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BEHAVIOURAL ACTIVATION AND THE DEMEDICALIZATION OF DEPRESSION

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Behavioural Activation (BA) emerges as the most effective therapy for treating depression. It has been shown to be more effective than cognitive therapy, and of similar effectiveness to but more efficient than medications used for treating major depression. BA therapy considers depression in contextual terms, trying to help depressed persons 'get their lives back'. BA represents an alternative view to the deficit models of depression that prevail in clinical settings, be they based on brain chemistry or psychological mechanisms.
Key words: *Depression, Behavioural Activation, Cognitive Therapy, Antidepressants*

La Activación Conductual (AC) emerge como la terapia más eficaz para la depresión. Ha mostrado ser más eficaz que la Terapia Cognitiva y tan eficaz pero más eficiente que la medicación para la depresión mayor. La AC entiende la depresión en términos contextuales y trata de ayudar a las personas deprimidas a reengancharse en sus vidas. La AC representa una alternativa a los modelos del déficit de la depresión que dominan el discurso clínico, sea en términos de química cerebral o de mecanismos psicológicos.
Palabras clave: *Depresión, Activación Conductual, Terapia Cognitiva, Antidepresivos*

Behavioural Activation (BA) is a new therapy for depression. In principle, the appearance of a new therapy for depression should not come as a surprise, since depression is one of the psychological disorders that respond most favourably to therapy, provided it is minimally coherent. Indeed, it is no coincidence that effective therapies for depression are so numerous (Pérez Álvarez & García Montes, 2003). The novelty of BA lies in the fact that it calls into question current clinical practices, even going so far as to propose the demedicalization of depression.

CURRENT CLINICAL PRACTICES CALLED INTO QUESTION

Doubts in relation to clinical practices refer to both medication and cognitive therapy. Medication is undoubtedly the most widely used treatment for depression at the present time. But it so happens that the enormous increase in the incidence of depression in developed countries over the last 25 years can be linked precisely to the availability of medication, not to mention the obvious influence of pharmaceutical marketing. And this is the case despite the fact that the new antidepressants, to which, ironically, the increase in depression is attributable, are neither as effective as the classic antidepressants – at least for the most severe depressions – nor free from harmful effects, as it was assumed when they were launched. What is an indisputable fact is the tremendous cost to healthcare systems of antidepressant medication. According to data from the Spanish Ministry of Health, consumption of antidepressants in this country rose from 7,285,182 bottles sold on Social Security prescription in 1994 to 21,238,558 in 2003. Up to now, antidepressant medication was justified on the basis of an assumed superior efficacy, compared to psychological therapy, in the treatment of major depression. As regards 'minor depression' (from mild to moderate), the efficacy of psychological therapy is also acknowledged. Even so, medication is also the commonest treatment for mild and moderate depression, which are indeed the categories that cover most diagnosed cases of depression (see, in relation to this, González Pardo & Pérez Álvarez, in press; Healy, 2004; Leventhal & Martell, 2006; Medawar & Hardon, 2004).

But BA has shown itself to be as effective as medication in major depression (Dimidjian, Hollon, Dodson et al., 2006). This finding calls into question the choice of medication as the preferred treatment for depression. Likewise, it raises doubts over the supposed biological

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nature of depression, and in any case its consideration as an illness. Furthermore, if we consider that a large part of patients with major depression (between 26 and 66% of primary care patients) would choose psychological therapy over medication if given the option (Craven & Bland, 2006), we might also question the health policies that continue to promote the availability of medication to the detriment of psychological therapy of proven effectiveness. All in all, BA appears to provide powerful reasons for the demedicalization of depression (Jacobson & Gortner, 2000; Pérez Álvarez & García Montes, 2003), bearing in mind that its growing incidence largely corresponds to the medicalization of unhappiness, suffering, dissatisfaction, misfortune, dissatisfaction and sadness (Dworkin, 2001; Pilgrim & Bentall, 1999).

As far as psychological treatments for depression are concerned, cognitive therapy is probably the most widely used, and certainly that which has been most frequently compared with medication. We are talking specifically here about Aaron Beck's Cognitive Therapy for Depression (CT) (Beck, Rush, Shaw & Emery, 1979/1981). Following its inclusion as part of a significant research programme on the treatment of depression under the auspices of the US National Institute of Mental Health (Elkin, Shea, Watkins et al., 1989), CT attained a degree of fame over and above the other psychological therapies (including interpersonal therapy, which also formed part of this study, and despite the fact that it was actually superior to cognitive therapy). In any case, CT continued to show its efficacy in comparison to medication in subsequent studies (DeRubeis, Hollon, Amsterdam et al., 2005; Hollon, DeRubeis, Shelton et al., 2005).

