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BEHAVIORAL ACTIVATION TREATMENT FOR DEPRESSION IN VIETNAM: A CASE STUDY OF ADOLESCENTS, MIDDLE-AGED AND ELDERLY ADULTS

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Abstract. Behavioral activation (BA) is an evidence-based psychotherapy for depression. BA a treatment for depression very effective, even for patients who have not had success with other psychological therapy. BA shifts away from cognitions and feelings to focus on a patient's behavior and environment. At the end of BA psychotherapy treatment, patients can continue to use the skills they have learned on their own, self-regulating their own cognitive behavior, without having to depend on therapists to help them in the future. In Vietnam common treatment for depression includes antidepressant medications and some other sedative medications. In all treatments of psychological disorders, especially depression, using BA therapy is the best treatment for patients. However, studies in Vietnam have not yet been conducted to assess the effectiveness of short-term psychotherapy for depressed patients of all ages, studies of middle-aged and elderly people are not yet available; only a few studies focused on behavioral psychological disorders in adolescents. In this article, I study three different age groups of subjects: adolescents, middle-aged, and depressed elderly adults using BA therapy in a psychiatric hospital in Vietnam. The results indicated that behavioral activation (BA) therapy was effective in the treatment of depression in adolescents, middle-aged and elderly adults. The results also showed the limitations of BA application to depression treatment among the chosen patients.
Keywords: behavioral activation (BA), depression, adolescents, elderly adults, middle-aged.

1. Introduction

Behavioral activation (BA) is an intervention with proven efficacy (Dimidjian et al., 2016; Mazzucchelli & Trevor, 2010; Mazzucchelli, Kane & Rees, 2009; Cuijpers, Straten & Warmerdam, 2007) that can be used to address the typical patterns of withdrawal, avoidance, and inactivity that characterize depression. It is a flexible and adaptable approach (Ekers et al., 2011) that can be used as a stand-alone intervention (Hopko, Lejuez & Hopko, 2014; Hopko et al., 2003), as part of a broader cognitive behavioral approach (Goldapple, Kimberly, Segal, Zindel, Garson & Carol, 2010) or as part of a case management approaches such as collaborative care (Susmita Kashikar-Zuck, 2013; Clarke et al., 2005; Unützer et al., 2002).

BA is an effective treatment for adult depression, however, little research has focused on the use of BA with depressed adolescents (Pass, Whitney & Reynolds, 2016). Besides, some studies

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showed that depression affects approximately 30% to 40% of those aged 65 and over (Hofmann & Smits, 2008; Reynolds et al., 2000). Therefore, mental health supports for the elderly who have depression is an extremely necessary. According to Predescu et al. (2018), numerous challenges such as medication side effects, reluctance to take medications, cognitive impairment continue to limit the effective treatment of depression in elderly adults. Many elderly adults with depression lack access to a mental health provider, yet could potentially benefit from brief, nonpharmacologic interventions such as BA.

Hue Psychiatric Hospital (HPH) is the largest psychiatric hospital in the province of Thua Thien Hue City, Vietnam, currently receiving treatment for 15.465 patients; including 3675 outpatients and 521 inpatients; with 95 inpatients and 1512 outpatients suffering from psychological disorders (statistics from January to September 2017). In this study, we conducted an empirical observation on the subjects (adolescents, middle-aged and elderly adults) suffering from depression who were or were being treated at the HPH. This study is necessary to have a better understanding of how to help those suffering from depression.

2. Content

2.1. Overview of behavioral activation for depression

The main goal of BA therapy is to assist patients to make changes in their behavior by taking them into active activities in life. Activating behavior is theorized that depressed individuals engage in behaviors that they are less likely to participate in the living environment around daily life (Kanter et al., 2010). According to this theory, patients with depression tend to withdraw from their environment in response to feelings of sadness or adopt avoidant behavioral patterns, they separate themselves from society and have dodging behaviors to minimize the possibility of short-term and long-term positive consolidation. Therefore, the goal of BA is to disrupt the negative behavior patterns of depressive symptoms by creating a system of activities that increase positive activities for patients to participate in those activities. Practical exercises in therapy are tailored to the needs of each individual and are coordinated with therapists. The process of performing the patient's practice activities is examined, and discussed in each process, the therapist and the patient will work together to revise these action plans if necessary. The nature, progress, and duration of symptoms, and the patient's emotional changes will be closely monitored during therapy (Barlow, 2013; Joanne-Dahl, 2010).

