the extent to which existing BA approaches encourage clinicians to engage in cultural competence processes. Third, we discuss what SCL can add to BA to better integrate a cultural perspective and offer specific ways the SCL's behavioral indicators of cultural competence can be integrated in BA treatment models based on our clinical experiences. We conceive of this exercise as a proof of concept. The successful integration of models is a first step toward evaluating the efficacy and effectiveness of the resulting treatment model.

A Process for Achieving Cultural Competence in Depression Treatment: The SCL Model

López and colleagues' SCL process model makes two important contributions to the study of cultural competence in mental health clinicians. First, it offers a conceptualization of culture and the social world, as well as how clinicians can best integrate their client's sociocultural perspective in treatment (Lakes et al., 2006; López, 1997; Lopez et al., 2002). Second, it specifies clinician behaviors that can facilitate culturally competent care across diverse treatment settings and symptoms (López et al., 2020).

Conceptualization

The SCL model is based on an anthropologically informed definition of culture (López & Guarnaccia, 2000) that draws on Kleinman and Kleinman's (1991) conceptualization of experience:

> Experience may, on theoretical grounds, be thought of as the intersubjective medium of social transactions in local moral worlds. It is the outcome of cultural categories and social structures interacting with psychophysiological processes such that a mediating world is constituted. Experience is the felt flow of that intersubjective medium. In Bourdieu's (1989) terms it is the social matrix out of which habitus is structured and where shared mental/bodily states in turn structure social interactions. Yet, in practical terms, that mediating world is defined by what is vitally at stake for groups and individuals.

[1]We acknowledge there is debate regarding appropriate terminology concerning this field of study. Scholars have proposed utilization of a wide array of terms that includes, but is not limited to, "cultural humility," "cultural awareness," "culturally appropriate," and "culturally sensitive and responsive." Understanding the complexity and nuances of these terms, herein, we utilize the term "cultural competence."

(p. 277)

López and colleagues have drawn on this conception of experience to define culture as *what's at stake*, or *what matters*, in our everyday lives given our lived experiences in local, social contexts (e.g., Lakes et al., 2006). As reflected in this quote, anthropologists define the social world in broad strokes that includes interpersonal (family, friends), community (neighborhood, town/city), and societal (nation and world) perspectives, not unlike Bronfenbrenner's (1986) conceptualization of ecological systems. In addition, anthropologists often consider the historical, political and economic context. For a given client, the historical and political can be most relevant (e.g., living as an undocumented immigrant in a country with anti-immigrant policies, or suffering the historical trauma of indigenous people; Gone, 2009). Our goal in drawing on Klienman and Kleinman's (1991) conceptualization of experience is consistent with past critiques of the cultural boundedness of psychotherapy treatment approaches (e.g., Hall, 2001). We encourage clinicians to move beyond largely psychological models of behavior, cognition, and affect, and incorporate the sociocultural world.

The crux of the SCL model is that of perspective taking, such that the clinician and the client shift between each other's cultural lenses (Kleinman & Kleinman, 1991) in an attempt to co-construct shared narratives (Mattingly & Lawlor, 2001) on various aspects of therapy. Cultural lenses refer to the ways people construct their experience. The model emphasizes the direct assessment of what's at stake for the client given his or her local social world and the consideration of what's at stake throughout the treatment process to facilitate change. For example, what matters to a client might be the implications any given intervention has for the client's family relations. The clinician might then listen carefully to what about the family matters to the client and engage him or her in determining whether and how to include the family in the various aspects of treatment.

SCL's Behavioral Indicators

López and colleagues (2020) specified behavioral indicators to guide clinicians seeking to implement the SCL model. The broad clinician behaviors are to (a) access and integrate the client's view; (b) present their own view and work toward client buy in; and (c) negotiate both views with the client to come to a mutual understanding, or shared narrative, on key facets of treatment. Behavioral indicators (see Table 1) are presented in this paper as a linear process, yet in practice, the process is organic and flexible with different indicators relevant depending on context.

The SCL behavioral indicator, accessing the client's view, refers to the clinician seeking to understand and identify the client's cultural constructions of his or her predicament. The clinician explicitly asks the client for his or her view on any key aspect of treatment, including and not limited to understanding the client's definition of the problem, the problem's cause, and treatment goals, and demonstrating understanding of these views (López, 1997; López et al., 2020). The clinician also integrates the client's perspective into the treatment by incorporating the client's words, notions, models, and ideas into therapy. Obtaining and incorporating what matters is done in the service of supporting change interventions.

Another behavioral indicator is to present the clinician's view on any key aspect of treatment from a position of mutual respect, in such a way that the clinician takes personal ownership of the view instead of presenting it as presumed fact (López, et al., 2020). The clinician also will work toward client buy in by requesting feedback from the client regarding the clinician's perspective, such as the value of utilizing a given treatment strategy. The overall goal of both behavioral indicators is to clearly communicate the importance of the client's voice throughout the treatment process.

The final SCL behavioral indicator is to negotiate both parties' views with the client to derive an agreed-upon understanding, or shared narrative, of key treatment facets. The clinician strives to identify differences in perspectives, explore strengths and drawbacks of each perspective, and arrive at an agreement between the client and clinician on treatment goals and methods (López et al., 2020). It may be that one perspective is favored over another or that a compromise between the two perspectives is forged. The clinician remains open to the possibility that there is a lack of fit between the proposed treatment methods and the client's cultural views (López, 1997), and that considering an additional approach to addressing the client's concerns may be indicated. When client-clinician differences remain for significant treatment issues, the clinician draws from his or her understanding of what matters to the individual and asks the client to consider how a given treatment direction reflects that view (Lakes et al., 2006). The clinician then helps the client match what matters most to the client with a given treatment issue (e.g., goal or intervention method). Ultimately, negotiating a shared narrative involves *meaningfully* considering both client and clinician perspectives in arriving at a shared view or narrative about how to proceed with elements of psychotherapy. Ultimately, the goal is to arrive at shared narratives that align with EBT and that do not compromise treatment integrity.

BA for Depression—BA is an empirically supported approach to depression treatment with a strong research base (e.g., Ekers et al., 2014). Several variants of BA (e.g., further described below; Lejuez et al., 2001, 2011; Martell et al., 2001, 2010), all sharing common core elements (Kanter, Manos, et al., 2010), have been supported for use with culturally diverse samples (e.g., Dimidjian et al., 2011). Because BA's rationale and techniques are purportedly straightforward, concrete, and easy to train and implement, BA's potential for widespread dissemination and implementation has been noted (Kanter & Puspitasari, 2016) and is being realized. BA has been effectively implemented by paraprofessionals (e.g., Moradveisi et al., 2013) in low-resource settings (e.g., Kanter et al., 2015) and by cost-effective providers with relatively little training (Richards et al., 2016).

BA proposes that depression is a function of changes in a person's environment (e.g., negative life experiences) and/or chronically depressing environments that produce decreases in productive, rewarding, personally meaningful, and effective behavior, and increases in avoidant and other ineffective behaviors. Continued engagement in the depressed behaviors perpetuates a spiral into deeper depression (Kanter et al., 2009). BA aims to help clients reverse this spiral, first by assessing the client's life situation and how the client's behaviors function in his or her life, and then by scheduling activities based on this assessment (Kanter et al., 2009).

Contemporary BA approaches, which are described below, emphasize a client's unique experiential history and current context as essential for understanding the function of client behavior and formulating effective treatment. To understand how the client's behavior functions in context, BA clinicians variously employ functional analysis, functional assessment, or other behavioral assessment strategies to hypothesize about and assess the specific variables that maintain the depressed behavior of a client. This assessment then guides the development of an individualized, tailored intervention plan (Jacobson et al., 2001; Lejuez et al., 2001).