But however efficacious CT may be, the question arises as to whether its efficacy is due to the therapy as a whole or rather one or more of its components, in particular, the behavioural or the cognitive ones. This question is not only of empirical-technical interest in relation to the specification of the active components with a view to perfecting the therapy, but also has important implications related to the status of CT and the nature of the depression concept itself. Specifically, if it turned out that the behavioural component by itself was just as effective as the complete therapy, the cognitive component – and hence the status of the therapy – would be called into question. And this is indeed what the relevant research shows (Jacobson, Dodson, Truax, Addis & Koerner, 1996). From the clinical point of view this would not, in principle, constitute a problem, insofar as we would be talking about the same efficacy but possibly greater efficiency. Confirmation of this research finding could lead to the constitution of the behavioural component as a full-blown therapy in its own right. This is actually what has happened, giving rise to the so-called BA therapy. Moreover, BA has succeeded in showing even greater efficacy than CT itself (Dimidjian et al., 2006). It is somewhat ironic that one of the CT components, duly exploited in isolation from the cognitive element, turns out to be more effective than the full therapy, applied with all of its assumptions.

Thus, BA would not be just another psychological therapy to fall in line along with the cognitive-behavioural therapies; rather, it actually calls into question CT itself, both its bases and its procedure. With respect to CT, BA represents a radically different model. Whilst CT endorses a medical model of psychotherapy, BA endorses a contextual model. In this sense, BA contributes to the demedicalization of depression that would also be desirable in psychological therapy represented by CT.

ORIGIN AND DEVELOPMENT OF BA

As already noted, the origin of BA lies in research on the components of CT (Jacobson et al., 1996). The components of CT fall into two broad classes of techniques: behavioural and cognitive. It goes without saying that the cognitive techniques constitute the essential part of the therapy, in accordance with the cognitive model of depression proposed by the therapy itself. The cognitive model of depression maintains that depressive individuals have certain cognitive schemas (assumptions or beliefs) that predispose them to negative interpretations of life events (cognitive distortions and automatic thoughts), which in turn lead to depressive behaviours (reduced activity and low mood). Thus, CT includes techniques designed to activate behaviours and to address distortions or automatic thoughts and schemas or underlying beliefs. The first objective is carried out by means of behavioural techniques, and the other two by means of cognitive techniques, some dealing with the automatic thoughts and others with the underlying beliefs. Although the therapy usually starts with the behavioural techniques, its efficacy is considered to be due primarily to the cognitive techniques, and all the more insofar as they restructure the underlying depressogenic schemas, which are (according to the corresponding cognitive hypothesis) the root cause of the depression.

Since CT is a multi-component package, explanations alternative to the *cognitive hypothesis* can be considered. Specifically, we might consider two alternative hypotheses: the *activation hypothesis* and the *coping hypothesis*. According to the activation hypothesis, efficacy would be attributable to what the therapy does to 'activate' patients and put them in contact with potentially beneficial environmental conditions. According to the coping hypothesis, efficacy would be due to the skills learned during the therapy for dealing with events and dysfunctional automatic thoughts. According to the cognitive hypothesis, efficacy would be due to restructuring of the underlying depressogenic schemas. In order to test these hypotheses, Jacobson designed a study in which these three conditions were carefully compared (Jacobson et al., 1996):

1)behavioural activation in relation to the activation hypothesis,
2)behavioural activation plus modification of dysfunctional automatic thoughts in relation to the coping hypothesis, and
3) full CT in relation to the cognitive hypothesis

The behavioural activation condition consisted in the behavioural techniques component of CT: programming of activities, rating of 'mastery and pleasure' of activities performed, graded task assignments, covert rehearsal of activities, discussion of specific problems and development of social skills. The behavioural activation plus modification of dysfunctional automatic thoughts condition consisted in adding to the previous condition techniques such as the detection of thoughts preceding mood changes, daily record of dysfunctional thoughts associated with events, review of negative thoughts, training in more realistic thoughts, reattribution of events and testing of negative interpretations. The CT condition consisted in the complete therapy, so that in addition to the above conditions it included cognitive techniques aimed at modifying the schemas, such as discussion of the underlying beliefs causing the depressive problems, identification of the basic assumptions and beliefs, the proposal of alternative assumptions, discussion of the advantages and disadvantages of different beliefs, discussion of the short- and long-term advantages of the different beliefs, assignment of tasks to do at home with a view to testing the validity of the beliefs and review of beliefs associated with events (Beck et al., 1979/1981).

If the structural changes in the underlying schemas are truly necessary for the treatment of depression, then CT (condition 3) should be significantly more efficacious than a therapy consisting of only the modification of dysfunctional automatic thoughts (condition 2), and certainly than one made up of no more than behavioural activation (condition 1).