In the process of using BA psychotherapy at Hue psychiatric hospital, we have adjusted BA for depressed adolescents, middle-aged and elderly adults that outline five phases of treatment that were designed to be flexibly implemented. The first phase guide is to identify the problems that cause psychological obstacles for patients. The second phase is to set out individual goals to activate and engage in behavior. The third phase is to improve problem-solving skills and to help patients reduce their avoidance behavior. The fourth phase guide is to help the patients to establish long-term goals, practice, and change behavioral activation strategies. The final phase is to evaluate the behavioral changes and benefits achieved during treatment as well as focusing on the prevention of relapse.

In Vietnam, BA was first introduced into psychiatric hospitals in recent years, so BA is still a new therapy that many people do not know yet. Vietnam is a developing country; some parts are still quite backward so the awareness of the necessary of psychotherapy is still limited. Some people still think that psychotherapy is unnecessary, and that psychological illness is just a feigned disease that does not require treatment to heal itself. This bias has prevented us from trying to persuade patients to address their problems with psychotherapy. Since 2014 up to now, Hue psychiatric hospital has received only 49 depression cases that underwent psychotherapy treatment. Of which there is only one case received successful psychotherapy treatment, other 28

cases gave up in the midway of treatment. The reason behind is the belief in the treatment. The patients do not believe that their symptoms of depression can be address by the process of the treatment. In this study, we can only record successful cases and select three typical cases to analyze the effectiveness of the use of BA therapy in the treatment of depression in Vietnam.

BA provides therapists with three primary skills to help patients: behavior activation, relaxation, and problem-solving. In the US, research has shown that evidence-based psychotherapy interventions are most effective when patients have eight to sixteen sessions. Interventions that include behavior activation and problem-solving skills often spend several sessions on each skill, providing patients with ample time for practice and generalization of the skill to their life. However, BA is still very new in the treatment of Depression in Vietnam. By the way, we are encouraged to use this therapy flexibly and extend psychotherapy treatment with patients.

2.2. Methods

Participants

A total of 49 Vietnamese patients were screened for this study, and treated with BA therapy: 16 cases with the year of birth from 1993 to 2002, 24 cases with the year of birth from 1957 to 1977, and 9 cases with the year of birth from 1937 to 1952. We classified into three age groups: adults, middle-aged and elderly. Each group was selected for a typical successful case presentation.

Measurements

Short-term Mood Rating Scales. The Mood Rating Scale is a method for assessing mood, seeing changes in mood when you try psychotherapy activities, and measuring progress over time.

Beck Depression Inventory-Second Edition (BDI-II). The BDI-II (Beck, Steer & Brown, 1996; Beck, Rush, Shaw & Emery, 1979) Contains 21 items designed to assess symptoms related to depression. It has four-point, from 0 to 3, to measure depression symptoms in the past two weeks. This assessment is used twice a week.

Patient Health Questionnaire-9 (PHQ-9) Depression Screening Tool. The Patient Health Questionnaire-9 (PHQ-9) is a screening tool that can be used to estimate the severity of a person's depression. The PHQ-9 includes items assessing leading depression symptoms in a brief self-report tool. The PHQ-9 can be completed in minutes and is rapidly scored by the health worker. PHQ-9 has a 61 percent sensitivity and 94 percent specificity in adults. The advantages of PHQ-9 include four aspects. First, it is shorter than other depression rating scales; Second, it can be administered in person, by telephone, or self-administered; Third, it provides an assessment of symptom severity; Last, it is well validated in a variety of populations.

The DSM-5 criteria for depression. Using the pocket guide to the DSM-5 Diagnostic exam on depressive disorders with screening questions to assess for the presence of, and perhaps differentially diagnose, a mood disorder (Nussbaum, 2013) of the patients. DSM-5 criteria for Major Depressive Disorder or other mood disorders, basically focus on the symptoms of depressed mood, loss of interest or pleasure, and other related symptoms that "cause clinically significant distress or impairment in social, occupational or other important areas of functioning" (DSM-5, p.161).

Mental Status Examination (MSE). During the examination as well as conducting psychotherapy, the therapists observed the patient's expression and attitude carefully. For psychological research, patients may not speak out, but their expressions can tell a lot of things. The MSE is a physical examination. It commonly moves from head to toe, the mental status examination begins with a person's outer appearance and progressively proceeds into her interior life (Nussbaum, 2013, p.203).