Challenges in Fostering Culturally Competent Care in BA

BA's functional, contextual approach to assessment and intervention limits the assumptions the clinician makes about an individual client until the client's behavior is assessed in context. Given this, BA is consistent with cultural competence as defined by process-oriented approaches that are concerned with the meaning ascribed to treatment-related issues based on the client's sociocultural context (Huey et al., 2014). Functional analysis has been said to facilitate incorporation of culture in psychotherapy because it allows a clinician to examine whether group-derived cultural constructs apply to the individual (e.g., Hayes & Toarmino, 1995). Yet, as is discussed below, existing BA manuals do little to guide the clinician toward assessing and understanding the client's cultural context versus other contextual features that are more readily known to the clinician (i.e., proximal and distal antecedents and consequences of a behavior). Cultural views may remain hidden to a BA clinician even if the larger framework within which BA sits is not inimical to a client's sociocultural background. The BA clinician may implement techniques or adopt a therapeutic stance that leads him or her away from understanding the client's cultural perspective and behaving with cultural competence. Most BA manuals lack instructions or provisions when conducting functional analysis that considers a client's idiographic sociocultural perspectives and needs.

BA has additional challenges with respect to fostering care that attends to culture. BA assessment may enable a clinician to develop some understanding of the meaning of events from the client's perspective, but the questions posed may be insufficient for acquiring a full understanding of the client's views. Typically, assessment questions in BA narrowly focus on behavior-environment relations and the information acquired may be limited to what is necessary to achieve activation assignments. For example, a clinician may ask, "What sorts of activities fill your life with meaning, mastery, and pleasure?" Moreover, accessing a client's cultural perspective goes beyond inquiring about the client's definition of the problem, responses to environmental events, and so forth. It requires a synthesis of information acquired through BA-focused questioning, as well as an assessment of the meaning of other aspects of the client's life and spontaneous client disclosures throughout treatment.

A related limitation of BA stems from its structured nature. As is typical of treatment manuals, BA manuals (e.g., Lejuez et al., 2001, 2011; Martell et al., 2001, 2010) guide clinicians to remain focused on BA treatment tasks from session to session. In the context of client disagreement with the rationale or direction of treatment, clinicians are encouraged

to problem solve issues with the client so as to maintain fidelity to the BA agenda. It is uncommon to read in any treatment manual substantial advice on how to engage in a shared decision-making process and address differences in perspective on how to approach treatment. The primary or exclusive focus on BA tasks will necessarily limit the clinician's ability to understand and incorporate the client's perspectives and develop a shared narrative when the client's perspective may be at odds with the BA approach. Some BA manuals (e.g., Martell et al., 2010) guide a clinician to validate a client's disclosures, but they do so with the more limited function of creating a good therapeutic alliance to help advance BA objectives rather than to openly consider the client's alternative approach.

Illustrating the Cultural Challenges in BA

We explore how BA manuals promote cultural competence and how they may fall short of achieving this goal. Consider the the following case of Dora.

Background

Dora[2] was a depressed Latina mother of four young children whose husband worked 6 days a week and was largely absent from family life. The family was working class and lived in a Latinx neighborhood of a large Midwestern city. Dora, who was bilingual in English and Spanish, was overwhelmed by her responsibilities, which consisted of addressing all home and child needs, and navigating social, health, and school services within and outside her community. Until recently, she had successfully managed to address her family's needs. This included helping her children do their homework regularly, attending most school events, and obtaining behavioral and other support for her third child, Michael, who had an autism spectrum disorder diagnosis. In her first session, she said, "I want to be the person I used to be—a strong person who could set any goal and reach it… . Right now it's as if I am missing what used to help me get ahead. It's like I'm getting weaker every day . . "

Dora originated from rural Mexico. She was born and raised until age 16 on a ranch several kilometers outside of the nearest town. She was the third in a family of eight children. While her father, eldest brothers, and other extended male relatives worked in the fields, Dora, her mother, and other female relatives worked within the home. Dora, as the eldest daughter, played a central role in helping her mother prepare family meals and assist with the rearing of her five younger siblings. The family's life was disrupted when Dora's father passed away unexpectedly; they were unable to make ends meet. Dora and two of her brothers emigrated to the United States to earn a better income and help support their family in Mexico. Dora worked 50–60 hours a week for several years, during which time she habitually sent remittances home.

Dora took English-as-a-second-language courses and became relatively fluent in order to earn a better income. Together with her husband, she decided to work at home to meet her family's needs after the birth of her first child. She recalled feeling excited about her new roles as wife and mother. In reflecting on her life, Dora noted, "My parents, especially my

[2]This case represents a composite of several cases. It has been disguised and deidentified to maintain the client's privacy. Accordingly, Dora is a pseudonym for this client.

mother, set a really good example for me. They taught me never to give up and to be strong. My mother always supported my father with what she could and she never complained about it… . For her, it was her duty to help her husband and children get ahead. My mother raised me to be like her and like her mother … That's how women are where I come from … I have been like her for so long … I have supported my husband and children in so many ways. It's all I have wanted to be able to do and what I really want, what I need to do now, for them and myself … I don't understand why I can't do it anymore."

Dora experienced some significant life events during the several months prior to the start of therapy. Dora's son, Michael, had worked for 2 years with an in-school behavioral interventionist who helped him to develop skills to adapt to school demands and reduce behaviors that interfered with those demands. Six months prior to the start of psychotherapy, the in-school interventionist left his position. At the time of Dora's first session, the school had not yet secured Michael a new interventionist. Unfortunately, her son's long-time in-home interventionist also left his position and efforts to replace the interventionist had been unsuccessful as well. Dora's son began displaying greater difficulty functioning at school and at home as his self-stimulation behaviors (e.g., loud clapping) increased, which in turn increased the level of stress experienced by Dora and her other children. Most recently, Dora's eldest son, Ray, started to come home with school notes reporting missing homework and disruptive behavior. Dora began to feel an unprecedented level of fatigue, stress, problems with sleep, and pain in her neck and lower back, which she attributed to poor posture and home chores. Increasingly, she began to think of herself as a weak and incompetent person, not like the strong mother and wife she set out to be years before. Dora began to have difficulty keeping up with her children's school and extracurricular activities, managing household finances, preparing daily meals, and anything else that came her way. She began to avoid social situations (e.g., children's events, family gatherings) that presented the risk of having to talk about her current situation, and she found herself taking breaks and napping during the day. Dora had supportive family and friends in her life, but she believed that there was nowhere to turn, and no one to turn to with her concerns. Dora was reluctant to talk to anyone about her problems, as the thought of doing so made her feel weak and like a complainer.

Dora was referred to the behavioral health unit at her clinic for psychotherapy after she reported the physical symptoms she experienced to her primary care provider. It was only after the third referral that Dora scheduled a psychotherapy appointment.

Initial Case Conceptualization

The BA clinician presented Dora with her view that Dora's depression was triggered by the significant life events she had recently experienced, including the loss of Michael's behavioral interventionists, the worsening of Michael's disruptive behaviors, and the rise of Ray's school problems. Combined, they led her to automatically experience distressing sensations, like increased fatigue, stress, bodily pain; poor sleep and concentration; and thoughts that she was not strong and incapable of fulfilling her roles. When flooded with these experiences, Dora shut down by avoiding friends, family, and acquaintances, and taking naps and other breaks to help herself feel better when the children were out. This,

then, led to Dora having difficulty fulfilling her roles as wife and mother. The clinician emphasized the view that Dora's response to life's uncontrollable events and symptoms, which the clinician called shutting down, could be making her feel even worse.