The finding was that none of the three conditions was superior to the others, all of them yielding an efficacy comparable to that already yielded by CT in previous studies. The results show that behavioural activation is as effective as the complete therapy; they also suggest that cognitive techniques are not necessary for therapeutic change. Thus, the results confirm the activation hypothesis as against the coping hypothesis and the cognitive hypothesis. Given the rigour of the study, it was ruled out that the results could be due to overlapping of the treatments (which were indeed different in accordance with their own protocols) or the inadequate application of CT, which was in fact applied by accredited cognitive therapists (Jacobson et al., 1996). Furthermore, these results were maintained in two-year follow-up, so that it could not be alleged that the cognitive therapy did not have time to show its contribution (Gortner, Gollan, Dodson & Jacobson, 1998).

This finding gave rise to the proposal of behavioural activation, up to now a component of CT, as a therapy in itself, but the consideration of BA as a therapy *per se* involved its reappraisal as a therapy that was strictly speaking behavioural. Thus, it is resituated in the tradition and the perspective of the functional analysis of depression as established by Ferster (1973), after Skinner (1957/1981). According to Ferster's analysis, depression would consist basically in the reduction of positively reinforced behaviours (reduction of interesting activities) and/or the increase of negatively reinforced behaviours (consisting in the avoidance of something negative more than in the attainment of something positive). It is understood that this situation is due to gradual or abrupt changes in personal circumstances. The point here is that depression involves a *situation* in which things that were previously of value or worthwhile have lost their value, or even taken on a negative value. Thus, depression would be more of a situation *in which* one finds oneself than something one has *within oneself*.

Likewise, BA is akin to the behaviour therapy for depression developed by Lewinsohn and colleagues from the 1970s onwards (Lewinsohn, Muñoz, Youngren & Zeiss, 1978; Lewinsohn & Gotlib, 1995). Lewinsohn's therapy stresses the development of pleasant activities

and social skills. However, with respect to Lewinsohn's behaviour therapies for depression and others that could be cited (see Pérez Álvarez & García-Montes, 2003), BA incorporates some important new aspects (Hopko, Lejuez, Ruggiero & Eifert, 2003).

First of all, BA is more idiographic than traditional behaviour therapies (and certainly than CT), insofar as it pays more attention to the personal circumstances that maintain a specific individual's depressive behaviour. In this line, and secondly, BA involves functional analysis of both the depressive behaviour and the activities proposed. Thus, for example, more than merely increasing activities assumed to be pleasant (or simply drawing up schedules), BA proposes activities that are relevant to the needs and values of that particular person. Thirdly, BA incorporates the acceptance-change model that already formed part of Acceptance and Commitment Therapy (ACT) (Wilson & Luciano, 2002). Thus, it proposes that patients carry out activities in spite of their mood or the negative thoughts they may have. In any case, the 'acceptance' of BA is oriented more towards change than to acceptance *per se*, since it is more a case of modifying the conditions on which the 'depressive experience' depends than accepting such experience in line with a 'philosophy of life'. A propos of ACT, BA also introduces the concept of avoidance, even if it refers to behavioural avoidance rather than experiential avoidance (as we shall see later). Fourthly, BA acknowledges the implication of cognition in depression, but does not consider it to be the immediate cause of the overt behaviour, or that it should be the direct object of treatment. BA 'treats' cognitions and emotions indirectly, on putting people in contact with the possible positive consequences of their overt behaviour.

CONTEXTUAL PHILOSOPHY

BA represents first of all a recovery of the contextual roots of behaviour therapy (Jacobson, 1997; Jacobson, Martell & Dimidjian, 2001).

In what could be considered as its first-generation version, from the 1950s, behaviour therapy had a markedly contextual approach, on stressing environmental contingencies as determinants of behaviour, including problematic behaviour. An example of this approach would be Ferster's (1973) above-mentioned functional analysis of depression (1973). In this sense, behavioural change would involve change in the environment in relation to it. This environmental change can be 'operated' by the therapist insofar as the necessary conditions are available – which often restricts things to institutional contexts. Another possibility for the therapist to 'manage' the environment lies in the clinical situation. This possibility was developed in particular by functional analytical psychotherapy (Kohlenberg, Tsai, Parker, Bolling & Kanter, 1999). Environmental change can also be 'operated' by patients, if they do something that can alter the circumstances in a beneficial way. In this case the patient's role would be transformed from a passive one to that of an active agent or operative subject. This is the strategy BA will follow.