Patient questionnaire. The questionnaire included 15 questions and focused on the causes why patients gave up the treatment process. Each sentence consists of five levels of choice: Strongly disagree, disagree, agree, and strongly agree.

Treatment and Therapists

Therapists in the study were trained in BA during two weeks on-site HNPH conducted by Ph.D.A. A. Pollack, VT University, one of the developers of the BA intervention in Vietnam and N. T. Tam (Basic Needs Vietnam) for their work to develop Behavior Activation for Depression Treatment for para-professional health care people in Vietnam (Baumeister, 2017). Following this training, the first and last authors consulted with Ph.D. A. A. Pollack on several occasions as planning began for this project and as work began to adapt BA for adolescents, middle-aged and elderly adults (e.g. when questions arose in manual development). BA treatment manual for adolescents, middle-aged people, and adults that we developed (Axelrod, 2017) includes five phases of treatment: orientation, conducting activities, problem-solving, setting goals and sub-goals, practice, and relapse prevention. It is important to note that therapists are not required to follow the instructions in a formula, session-by-session manner. The therapist needs to be flexible in using treatments to help patients. Patients are invited to attend up to 5 sessions in 5 weeks, youth, middle-aged and elderly people are allowed to invite parents, friends, and others to attend sessions. The therapists for this study were two psychologists. The therapist meets the patient every week to discuss issues during treatment.

Ethical Considerations

The study was conducted with the consent of the patient and the patient's family and is clearly explained in the treatment methods and techniques. In addition, patients can stop treatment at any time. Personal information collected from patients is for research purposes only and confidentiality is guaranteed.

Procedure

This study was conducted at an outpatient treatment clinic in the HPH, Vietnam. Except for BDI-II, self-reporting was completed before the first treatment session and again after treatment. Evaluation of the midpoint was completed in the second or third week, and evaluation of treatment completion was completed in the fifth week. This is the expected time for a basic procedure, and the amount of time may be longer depending on the level of the patient's illness. However, providers are encouraged to use this therapy flexibly and extend psychotherapy treatment with the patient if possible. After the termination of the treatment, the follow-up examination of the client’s status was made after three months.

Data Analysis Plan

With three-time point baseline, midpoint, and end of treatment were conducted to evaluate changes on PHQ-9, BDI-II and I used Mood Rating Scale scores to track the score change in the mood of patients during treatment sessions. To examine temporal changes, Mood Rating Scale tests compare baseline to first of treatment, mid of treatment, and end of treatment scores. Changes in the scores from baseline to end of treatment were also evaluated using Mood Rating Scale tests. End of treatment, the one-month follow-up, and the three-month follow-up were conducted to assess maintenance of gains on PHQ-9, BDI-II, and Mood Rating Scale scores over the three months following treatment.

2.3. Results

Overview of three groups of patients shows that mostly good cooperation with psychological therapy can be seen in middle-aged and elderly adults, while Vietnam adolescentsdid not cooperate well in treatment yet. This shows that these results are quite the opposite of those of

Ritschel in the article "Behavioral Activation for Major Depression in Adolescents: Results from a Pilot Study". (See Table 1)

Table 1. The reasons for giving up psychotherapy

Serial	Cause	%
1	I do not believe in psychological treatment	93,3
2	I fear that others scoff mocking when they know I have a mental illness	93,3
3	I do not have enough patience	46,6
4	I can know what to do, do not need treatment	73,3
5	I do not need others to advise	66,6
6	I do not want others to know my privacy	73,3
7	I do not want to tell my story	73,3
8	I am mature enough to decide my own life	73,3
9	Psychological therapy? what is it? I do not need it	80
10	If there is a disease, just taking medicine is enough, do not need psychological therapy	86,6
11	I do not have transportation	66,6
12	I'm afraid that will cost money	33,3
13	I fear that will take time	46,6
14	I am so tired so lazy, do not want to go anywhere	33,3
15	I have no disease at all, do not need treatment	26,6
16	Other causes: I forgot, I did not like, listening to adults is a real headache	13,3