At the clinician's request, Dora shared her view that the clinician's explanation for why Dora felt as she did made sense to her. The clinician further proposed that, rather than shut down, Dora could experience improvement by responding in alternative, more adaptive ways to the uncontrollable events and internal experiences in her life. Together, they could find ways of effectively responding that were consistent with Dora's goals and with what was important to her more generally. Dora was receptive to the clinician's approach and they proceeded accordingly.

Assessment

Dora's goals included meeting her family's needs (e.g., helping to find behavioral interventionists for Michael, addressing Ray's in-school difficulties) and meeting her needs (e.g., improving sleep) in order to be better able to fulfill her roles. Dora and the clinician used several approaches to help Dora respond more effectively or, put differently, to select activities to schedule and structure from week to week. They monitored Dora's activity to gauge her baseline activity and understand the relationship between her activities and her mood.

The clinician and Dora also carried out an assessment of Dora's values to think about and incorporate activities that could help Dora behave according to her values. They used the Values and Goals Assessment Sheet (Kanter et al., 2011) to first identify the life areas that were particularly important to Dora. Consistent with her disclosures up to that point in therapy, Dora ranked parenting as the most important life area, which was followed by marriage. With the clinician, Dora explored and clarified the type of person she wished to be in each of these areas. In thinking about her role as mother, Dora immediately stated that she deeply yearned to be "a capable mother." The clinician asked her to clarify further what she meant by "capable mother" and Dora stated, "I want to be a mother who is capable of doing whatever is necessary for her children." Given the focus on behavioral specification in BA, they engaged in a conversation about what it would look like if Dora was acting like a capable mother in order to give shape to immediate concrete goals and activation assignments to meet those goals. Their productive conversation led to brainstorming goals that could help resolve Michael's need for behavioral interventionists and address Ray's in-school behavioral issues, in addition to specifying other concrete ways in which Dora could behave like a capable mother. With respect to marriage and her role as wife, Dora wanted to be a more communicative and engaged wife. A consequence of her fatigue and increased downtime was that she spent less time interacting with her husband whenever there was opportunity to do so. In selecting value-based activities, Dora and her therapist sought to focus on the parenting life area.

The clinician and Dora also reflected on Dora's history, current context, and views shared over sessions to select assignments that were meaningful to Dora. The clinician shared her impression that for Dora, it was important to be a strong person, much like her mother. Dora shared that it was very important to her to move forward bravely, without complaining

about her problems, as she had throughout her life. Dora and her clinician set out to select activities that would allow her to meet her goals and that were congruent with what was important for her.

Dora and her clinician also agreed about the utility of reducing avoidance behavior (e.g., social avoidance, naps, and other day breaks) and reengaging in social activities and productive weekday activities, noting that doing so aligned with what was important to Dora. For instance, rather than avoid people in her social network, Dora would attend social gatherings at her children's schools to support their extracurricular activities. In doing so, Dora would live by her value of being a capable mother as she defined it. In putting their heads together, Dora and her clinician also recognized the Herculean effort Dora was putting forth already to support her family, the limited time and energy she had to do all she had to do to meet her goals, and the need to think creatively about how Dora could make use of her resources in new ways.

In this context, the clinician proposed that Dora consider requesting tangible support from important and trusted others. As could be expected, Dora was ambivalent to follow the clinician's suggestion because Dora believed that it went against her value of being a capable wife and mother. The clinician acknowledged the seeming inconsistency between the activity and Dora's values, and noted that the suggestion seemed to conflict with Dora's desire to be a strong person. Over the course of the first couple of sessions, Dora redefined what it meant to be a capable wife and mother and a strong individual. Dora arrived at the view that one way of demonstrating that she could carry out her roles effectively and in a way that demonstrated strength was precisely by making good use of resources at her disposal, including social supports. Ultimately, Dora bought into the idea of including help-seeking activities in her treatment plan.

Treatment

Over the first few sessions and after experimenting with a few variants of the treatment plan, Dora carried out the challenging activities of requesting help from a close friend, relative, and neighbor as part of a larger activity plan. However, pronounced barriers seemed to interfere with activities that involved requesting support from her husband, Benjamin. Dora's initial activity of this type involved asking Benjamin for help with managing bills once he arrived home from work and had an opportunity to eat dinner. Together, they wondered whether Dora did not complete the assignment because it was scheduled during a time when Benjamin appeared particularly tired and Dora felt especially concerned with not burdening him. The revised plan involved Dora asking for help when Benjamin was well rested—after breakfast the morning of his day off from work. At the next session, Dora again reported that she completed all activities except the one involving Benjamin. They revised the plan once more and, again, Dora did not ask her husband for help.

The clinician considered various possibilities. Perhaps Dora's pronounced avoidance of asking others for help, which initially interfered with other help-seeking activities, was again interfering with BA. What if Dora's value of being a capable wife as defined early in session, and her deep desire to be strong were particularly salient in the context of this activity? The clinician began her exploration with a focus on avoidance. The clinician

hypothesized that, when faced with the activity of asking her husband for help, Dora came in contact with especially aversive feelings and thoughts of worthlessness (e.g., “What am I here for then? What am I, weak?”), which she had to varying degrees in the past whenever the idea of asking for help from anyone surfaced.

CLINICIAN (C): What happened for you as you waited for Benjamin to finish up his breakfast to ask him for help with keeping track of the bills?

DORA (D): I started feeling depressed, like there’s no hope, and just bad about myself again … I thought, “I’m so useless and weak … Why can’t I just get things done?”

C: It sounds like you started having those very familiar feelings and thoughts you’ve had before, the ones that have made it pretty hard for you to reach out to others for help in the past.

D: Yeah …

C: Are these thoughts and feelings getting in the way again?

D: They are definitely making it hard.

C: You’ve been able to face these thoughts and feelings and ask others for help … How is this situation, which involves asking Benjamin for help, different from situations in which you have asked others for help?

D: It’s just harder, a lot harder … I think of asking Benjamin for help and I feel … just so bad … I feel even more depressed, just more convinced that I am just weak … I keep thinking that I don’t want to ask him for help. When I’m here, I think, “I should ask him for help.” But when I get home, I just really don’t want to, it doesn’t feel right.

C: It sounds like those familiar thoughts and feelings are stronger, maybe much stronger with Benjamin than with others. I wonder whether these stronger thoughts and feelings led you to decide not to ask for his help as planned.

D: Yeah, I think so.

C: I think it might help us to better understand why it’s different with Benjamin or why you keep thinking that you really do not want to ask him for help. Can we explore that a bit?

D: (*Sighs.*) If you think it can help … but … the more I think about it, the more I think it’s the right thing for me not to ask Benjamin for help. I asked Laura and Mayra for their help and it was good for me … I can honestly say that it’s been good for me. I don’t feel alone, and I also don’t feel weak because I asked them for help … I feel okay doing that now. I know it’s good to do that. But with Benjamin, it’s different. I know I want to keep figuring out how to take care of my family like I’ve learned how to do here, but without asking for his help.

C: I hear that you feel very strongly about not moving forward with this activity. That's coming through very clearly. (*Pauses*.) As you know, I strive to be open and honest with you and tell you when I think there is something important to consider or just reflect on. With that in mind, if it's okay with you, I'd like to share my thoughts about what it could mean for your avoidance patterns to move forward as you propose. Can we spend just a few minutes on that?