Based on Table 1 questionnaire for 15 adolescents patients who have given up the treatment, we give four causes for this: Firstly, psychological shyness. They are afraid to talk about the sadness that makes them sad, do not want others to know about their sad story, they are very shy, and confused with strangers: "*I fear that others scoff mocking when they know I have a mental illness; I do not want others to know my privacy; I do not want to tell my story*". Secondly, the ego in the psychological developmental age is not stable. They do not want to spend time listening to others: "*Listening to adults is a real headache; I can know what to do, do not need treatment; I do not need others to advise; I am mature enough to decide my own life; I have no disease at all, do not need treatmen*t". Their ego is quite large, they are quite stubborn. Most of the young people themselves are self-sufficient enough to decide, without advice. At this age, they are not really mature (including psychological and physiological), their personality and way of thinking at this stage are quite complex. Thirdly, poor understanding of psychotherapy, not understanding the role of psychotherapy: "*I do not believe in psychological treatment; Psychological therapy? What is it? I do not need it; if there is a disease, just taking medicine is enough, do not need psychological therapy".* Psychological treatment for Vietnamese is still new, and too strange; Depression, people still think that it is not a disease but just a normal feeling and people do not mind depression, they can adjust themselves, automatically disease out. Lastly, the condition of transportation is not favorable: *"I do not have transportation"*. In Thua Thien Hue, public transportation is not developed, and those who want to go back must use their personal vehicles as motorcycles, for people under the age of 18 cannot drive motorcycles, so they must depend on

their parents to pick up or ride their own bicycles. Some children are far away or have no money to buy bicycles, travel is extremely inconvenient.

For 1607 patients with psychological disorders, the symptom included social fear syndrome, depression, insomnia, post-traumatic stress disorders, bipolar disorder, personality disorders, autism, schizophrenia, obsessive-compulsive disorder, and anxiety disorders; Of these patients, 307 are depressed. However, only 49 patients were appointed by doctors at the psychiatric hospital to use BA therapy to treat depression. As a result, of those 49 patients, 28 patients were successfully treated with BA therapy.

In particular:

16 cases have the birth year from 2002 to 1993. There was one case successful.

24 cases have the birth year from 1977 to 1957. In which 20 cases were successful.

9 cases have the birth year from 1952 to 1937. In which 7 cases were successful.

I classified into 3 age groups: adolescents, middle-aged and elderly adults, each group selected for a typical successful case presentation.

Case 1 (C1): adolescents

Full name: N.T.H., Year of Birth: 2000, Gender: Female

Symptoms: headache, dizziness, difficulty falling asleep, restlessness, sometimes insomnia, usually crying, not eating well, difficulty focusing, always feeling tired and not wanting to go out; the patient does not want to do anything. These symptoms lasted for 6 months. Meet the criteria of DSM-5. Very high score depression: Beck Depression Score (BID): 56; PHQ9: 25. Diagnosis: extreme depression.

The patient is the first child in the family having 5 children, the family has average economic conditions. Previously, she was a good student but recently falling behind with studies, sometimes she dropped out of school for no reason. Her father is an electric worker, her mother is a freelance trader, earning enough to support her life. Her sisters go to school, the oldest is in grade ten, and the youngest is in grade one. The marriage life of her parents does not have conflicting issues. Her relatives did not know the reason why she had become that, they told her not to tell anyone.

In the first meeting, her mother came with her and she hardly cooperates with therapists, then therapy sessions can only get acquainted. Mood Rating Scale: 0. In the second meeting, her mother still came with her, but this time she cooperated better with the therapist. She understood how behaviors and mood are linked but her attitude was still indifferent, not a good mood. At the end of the session, I gave homework to H, and told her to complete the exercise and bring it to me in the next session. The rating scale for this session is still 0 points. In the third meeting, her father came with her, she did not say anything, only answered when asked. As the therapist asked about homework, H. shook her head. She did not do the homework. The reason was that she was tired and did not want to do it. During this session, H. began to realize the benefits of practicing and doing homework, understood activities that may improve mood, and promised after this session to go home to perform the same activities as discussed with the therapist. Her Mood Rating Scale: 2. Today therapist recheck the Beck Depression Inventory, and her score was still severe, BID: 54; PHQ-9: 21. In the fourth meeting, H. mother took her when she saw me, she actively greeted, and the homework after the pre-therapy session was completed, she told me that the activity really helped her get out of her laziness all the time. She agreed to meet friends, play badminton, and go to the park with them. She began to talk about the pressure of her being pent up for a long time, The main cause of her departure from her classmate whom she likes. He is handsome and good at studying but he does not like her, She is very upset, everyday she comes to class to meet him is she is feeling uncomfortable, and vexatious. Today she confided a lot. Her Mood Rating Scale: 5. In the fifth meeting, H. came alone to see the therapist without parent or

mother pickup. She completed previous homework and suggested more activities she loved. She realized that the activity made her feel much more comfortable when participating in activities with the school, she now has more friends, she has a lot of good friends, there are many good students and more handsome than her boyfriend whom she likes. Her Mood Rating Scale: 7. In the sixth meeting, H. and her mother came together, she pulled her mom's hand to run toward my office, calling out my name when they were still in the hallway, today she has a fresh smile she greeted me and then presented homework, explained clearly what activities she has done in the past week. The therapist provided her plan for how to continue to use skills and support to cope with difficulties and prevent relapse. Her Mood Rating Scale: 8. Therapist rechecked with the Beck Depression Inventory, her score has dropped dramatically: BDI-II: 18, PHQ-9: 10. The therapy ended, she and her mother thanked me and left for fun.

Summary: Therapy for patients N.T.H. was held in 6 sessions, the first session did not apply BA because the patient did not cooperate, 5 sessions of BA followed and increased effectiveness after treatment sessions (see Figure 1).

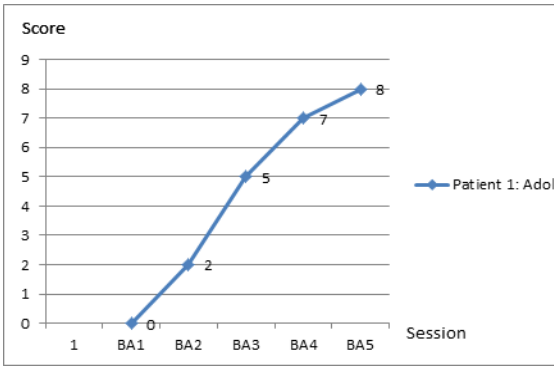

Figure 1. Mood Rating Scale scores across sessions

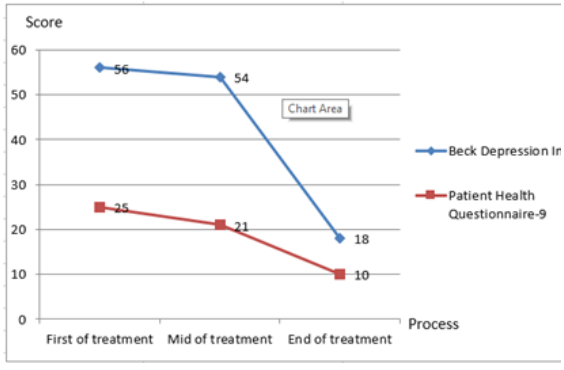

Figure 2. Beck Depression Inventory-Second Edition (BDI-II) and Patient Health Questionnaire-9 (PHQ-9) scores across sessions

Her mood has been gradually increasing with the therapy sessions (see Figure 1), while BID depression and PHQ-9 decreased through each stage of treatment: beginning, middle, and end of the process BA (see Figure 2).

Young patients are the few of the adolescent cases successfully applied to BA therapy. Initially, she hardly cooperative attitude but then BA has helped her realize that activity is the key to unlocking the negative thoughts that exist in oneself. This treatment is considered a successful case. The unsuccessful case I have explained the cause in the above.

Case 2 (C2): middle age

Full name: D.S.C., Date of birth: 1954, Sex: Male

Symptoms: tired, dullness, not awake, asking nothing and also answering nothing, relatives said patients over two months did not go to work, insomnia, poor eating, little talk less laughing, not communicating with people, less interested in the wife and children around; he once wanted to jump into the river to commit suicide. These symptoms lasted for 10 months the level is getting heavier. Meet the criteria of DSM-5 Beck Depression Score (BID): 40; PHQ-9: 21. Diagnosis: severe depression.

D.S.C.was the only child in a poor peasant family in Phuvang District, Thuathienhue Province, previously his work was farming, he is married and has four children, the oldest child is in grade 8, the youngest 3 years old, his wife is growing and selling vegetables, his family life

is very poor. D.S.C.mood depression, after the examination the first week did not accept psychological treatment, therapists can only ask for his health =. 2 weeks later, he agreed to begin treatment of BA.

Session 1:he greeted politely, he understands the relationship between behaviors and depression, understands the importance of activities. He Mood Rating Scale: 4.

Session 2: he did his homework and answered clearly about the activities he had written in the exercise. Today he realized that:"*The more I did not work, the more tired I was,the more tired the more I see myself meaningless, the more you think myself meaningless, the more seriously illand I just want to die*." He Mood Rating Scale: 6.