Analysis

Upon learning that Dora had been unable to move forward with asking her husband for help, the clinician sought to understand with an open-ended question why Dora had been unable to complete the activitiy. The clinician's exploration allowed the opportunity for Dora to guide the direction of the discussion. Dora focused the conversation on the automatic internal experiences that surfaced in the moment in which she was set to carry out her activity. The clinician took the client's cue and began to delve into Dora's thoughts and feelings, and the role they played. The clinician presented Dora with another open probe that allowed the opportunity to explore what else might be contributing to her behavior and, again, Dora focused heavily on her thoughts and feelings. The clinician's attention to the prominent content in Dora's response is reasonable for at least three reasons. First, addressing Dora's salient responses allowed the clinician to communicate to Dora that the clinician was interested in Dora's perspective. Second, it permitted the clinican's actual consideration of Dora's perspective. Third, the clinician was adhering to BA manuals by concentrating on client disclosure about private experiences that preceded target behavior. As stated above, BA manuals emphasize conducting BA efficiently, in which a focus on activation is maintained in sessions throughout treatment. By exploring thoughts and feelings that arose for Dora, the clinician laid a foundation for future discussion centered on activation-focused topics, such as decreasing mood-dependent behavior, decreasing avoidance, and troubleshooting barriers to activation (e.g., Martell et al., 2010).

In maintaining an activation focus, the clinician moved away from examining other factors that may have contributed to Dora's decision to not request her husband's help. Certainly, the clinician's probes could have led to the exploration of other factors. However, the clinician was presented with an opportunity to move the discussion from thougths and feelings to other potential contributors. In that moment, the clinician could have asked Dora, "Why does asking Benjamin for help not feel right?" Albeit briefly, the clinician instead continued to focus on thoughts and feelings before shifting to explicitly suggest that they explore the reasons for why Dora did not want to ask Benjamin for help, and finding that Dora was ambivalent about doing so by that point.

Prior to this moment, the clinician could also have drawn from prior discussions with Dora about what was important to consider in working toward improvement. Prominent in Dora's narrative was her desire to embody qualities she observed in her mother: to be strong, carry out her roles bravely and without remonstrance, and be a supportive mother and wife. Dora and the clinician developed a treatment plan that attended to Dora's value of being strong, but paid less attention to other ways of being that Dora had a desire to demonstrate day-to-day. In seeking to understand why asking her husband for help did not fit for Dora,

it could have been fruitful to discuss with Dora the possibility that the activity contradicted what mattered deeply to her, like helping her husband get ahead. Thus, rather than just ask what about asking her husband for help did not feel right, the clinician could have also gone further and stated, “I am also wondering whether something else came up for you and led to your decision not to ask for his help. Early on in our work together, you shared with me that it was very important for you to be a supportive wife … to be there to help Benjamin get ahead in life. Is it possible that the activity of asking for his help does not quite fit with the idea of helping him to get ahead?”

From a BA perspective, the clinician’s decision to discuss Dora’s internal experiences was perfectly reasonable, as was the decision to propose a discussion on the implications of not proceeding with the activity on Dora’s avoidance patterns. In fact, the clinician’s responses in the situation could be deemed consistent with the behavior of a highly competent BA clinician based on an application of adherence coding scales developed for BA trials (e.g., Dimidjian et al., 2006; Kanter et al., 2015). The clinician’s behavior also demonstrated clinical competence, as the clinician strove to understand Dora’s perspective on the challenges to completing her activity, accurately reflected back Dora’s responses, and was responsive to Dora’s position about not moving forward with the activity in question. The clinician’s understanding and consideration of Dora’s wishes is evidenced in her explicit reflection of Dora’s view and subsequent reponse. By proposing to share their views on the implications of not proceeding with the activity, the clinician showed a willingness to attend to the client’s prespective. However, although the clinician demonstrated BA and clinical expertise, the clinician’s behavior was less reflective of skill in cultural competence. Greater attention to the cultural basis of the treatment, and hence cultural competence, could have been accomplished by bringing in the client’s views about what mattered in proceeding with BA. What was the meaning of asking her husband for help? What was at stake in refraining from doing so? Through this line of questions, the clinician would have accessed Dora’s cultural perspective, as based in her lived experiences in local, social contexts (e.g., Lakes et al., 2006). In time, Dora and the clinician arrived at the understanding that what mattered to Dora was uplifting her husband as he too struggled to fulfill his responsibilities to his family as sole breadwinner, and this involved not adding further to the load he carried.

The case of Dora suggests BA manuals can help a clinician deliver BA with some degree of cultural competence, particularly when the clinician also demonstrates strengths with respect to clinical competence. The structured values assessment, which is included in some BA manuals (e.g., Lejuez et al., 2001, 2011), is one component that can help strengthen a BA treatment plan’s cultural basis. In Dora’s case, it helped schedule activities that would allow Dora to meet her children’s needs, and that thereby led her to behave in accordance with what was at stake for her—being a capable mother. Some BA manuals also encourage clinicians to carefully attend to a client’s disclosures (e.g., Martell et al., 2010). Although this is encouraged for the purpose of identifying a client’s goals, listening vigilantly to a client’s narrative can lead to uncovering what matters to the client. This process led to the recognition that it was important to Dora to exemplify strength in responding to her problems. The cultural information acquired did guide the work of treatment, notably in the form of the activities that were selected. Thus, given available manuals, a BA clinician can access and incorporate cultural views on what matters to a client in treatment.

However, even when a clinician demonstrates strengths in applying BA with clinical competence, we contend that it is possible to miss some key aspect of what's at stake or to fail to incorporate it into treatment, if it is identified. In Dora's case, we observed the latter. Given mandates in BA manuals, the clinician attended to client disclosure in such a way that maintained the focus on traditional BA topics—namely, automatic experiences that arise in association with target behavior and avoidance patterns. The clinician pursued these topics rather than attend to the client's cultural perspectives that could have been influencing her behavior. The clinician's decisions at the highlighted choice points in the interaction likely would have been different had the clinician been more focused on strengthening the cultural basis of treatment. As stated previously, the clinician may have instead drawn on the client's narrative to understand Dora's decision making around asking her husband for help.

We also propose that a BA clinician with less clinical and BA skill may not have done as well given existing BA manuals, and may be able to benefit from greater conceptual and concrete guidance for how to strengthen BA's cultural basis. It may be asssumed that manuals will be used by clinicians who are able to adhere to current standards of clinicial competence (APA Presidential Task Force on Evidence-Based Practice, 2006) and culturally competent practice (American Psychological Association, 2017). This is suggested by the relative lack of emphasis on providing clinicians with direction on how to adhere to standards of practice in BA manuals. Although some features of BA manuals can help such a clinician incorporate cultural information into treatment, manuals vary with regard to their inclusion of such elements—such is the case with the structured values assessment.

As discussed in greater detail below, we propose that even under conditions in which values assessment procedures (e.g., applying a values checklist) are competently implemented, efforts to capture client cultural perspectives may fall short if they solely rely on this structured treatment task (i.e., that of deriving a preliminary list of potential activities to assign). (See the supplement to the manual for a discussion on the prevalent appraisal that cultural competence strategies, such as those that comprise the SCL model, simply reflect clinical competence. A clinical case is also presented to elucidate our position.)

The case of Dora helps to illustrate areas where increased attention to cultural matters could potentially enhance the delivery of BA for depression. A process approach to cultural competence has the potential to bring to bear a client's treatment-relevant cultural perspectives in the context of BA, a treatment with characteristics and components that may simultaneously foster and interfere with the delivery of culturally competent treatment.