Session 3: his homework very good practice, he demonstrate increased ability to engage in healthy activities andwill see link between activities and mood. Today he learns and practices skills for emotion regulation and solving problems. Mood Rating Scale: 8. Today therapist recheck the Beck Depression Inventory, his score has decreased 28 of BID and 14 of PHQ-9.

Session 4: he told the therapist some of the activities he had done, He told me that when he did not perform the activity he did not want to do it but BA has indicated that behaviors and mood are linked so he tried to change his mood and now his activities have improved his mood a lot. In addition to his favorite activities, he also plans to do useful activities for himself and his family. Mood Rating Scale: 8.

Session 5: he has the advantage of meeting the therapist on schedule very punctual, and homework is always good. He told me he used the vacant land behind the house to grow flowers and vegetables. Also, he will raise more chickens and dig ponds to raise fish. The therapist gave his plan for how to continue to use skills and support to cope with difficulties and prevent relapse. Today he Mood Rating Scale: 10; BID:7; PHQ9: 5.

Summary: In 24 cases in middle age, there were 20 successful cases this is a very high proportion of Vietnamese middle-aged people who cooperate very well with psychotherapy. Cases of D.S.C. is one of the typical cases with the highest indicators of success, Mood Rating Scale: 10. Initially, D.S.C. got into a deadlock due to family economics, his children were sick and needed money. He was overworked, worried too much, and gradually got depressed. BA has helped him realize that activity is the crux of the problem, and his behavior was BA-activated, which quickly made him love life back. His mood has been gradually increasing with the therapy sessions (see Figure 3), while BID depression and PHQ-9 decreased through each stage of treatment: beginning, middle, and end of the process BA (see Figure 4).

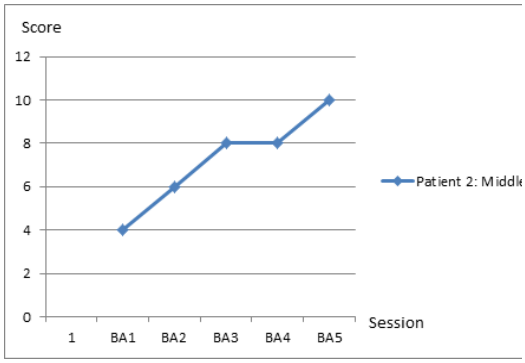

Figure 3. Mood Rating Scale scores across sessions

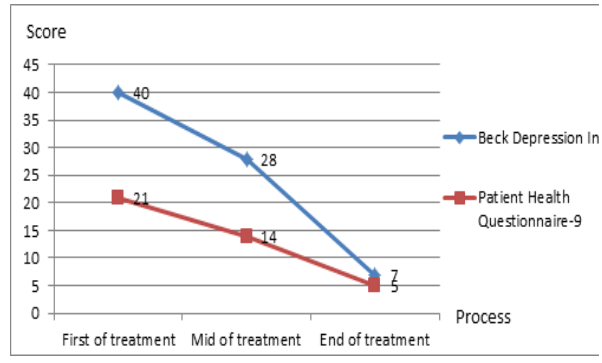

Figure 4. Beck Depression Inventory-Second Edition (BDI-II) and Patient Health Questionnaire-9 (PHQ-9) scores across sessions

Not only the case of D.S.C. the remaining cases of middle-aged people are very respectful listening to the therapist in the process of discussing the problem. Unlike the young people mentioned above, there is a middle-aged patients cooperate very well with psychotherapists from discussing issues during treatment to complete homework. The remaining 4 cases failed for two reasons: Firstly, distant houses have no means of transportation, secondly, the busy family can not cooperativeof treatment,however, three out of four cases have called to tell me the reason. I appreciate the success in working with middle-aged people.

Case 3 (C3): elderly adults

Full name: V.T., Year of birth: 1948, Sex: Male

Symptom: The family has eight children, his children have grown up and married, his wife died three years ago, and he is currently living with his couple's first child and two grandchildren. Since his wife died he always wanted to die and did not want to live anymore. The children have advised him a lot, but his spirit was always not good, ate very poorly, slept less, and cried more; from the day he retired he was no longer working, stayed only at home around the house; his family always feared he would commit suicide. These symptoms lasted for 1 year. Meet the criteria of DSM-5. Beck Depression Score (BID): 62; PHQ-9: 26. Diagnosis: extreme depression.

Communication with the patient at first was difficult because he was very apathetic. After three meets, he accepted to talk with the therapist, the fourth meeting can be conducted with BA.

Session 1: patients cooperated with the therapist, but the effect was not high. He understands "*Doing nothing is doing ill*" but did not want to work, He said he could not do anything, even things he had loved to do before. The therapist instructs and motivates the patient to perform activities. Mood Rating Scale: 2.

Session 2: patients have done their homework but incomplete. He only did it for 3 days, He said he did not want to do it. The therapist instructed the patient to better understand the types of activities including activities with other people, and tried to encourage patients to perform activities with others than to write in the homework section. Mood Rating Scale: 2.

Session 3: the patient has performed the activity for a week but was still incomplete. He told me that the person who had helped him complete the activities in his homework was his grandchildren, but not often. He was glad to do activities together with his grandchildren and son but did not do the activities alone. Mood Rating Scale: 5. Today therapist rechecks the Beck Depression Inventory, his score has decreased BDI: 22, PHQ9: 15.5.

Session 4: homework today is progressing because he completed five days a week, all are activities with son and grandchildren to join him. The therapist continued to encourage his family to spend time with him in activities. Mood Rating Scale: 6.

Session 5: with the support of his family, he participated in many healthful activities, now he has joined the local bonsai lover’s association, he has more friends and starts to love his life again. The therapist instructs the patient on how to prevent depression relapse and how to overcome depression in the future. Show the patient how to improve his mood by relying on himself rather than relying on others. The patient promised to continue to activate and plan to some other useful plans in the future. Mood Rating Scale: 8; BID: 16, PHQ-9: 7.

Summary: The patient is elderly, the lack of emotion due to the loss of the wife, while his son and grandson have little attention to him, so he was depressed. He is still healthy, but he lacked attention, he needs more encouragement and caring from everyone, and his spirit will soon return joyfully. Although V.T. progressed slower than the two cases mentioned above, his progress was evident during therapy. His mood though progressed very slowly but increased gradually according to the therapy sessions (see Figure 5), while BID depression and PHQ-9 decreased through each stage of treatment: beginning, middle and end of the process BA (see Figure 6).

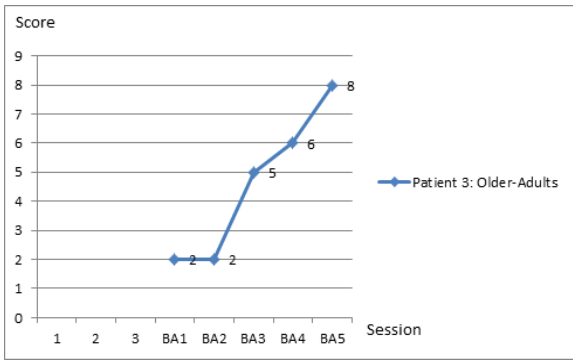

Figure 5. Mood Rating Scale scores across sessions

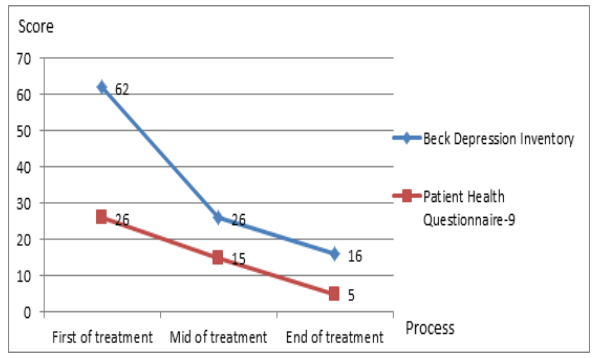

Figure 6. Beck Depression Inventory-Second Edition (BDI-II) and Patient Health Questionnaire-9 (PHQ-9) scores across sessions

Of the 9 cases of depression for the elderly, most 100% of the factors that cause depression for the elderly are related to feelings of lack of sentiment from family members. In the use of BA therapy for the elderly, 7/9 successful cases are a good number, this suggests that elderly adults respond well to BA therapy. The problem here is in the area I studied that the activities for elderly people involved are too limited.

Treatment results after 3 months

C1: number of depression relapse:5

Ability to overcome depression with BA therapy: 75% (therapist interviews patient, patient self-assessment: "You have been using BA therapy to help yourself overcome depression when depression relapse, so how do you assess your ability to overcome depression?").