Integrating the SCL Model and BA

Several contemporary versions of BA have achieved empirical support (Dimidjian et al., 2011; Kanter, Manos, et al., 2010) and some are in widespread use by clinicians (e.g., Lejuez et al., 2001, 2011; Martell et al., 2001, 2010). We base our analysis of SCL's contribution to BA's core techniques that are common across all published variants of BA (Kanter et al., 2009)—namely, presenting a treatment rationale, assessment, and activity scheduling. We are not conducting an exhaustive description of all BA techniques nor are we carrying out a systematic review of BA manuals. Instead, we are assessing how the

SCL model intersects with key, defining aspects of BA treatment. Our descriptions of these treatment components are based on the two popular contemporary versions: BA (Martell et al., 2001, 2010) and behavioral activation treatment for depression (BATD; Lejuez et al., 2001, 2011), and our own articulation of the treatment (e.g., Kanter et al., 2009; Kanter et al., 2011), which is based on experiences adapting BA for depressed, low-income Latinx individuals residing in the United States (e.g., Kanter et al., 2008, 2015; Kanter, Santiago-Rivera, et al., 2010; Santiago-Rivera et al., 2008). These core BA treatment components have been developed and packaged into effective methods for training clinicians in BA techniques (Puspitasari et al., 2013, 2017). We describe typical BA clinician repertoires with respect to these three treatment components and what the SCL model would suggest the clinician could do. Concrete examples of culturally competent care according to the SCL model in the context of specific BA components are found in Table 1.

Presenting the Initial Treatment Rationale

In standard BA, a primary goal of the clinician during the first psychotherapy session is to present the BA treatment rationale. In their BATD guides, Lejuez et al. (2001, 2011) present a very structured and scripted approach that does not offer much guidance to the clinician on how to interact with and be influenced by the client's narrative to determine how the BA model fits for the client. Martell et al. (2001, 2010), on the other hand, present an interactive approach in which the clinician listens closely to and integrates the client's narrative into the presentation of the rationale. As per Kanter et al. (2011), the clinician listens to the client's narrative to discover the negative life experiences that may have led to the onset of depression, assesses to discover the behavioral and emotional reactions of the client to these experiences, and discusses how these reactions may have created and perpetuated a spiral into depression. The clinician highlights these major elements of the client's narrative in an empathic, validating, and normalizing way. Then, the clinician describes how an activation approach may help the client reverse the depression spiral, minimize negative life experiences, and cope more proactively with negative experiences that occur in the future.

A BA clinician might present the rationale modeled after a sample presented by Kanter and colleagues (2009):

> "I have been listening to your story. I would like to share with you some of what I've been hearing. Would that be okay? I hear that you really have gone through a lot and your depression makes sense to me given all you have been going through. You mentioned the loss of your career and of the hopes and dreams for the future you placed in it. You also shared about how you are struggling financially and how it is a constant source of stress for you. I also hear how you do not feel as if you are doing things that are worthwhile or meaningful any more. Overall, I am seeing that your life is filled with loss and negative experiences, and that how you feel is how people feel when their lives run the course yours has run. Given what has happened to you and how you feel, you have shut down and become depressed—this all makes sense to me. One way to combat this is with behavioral activation. In this approach, we figure out how to make your life meaningful again—how to get you active doing the things you used to enjoy doing, things that bring you pleasure and purpose, and things you have been avoiding but are important to do.

> We focus on your behavior and what you are doing each week that is either helping you overcome your depression or maintains it. We can come up with activation assignments together, so that each week you engage in some new, antidepressant activities, and in this way you start to feel better again and learn how to get active in response to negative experiences. The first thing we have to do is get you active and engaged in life by getting you moving toward your goals. How does this sound to you?"

The standard BA clinician appeared to reflect and integrate the client's perspective into the treatment rationale, but the integration is limited. The client's narrative is incorporated primarily to justify the behavioral rationale, rather than to more deeply understand what's at stake for the client to guide treatment. BA clinicians may intuitively or naturally explore the client's narrative with follow-up questions to further access the client's perspective, learn about his or her social world, and add to his or her understanding of what's at stake. These exploratory behaviors, which have the potential to advance a cultural understanding of the client's predicament, are not prescribed or emphasized in any manualized version of BA. This exploration would be left to the idiosyncratic tendencies of the BA clinician.

An SCL approach, in contrast, explicitly encourages the clinician's exploration of the client's narrative for the explicit purpose of understanding the client's local, social, cultural world to inform treatment. The SCL clinician is encouraged to understand the client's experience in the client's own terms. A BA clinician influenced by the SCL model (henceforth referred to as a BA+SCL clinician) would ask, "How do you see what has happened to you?" in addition to presenting his or her own view. Subsequently, the clinician might ask, "Am I missing something important?" in addition to eliciting feedback by stating, "How does this sound to you?" The BA+SCL clinician would approach a new case with a primary goal of deeply listening to the client's story to begin to understand what's at stake for the client in general and in accessing care specifically.

Furthermore, the BA+SCL clinician would explore the client's views on treatment and consider alternative forms of treatment prior to moving forward with BA. This puts the client's views and the clinician's views on comparable footing rather than presuppose the priority of the clinician's views. Existing guides acknowledge that BA may not be right for some clients (e.g., Lejuez et al., 2001), but not on grounds of a poor fit due to inconsistencies between the clinician's and client's cultural perspectives. The BA+SCL clinician would formulate a behavioral conceptualization and simultaneously remain open to the possibility that presenting the BA rationale might not be indicated given what appears to be at stake for the client in accessing care. The BA+SCL clinician would be cognizant that his or her understanding of the problem and its solution is one cultural conceptualization among other valid ones. As such, the BA+SCL clinician would take ownership of his or her perspectives and present them as tentative guides for treatment. The BA+SCL clinician would also know to move between his or her and the client's perspectives on the nature of the problem, its origin, and possible solutions before drawing conclusions about these aspects of treatment and taking definitive therapeutic action.

Assessment

Monitoring Activity—Activity monitoring, a component of almost every BA variant, helps gain information about the nature, breadth, and frequency of client activity for a given week. It informs the development of a case conceptualization that guides the selection of activation assignments and evaluation of progress over time (Kanter et al., 2011).

Lejuez et al. (2001, 2011) take a prescribed and straightforward approach to activity monitoring in which clients are briefly presented with a rationale and instructions for completing the forms (Lejuez et al., 2001, 2011). Great detail on how to present the clinician's view on activity monitoring is provided in Lejuez et al. (2011). The BATD manual, however, does not instruct clinicians on how to engage a client's narrative nor on how to access what is specifically at stake for the client. Information on what's at stake could shape how the task is introduced, the determination of whether the task is used, and how to best implement it.

Lejuez et al. (2011) note the importance of considering the client's culture in implementing activity monitoring. They advise clinicians that their monitoring form may not be appropriate for individuals of all sociocultural backgrounds and encourage them to develop forms that are more relevant for particular client populations. They offer their form for use with low-literacy clients as an example of an adaptation. Although their recognition of culture as important to treatment represents a step forward, Lejuez et al.'s conceptualizations of culture and how to address it are limited. They ground culture in specific social group membership, and thereby do not acknowledge the role culture plays in the lives and treatment of all individuals. The effect is that clinicians may not consider and integrate culture in working with all clients.

Like Lejuez et al. (2011), Martell et al. (2001, 2010) offer clinicians considerable guidance on how to present the clinician's perspective on activity monitoring to clients, but not on accessing, considering, and incorporating the client's perspective on what matters in presenting or implementing this task. Martell et al. (2010, p. 69, Kindle) emphasize that this assessment task should be implemented such that the specific preferences of the client are addressed, stating that clinicians should "allow considerable flexibility in how clients monitor themselves." However, they are narrowly focused on understanding the client's preferences on how to best carry out the task, such as the best monitoring method and assessment schedule to develop the most successful assessment plan. Given that Martell et al.'s emphasis is explicitly confined to the effective design of activity monitoring tasks, a BA clinician may be unlikely to expand their assessment of client views to what deeply matters to the client. That said, their procedures may lead to gaining some understanding of what's at stake for the client. They encourage clinicians to assess progress toward overall life goals as part of the activity monitoring task. By asking, "In looking over your chart, do you get the sense that you are moving toward your goals?" the clinician creates the opportunity to discuss whether the client's actions are consistent with what's at stake for them.

The following is an example of how a clinician may present the activity monitoring assignment by Kanter et al. (2009):

> "I would like you to fill out this chart so that I can begin to think about why you are depressed using information about your current activity. Since I don't know very much about what your days look like, I'd like to ask you to record as much of your day as possible, including activities that might seem unimportant. I would also like to learn how your mood changes depending on the types of activities that you do and situations you are in. For that reason, I would like to have you rate your mood on a scale from 0 to 10; 0 means low mood and 10 means high mood. Can you do that for each activity you record?"

In contrast to the BA clinician, the BA+SCL clinician adopts a tentative stance in presenting the activity monitoring task rationale. The posture reflects the BA+SCL clinician's acknowledgment of the existence of two sets of cultural perspectives (i.e., the clinician and the client views) on how to understand the problem and the best approach for targeting the problem. In the aforementioned scenario, the standard BA clinician moves quickly from introducing his or her activity, giving instructions on how to carry it out, and asking whether the client can complete an aspect of the task. In doing so, the BA clinician appears to make assumptions about the client's perspective on how to proceed with the work of therapy. Specifically, the BA clinician seems to take for granted that the client's views on how to improve his or her understanding of the problem is consistent with the clinician's own and that the client therefore buys in to using the assessment method proposed by the BA clinician.

The SCL clinician considers that asking whether the client can complete the task is premature at this point in the therapy. The SCL clinician first seeks to understand the client's views on how to approach assessment, which the client may have expressed prior to this interaction. For instance, at an early point in therapy, the client might have volunteered the belief that to understand his or her current depression, they would need to explore his or her early childhood experiences. The SCL clinician would acknowledge this client perspective in moving to present his or her own view on a useful approach for understanding the problem.

The BA clinician's quick jump into implementing activity monitoring conveys his or her belief that his or her strategy is the correct approach to exploring the problem. One drawback of conveying this message is that it undermines buy in to use evidence-based assessment strategies, like activity monitoring. Activity monitoring has traditionally been a component of evidence-based behavioral treatments to guide intervention (e.g., Kanter, Manos, et al., 2010), and may uniquely contribute to increases in healthy behavior (see Santos et al., in press, for a review). To maximize buy in to use this science-grounded approach, the BA+SCL clinician can first elicit the client's view on the utility of the client's perspective. Then, the BA+SCL clinician can take ownership of the client's cultural perspective by presenting the clinician's strategy tentatively. The clinician might acknowledge that there are multiple ways to understand the problem and that he or she is open to alternative assessment approaches. This can be done by using language such as "I think" and "I believe this strategy could be useful." By presenting the clinician's cultural view on a useful assessment strategy as one view among other viable perspectives, the BA+SCL clinician makes space for the dyad to consider other views on the indicated

assessment method, including the client's (potentially divergent) perspective, and evidence-based approaches to assessment.

After having explored and integrated the client's perspective into the assessment strategy dialogue and presented the clinician's view on a useful strategy, the BA+SCL clinician would encourage feedback on the clinician's activity monitoring plan. Feedback would be incorporated into a negotiation process in which the clinician and client work together to arrive at a shared narrative for how to proceed with assessment. One possible outcome of this process would be the decision to move forward with an assessment strategy that is grounded in the evidence base, has maximal client buy in, and may also be informed by the client's perspective or some aspect of it. In this context, the BA+SCL clinician would proceed with implementing the strategy and would only then deem it relevant to ask whether the client is capable of carrying out the task.

Values Assessment—In BA, a value has been defined as "an ideal, quality, or strong belief in a certain way of living" (Lejuez et al., 2011, p. 129) and as "desired life consequences that provide one a sense of direction" (Hayes et al., 1999, as cited in Martell et al., 2010). The values assessment is explicitly designed to inform the selection of activities that are aligned with a client's values. Selecting values-based activities helps ensure that activities are maintained over time because they are meaningfully and not arbitrarily selected (Lejuez et al., 2011). The structured assessment helps a client identify important life areas (e.g., family relationships, social relationships, and physical/health issues), formulate specific value statements that describe how the client wants to live his or her life in each area (e.g., "I value being a good mother"), and clarify actions that allow a client to live by his or her values (e.g., read to child before bed or listen actively to child's stories; Lejuez et al., 2011).

Values work is emphasized primarily in BATD (Lejuez et al., 2001, 2011) and to a lesser extent in BA (Martell et al., 2001, 2010) and other variants (Kanter, Manos, et al., 2010). Martell et al. (2010) affirm that values is a key concept that underlies behavior therapy in general and is essential for taking committed action in BA. However, given Martell et al.'s (2001, 2010) more limited discussion on the topic, we focus our discussion largely on Lejuez et al.'s contributions. The values assessment form is introduced early in treatment at Session 2 of a 10-session protocol and thereafter clients are encouraged to reflect on their values in between sessions to ensure that they identify all of the activities that are most associated with their values. Clinicians revisit the inventory again at Session 7; one objective is to identify any new values that may have come to mind since the start of treatment.

The values assessment initiates and encourages a dialogue of what's at stake for the client. Procedures delineated in BATD are based on acceptance and commitment therapy (ACT; Hayes et al., 1999). Of fundamental interest in ACT is understanding the client's response to the question "What truly matters to you in the big picture?" In BATD, clients answer the question "What are you striving for in this area of your life?" to identify their values as they consider the notion that "a value is something that is important to you in your heart" (Lejuez et al., 2011).

Values assessment procedures, however, pose limitations with regard to understanding what matters. First, the approach to describing values is prescriptive and may limit the exploration of what's at stake to the content areas outlined in the values form (e.g., education/training, employment/career, hobbies/recreation, volunteer work/charity/political activities). From our perspective, the life domains are a reflection of the areas that matter most to the clinician delivering the treatment or therapy developers given the local, social worlds they inhabit. What if what's at stake for the client exists outside of or does not perfectly fit within these life domains, given client experiences in a different set of local, social worlds? What's at stake for an immigrant may be preserving his or her native community identity in a new local, social world. For a client experiencing dissonance between his or her birth gender and experienced gender, better understanding the incongruence may be what's at stake in being activated. Clinicians may miss what matters to these clients due to the narrow assessment focus and inattention to these specific value areas in the manual. BATD developers appear to acknowledge that their structured assessment may not fully capture what matters to a client in their brief discussion of cultural values (Lejuez et al., 2011, p. 150). They acknowledge that what matters to the client may be better reflected by interactions among life domains.