BID:18 ; PHQ-9: 9 ;

No longer meet DSM-5 criteria.

C2:number of depression relapse: 2

Ability to overcome depression with BA therapy: 90%

BID: 15; PHQ-9: 8 ;

No longer meet DSM-5 criteria.

C3: number of depression relapse: 2

Ability to overcome depression with BA therapy: 95%

BID: 11; PHQ-9: 5 ;

No longer meet DSM-5 criteria.

2.4. Discussion

The present study provides moderate support for the efficacy of a five-week BA intervention in treating. The data indicates that three patients no longer meet DSM-5 criteria at the end of treatment. Although patients still experience some symptomatology, but the symptoms generally occur less frequently and severely than before using BA therapy.

Individual Participant Data

Case1: The data of Figures 1 and 2 clearly demonstrate that the patient's depressive symptoms have begun to improve markedly right after the introduction of BA therapy. This improvement is expressed consistently through mood rating scale and data evaluation of observers. This patient demonstrated that the support of the BA method was effective. At the beginning of treatment, the patient did not cooperate and did not want to proceed with therapy,

she did not want to go out and did not want to do anything. Her study results are not good. Gradually BA made her realize that activity can improve cognitive, emotional improvement, and she has agreed to go out to participate in activities. The result of her mood has improved a lot.

Case 2: Figure 3 and 4. Mean this patient demonstrates the strongest support for the efficacy of BA. From being unable to do anything to improve his family life, he fell into a stalemate, BA has helped him to quickly identify the activity that is the crux of the problem, he has a comprehensive change in both thinking and action. This is the patient who attained the highest absolute mood score which demonstrates that activity has changed the perception of the person from which emotional change is evident.

Case 3: Figure 5 and 6. For the C3 with BA therapy, he is attempting to increase his level of activity outside. He would agree to do homework assignments and would participate in more activities; however, for the initial therapy sessions he encountered psychological difficulties with the assignments; This issue was then gradually improved. Each week the therapist attempted to revise the assignments to greater facilitate their completion. Finally, he succeeded and achieved good results.

Homework and daily follow-up activities are considered essential components of BA. BA's expressive goal is to change individual behavioral repertoire. Finally, this participant needs regular support from his family members, with whom he always participates in activities, he can do activities. With the help of his family, he gradually made positive changes in his motivation for making therapeutic progress.

Limitations and Future Directions

There are some limitations in this study that should be addressed. First of all, in Vietnam, psychotherapy is too strange for many people. Society has not yet realized the role of psychotherapy, which makes it difficult to bring psychotherapy to people. Second, there are only two treatments for therapists. The number of staff in the Department of Psychology is too small, the staff is too young and inexperienced. Third, after treatment, I only tracked three patients, no human resources, no time, no funds for research. If the research continues, I hope that I can track all patients who are treated with BA including unsuccessful patients.

Future studies with larger sample sizes can provide further evidence that an individual is getting effective treatment. In addition, almost all participants indicated that they would like the duration of the treatment phase to be longer. Given the long-term nature of the psychological difficulties of many participants, there is a reason to believe that the five courses of treatment are not sufficient to demonstrate a significant reduction in symptoms. Future studies may be related to expanding the number of treatments to determine whether dose efficacy is related to administering BA. Finally, we hope that future research will expand the scale of treating depression by using psychotherapy, and continue to show that BA is not only introduced to patients who come to the hospital, but also to everyone to know the important role of psychotherapy in society in general, family, school, and other areas in particular.

3. Conclusion

Psychotherapy for treating mentally ill patients, depression for example, in Vietnam, has not received much attention. In general, Vietnamese psychotherapy is still very limited. However, in the process of using psychotherapy for depression in the Vietnam HPH, it has been shown that people really need the development of psychotherapy. The application of behavioral activation therapy brings the expected effectiveness, which saves patients' time, cost, and effort. By using BA, patients can fully control their activities to help themselves without relying on the therapist;

BA can be applied at home, at work, anytime, anywhere, and very convenient. After the end of the BA, patients will receive useful knowledge for future recurrent depression.

The main problem for people with depression is that they don't want to be active. BA helped them change their mindset and behavioral activities. Participating in activities that significantly change mood can improve a patient's health. BA has been shown to be effective in patients at the HPH. Emotional scores, BDI scores, and PHQ-9 scores were significantly improved and therefore did not meet the DSM-5 depression criteria.

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