Additional disadvantages relate to the fixed and low-frequency approach for implementing the values assessment. One drawback arises from the assumption that the client will be able to successfully reflect upon and identify his or her values presented in a decontextualized format (questionnaire) and that the client will do so during the sessions (i.e., 2 and 7) designated for values discussion. Although the client is instructed to reflect on his or her values between these sessions, the focus is on reflecting on previously identified values rather than exploring other, new values. It is only at Session 7 that the client is encouraged to think about whether a new value has been identified. In fact, this occurs toward the end of the session when there is considerably less time to activate associated behaviors. Discussing values in this confined way risks not fully exploring cultural values in the course of treatment. See this article's supplemental materials for an illustration of the advantages of identifying values contextualized in the client's narrative.

A final, related limitation stems from the notion that values are relatively stable over time (e.g., Rokeach, 1973, p. 11). Though values remain largely constant over the life span, value change is theorized to occur. One definition of value change posits that change occurs with regard to the importance of a value to a person. They form part of a "personal hierarchy of importance" and where on that hierarchy a value falls influences its impact on behavior (Bardi & Goodwin, 2011). Value change may occur in response to adaptation to major life transitions, like migration and living in a different sociocultural environment (Goodwin, Polek, & Bardi, 2012). Changes in the importance of a value may be subtle and may not be captured by a BA clinician given how the values assessment is structured, such as in BATD. Treatment procedures should allow a clinician and client to detect shifts in what matters to a client. For clients undergoing major life changes, which is often the case in depressed clients, it may be particularly important to attend to what matters and how this may be undergoing adjustment.

The SCL model can address the limitations built into the values assessment for accessing what matters. As a process model, its strength lies in the series of behaviors the clinician

is encouraged to undertake across time and the treatment component (see Table 1). In particular, these behaviors serve to carefully and continuously attend to the client's narrative about what matters and solicit information to clarify this narrative. One advantage of this method is that the client's narrative determines the focus in the exploration of what matters, which may represent a richer conceptualization of values. Another advantage is that the method of attending to the narrative is ongoing throughout treatment, maximizing the likelihood that what's at stake will be detected, discussed, and incorporated into care. This may mitigate any obstacles to accessing what matters that stem from the client's restricted clarity about, or limited contact with their values. The SCL clinician encourages discussion that can increase the client's own understanding and awareness. Furthermore, the clinician takes on an active role in clarifying what matters, making connections based on clues that emerge from the client's narrative. A final advantage of this process approach is that a reorganization of values over time can be detected and considered.

A caveat regarding accessing the client's perspective and introducing the clinician's perspective may be useful here. We encourage the clinician to be vigilant about potentially shaping the nature of a client's value statements, given the clinician's own views, in ways that move a client away from what matters to the client. For instance, a well-meaning clinician may discourage a client from exploring and adopting values that are commonly held among other members of the client's sociocultural community. The revised BATD manual (Lejuez et al., 2011) instructs clients to "be sure that the values [they] identify are personal to [them] and not the values of other people or society." In some cases, clients may be at risk of selecting others' or societal values that have little or no personal relevance. In other cases, a client may find it important to adopt values held by others in his or her community given what's at stake for the client. The clinician's perspective can interfere with discussion and consideration of such values unless the clinician remains aware and avoids this potential risk. Drawing from the client's narratives, often unsolicited values appear, reducing the risk of the clinician imposing his or her views onto the client.

The following excerpt is based on an example presented by Kanter et al. (2011) for introducing the values assessment:

> The point of our work together is to get you active in your life. I would like you to become active in ways that are personally meaningful to you. In working with other clients, I have found that they find it helpful to think about areas in their lives that are important to them, what they value in those areas, and then think about actions that align with their values. For instance, it seems that you value being a good mother. We can think about activities that line up with this value, like spending more time playing with your son. How would you feel about doing this more consistently? When clients are depressed, remembering that their activities are important because they are tied to their values is often helpful for keeping on with action when it feels very difficult to do so.
>
> (p. 138)

From an SCL standpoint, the BA clinician appears to have accessed and integrated some of what's at stake for the client and could do more to build on these efforts. Earlier in their

work together, the BA clinician seems to have attended to the client's narrative and derived the notion that the client values "being a good mother." A BA+SCL clinician would ensure that his or her understanding of what's at stake is accurate by consulting the client earlier or during the current interaction. If correct, then the BA clinician could be said to have demonstrated cultural competence when he or she incorporated the notion that the client values being a good mother. The BA clinician could further integrate the client's perspective by encouraging the client to identify another strongly held value or introducing another hypothesized value that previously emerged from the client's narrative. Alternatively, the clinician could have moved toward identifying an activity grounded in the client's value. Although the clinician introduces an activity ("playing with your son"), it is not clear that this idea is based on the client's narrative.

In this excerpt, the BA clinician varies in his or her degree of cultural competence according to the SCL model. At the outset, the BA clinician presents a view on the objective of treatment in a clear but factual and directive manner. Assuming this is solely the clinician's view (rather than a view also held by the client), the BA clinician could do more to avoid imposing his or her view on the client, acknowledge the view as his or her cultural perspective, and demonstrate openness to other cultural perspectives on the point of therapy. The BA clinician could do this by taking ownership of his or her view via statements such as "From my perspective," "The way I see it …" and "I really believe …" After the opening sentence, the BA clinician demonstrates a greater degree of competence by adopting a more tentative stance in presenting his or her perspective, which is reflected in prefacing his or her views on the utility of being active with "I would like you to …" and using the values assessment procedures with "I have found that …" Further, the BA clinician requested the client's feedback on his or her perspective regarding the utility of consistently engaging in an activity that is (potentially) congruent with the client's value. To achieve a higher level of competence, the BA clinician could also request feedback on the notion of using values to guide the selection of activities or the values assessment form.

In our excerpt, the BA clinician does not move toward negotiations to arrive at shared narratives regarding the values assessment after presenting his or her task rationale and incorporating the client's view in it. Particularly when differences in perspectives exist, the BA+SCL clinician would encourage negotiation around the relevance, utility, and adoption of values work.

Activity Scheduling

Activity scheduling involves setting plans for a client to engage in antidepressant activities or healthy behaviors consistently over time. Activity completion is theorized to lead to increased contact with diverse and stable sources of positive reinforcement, which sustains future healthy behavior and also can result in improvements in mood. As such, this method is thought to directly account for BA's ability to effect improvements. Other BA techniques are conducted in the service of activity scheduling. Activities assigned can be informed by activity monitoring and values assessments, in order to increase mastery or enjoyment/pleasure; to address problems (Lejuez et al., 2001, 2011); or to regulate routines (e.g., scheduling basic activities, such as hygiene activities and home chores; Martell et al., 2010).

Diverse activities may be ordered by level of difficulty using an activity hierarchy through which the client may progress gradually as treatment progresses. The activation sheet can be used to ensure behavioral specificity (Martell et al., 2010) as it details the parameters of each activity (with *whom*, with *what*, *where*, and *when* the activity is to be conducted). The sheet also preemptively addresses obstacles to activity completion and establishes realistic goals, which align with the client's current context and level of functioning, and increases likelihood of successful activity completion.

The following is an excerpt based on Kanter et al. (2011) on presenting the rationale for taking a detailed approach to activity scheduling:

> Developing an activity plan can sometimes be helpful because it makes you think through details, which can make it more likely that you succeed in carrying out the activity. In the end, you may not do the activity exactly as we plan it and that's fine. Still, developing the plan can be helpful because by thinking through the details, the activity becomes more realistic and doesn't just remain a good idea. It also helps give me something to address at the following session, which helps me help you get activated. If you choose to do the activity differently, like at a different time, because you think it makes better sense, I'm not going to be concerned by it because the therapy should work for you. If you do not do the activity, we will have the opportunity to go over what got in the way of you doing the activity. We will be able to get specific and ask, "what were you doing at X time on that day?" which is more helpful for problem solving than having a vague conversation. The more specific we can be, the more helpful I will be and the more likely it is that you'll do the activity.

The BA clinician does not ask for or refer to the client's perspective in the excerpt above. A BA+SCL clinician might have taken this opportunity to exemplify the activity plan using the client's views. The BA clinician could have requested the needed information during this interaction or incorporated what he or she knew about the client's perspective already. For instance, if the client indicated that what matters to her is being a good mother by reading to her daughter at bedtime, the BA clinician could have explained that developing a detailed plan involved specifying the book that would be read and the time during which it would be read. That said, the BA clinician demonstrates that he or she is open to the client's views on how to proceed with therapy tasks, which is reflected in the statement about it being fine if the client chooses to carry out an activity in a manner that diverges from the plan.

The BA clinician makes a considerable effort to help the client understand his or her perspective by providing a relatively full and clear explanation on the utility of developing an activity plan. The BA clinician makes an effort to frame his or her view as his or her own, but could do more in this regard (see example in Table 1). However, the BA clinician does use language that moves away from presenting views as fact and toward presenting them as perspectives. In making the statement, "Developing an activity plan can sometimes be helpful …" the BA clinician makes an implicit acknowledgment that his or her view on a useful approach may not be a good fit for this particular client and suggests a willingness to consider other options. However, the BA clinician could go a step further and be more tentative by initiating his or her statement with "In my opinion …" The BA clinician

does not, however, request client feedback on his or her perspective. By not doing so, the BA clinician reduces the likelihood of negotiating a shared narrative with the client on approaching their activation work.

Conclusion

We presented the SCL model as a specific framework that can be integrated into EBTs, such as BA for depression, and a conceptual rationale for integrating SCL and BA. A BA clinician would benefit from more guidance on how to practice with cultural competence since BA does not offer a framework or delineate cultural competence behaviors. We therefore present this framework and concrete suggestions that can be seamlessly applied to BA. Both the cultural competence and treatment models share a foundational notion that encourages clinicians to consider clients' current and past-lived experiences. However, the SCL model helps BA clinicians move beyond the goal of incorporating client experience for the purpose of implementing standard BA interventions to considering experience to deliver culturally competent care. Specifically, it allows the BA clinician to meet the cultural needs of any client, independent of his or her ethnic, racial, and national group affiliation, and in a manner that attends to the intersectionality of diverse and expansive circumstances and identities.

The contribution of our approach builds on past critiques that EBT gives little attention to culture, as well as current efforts to integrate culture within evidence-based practice. What is innovative about our approach is both conceptual and behavioral. Our conceptualization of culture as what's at stake in local social worlds goes beyond ethnicity and race and provides a coherent conceptual grounding to include multiple social identities that are at the center of the therapy process. An additional conceptual innovation is that we draw on Kleinman and Kleinman's (1991) conception of ethnography as shifting cultural lenses to inform the behavioral indicators of our model. Most critiques remain at the conceptual level. By articulating specific clinician behaviors, we are in a position to assess the extent to which clinicians carry out these process-oriented principles. Defining at least some of the relevant clinician behaviors has the potential to advance both clinical training and research.

Our SCL BA integration serves as proof of concept and has the potential to facilitate clinical training and research. We believe this integration is important given that depression remains one of the most significant public health problems globally, and that BA has potential as an effective and relatively easy method to disseminate and implement treatment options across cultures (Kanter & Puspitasari, 2016). However, many questions remain: To what extent are trainings protocols in BA and SCL compatible? What dose of training in SCL is necessary to improve the cultural competence of BA practitioners, and how will these outcomes be assessed? What obstacles need to be addressed to maximize the impact of training on practitioners? Ultimately—can integrated BA and SCL training protocols produce downstream improvements in client engagement, retention, and outcomes that matter? Whether the integration between BA and SCL would result in superior clinical outcomes and acceptability, compared to standard BA, remains an empirical question and ought to be addressed in future studies.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Highlights

- We integrate a cultural competence process model and behavioral activation (BA).
- We review the shifting cultural lenses (SCL) model and BA concepts, and clinician behaviors.
- We discuss what SCL adds to BA to provide culturally competent care.

Table 1

Examples of SCL Clinician Behaviors to Assess and Ensure Fit of BA Technique Implementation

	BA components			
SCL behavioral indicators	**Treatment rationale**	**Activity monitoring**	**Values assessment**	**Activity scheduling**
Accessing the client's view	"How do you make sense of the issues that have brought you to therapy?"	"What do you think we can do together to learn more about your problem in ways that can help us tackle it?"	"In doing this activity, we would get very specific about what being a 'good mother' looks like for you. When you feel that you are closest to being a 'good mother,' what sorts of things do you do?"	"In developing your activity plan, we would take an activity we've identified together and come up with a specific plan for carrying it out. I'd like to share with you what your plan might look like. Off the top of your head, what's an important activity that you'd like to engage in during our work together?"
Integrating the client's perspective	"I hear you saying that you are not sure how your problem has come to develop, but that you think that having lost your stable job may have something to do with it… ."	"I would like to propose a strategy for better understanding your problem. I know you have an idea for how we can do that. Earlier today you talked about how you think it would be important to talk about some important events you experienced in childhood… . Do I have that right?"	"You've shared a lot about how you think you've been a bad mother since you began to feel down. You've also said that something you want to work on is being better at motherhood. It sounds like you value being a good mother. Do I have that right?"	"One activity we discussed during your last session is reading to your daugther at bedtime. As part of the plan, we might pick the book that you will read to your daughter and the time during which you will do it. For example, …"
Presenting the clinician's view	"I'd like to share with you one way of thinking about your problem and how we can work together to address it."	"In thinking about how we can go about understanding your problem, I think it could be fruitful if you filled out this chart. In the past, I have found using it helpful in developing ideas for why a client might be feeling depressed."	"The way I see it, the point of our work together is to get you active in your life and to do so in a way that is personally meaningful to you."	"The way I see it, the more specific we can be, the more helpful I will be… "
Requesting feedback on the clinician's view	"How do my views on how your problem came to be fit with your experience? Is there something that doesn't fit?"	"I would really like to know what you think of the plan I propose to learn more about your problem. What are your thoughts?"	"What do you think about spending some time talking about what you value—what is deeply important to you—and using what we learn to figure out how to engage you in your life?"	"What thoughts do you have on approaching our activity work in this way?"
Negotiating a shared narrative	"As we talk about your problems, I continue to think that BA has a lot to offer you. It sounds to me as if you think that it would be a good idea to try it out. Was I hearing you correctly? What are your thoughts on how to proceed based on everything we've talked about today?"	"We've spent some time sharing our views on how to explore your depression in ways that will help us move forward with treatment. Based on what we talked about, what are your thoughts on how we should proceed? Does using the activity monitoring form seem useful?"	"As you know, I hold the view that choosing activities that you value will help you keep going when it feels very difficult to do them. I'm hearing, however, that you have some reservations about using this approach to select activities. I think it could be helpful to spend some time talking about our views to figure out how we want to move forward with our work. What do you think?"	"We both seem to think that putting together activity plans could be useful. We seem to see things a little differently with regard to how detailed we should be when creating activity plans. What do you think about deciding together on how specific we want to get as we go along, one activity at a time?"

Note. SCL = shifting cultural lenses; BA = behavioral activation.