However, this contextual approach largely disappeared when behaviour therapy allied itself with cognitive therapy, giving rise to the well-known cognitive-behavioural concept, which would constitute a second generation of behaviour therapy, from the 1970s onwards. Now, the aim of therapy would be to change not the environment but the mind. Psychological problems would no longer be due to life conditions, but rather to perceptions, information processing, and so on: in sum, there was a shift from a contextual approach to a cognitive one. An example of this *descent* into the cognitive approach would be precisely Beck's Cognitive Therapy for Depression. The point is, however, that much of the success of the cognitive approach would be at the cost of distorting the contextual and idiographic sense of behaviour therapy and adopting in its place a medical, internalist, nomothetic model, largely decontextualized from psychological problems, as though all cases of a condition were equal and its causes consisted in a deficiency or dysfunction of some supposed internal mechanism. Furthermore, the cognitive approach may impede more effective therapeutic applications, given its explanatory rigidity and the standardization of its procedure (Addis & Jacobson, 1996; Kohlenberg, Kanter, Bolling et al., 2002).

As a result of these problems (distortion of contextual sense and limited efficacy), together with improved development of the contextual approach, there emerged during the 1990s a new generation of therapies, already dubbed the third wave or third generation of behaviour therapies (Hayes, 2004; Pérez Álvarez, 2006). Among these new therapies is BA. A characteristic of all of them, beginning with BA, is precisely the recovery of the lost contextual roots. But it is not simply a question of reclaiming lost roots; rather, BA represents an entire contextual philosophy in relation to the understanding of

psychological (psychiatric or mental) disorders and their treatment.

The contextual philosophy situates psychological disorders in the context of personal circumstances and not, for example, in that of some supposed internal, psychiatric and psychological malfunction. The 'symptoms', far from being seen as emanations (outbreaks or signs) of underlying causes, would be seen as dramatic (in various senses) actions that develop in the course of life. These 'symptoms', like all behaviours, have some function, obviously in the context in which they occur. In this sense, 'symptoms' would be both a problem and an attempted solution, albeit unsuccessful. It could be stated, then, that 'symptoms' are failed attempts to solve a life problem. In this perspective, chronification could be seen more as the installation of a person in the 'symptom' than as the 'symptom' installed in a person, whose installation *in* the 'symptom' can be influenced, indeed, by some clinical practices.

This contextual philosophy, in turn, conceives psychological treatment as a task consisting, above all, in helping the person to solve the problems presented. More specifically, psychological therapy would be conceived as behavioural consultancy (Froján, 2004). The role of the therapist is thus defined, and is explained to the client in terms of consultant, counsellor, collaborator or even '(personal) coach', in spite of being within the framework of a clinical-medical context, or perhaps precisely because of that. This role would have to generate the complementary role of client or consulter, more than that of patient or sufferer. In any event, the point is that the 'patient' adopts an active role in relation to his/her problem, rather than waiting for the clinician to provide him or her with the necessary solution (if one exists). It goes without saying that this therapeutic relationship is somewhat paradoxical in the clinical context as it is "formatted" in the image of medical practice. The clinical psychologist, although a clinical professional, would not be a clinician in the medico-psychiatric sense.

BA is a paradigmatic example of this contextual philosophy of clinical practice, consisting in making patients active agents in changing the real conditions on which their problem depends. It would also be relevant in this line to cite Costa and López's (2006) psychological help model, conceived expressly to 'give power for living' in the sense of 'strengthening people', in contrast to the tendency to convert them into patient-consumers of remedies that promote helplessness.

DEPRESSION IN CONTEXT

According to this perspective, depression is not something that one has, as we are often given to understand, as though one had an internal pathogenic condition (a neurochemical imbalance or a deficit in psychological functioning), but rather a situation in which one finds oneself, typically a situation without incentives, at least without the incentives that were previously important. This depressive situation may be due to a range of circumstances, though these are not always easy to identify. For many people, the onset of depression may follow a situation of sudden loss, such as losing one's job, the end of a relationship or the death of a close one; failure to achieve a personal goal; or difficulty in coping with the vicissitudes of everyday life. For others, however, the onset of depression is not easy to associate with any circumstances or events in particular. Even so, this does not mean they do not exist. In the contextual perspective the antecedent conditions can be considered to have been present for a long time – even years – without the individual him/herself realizing it. In any case, it does not follow that it is necessary to assign the aetiology of depression to supposed biochemical conditions; nor do we gain anything by labelling it as endogenous. The attribution of depression to biochemical or endogenous causes is more representative of ignorance of personal conditions than of actual knowledge of causal factors.

The guiding principle of BA is that people are susceptible to depression for a range of circumstances. Thus, depression would be nothing more than a possible form of being-in-the-world, given the circumstances. The fact of anyone having more propensity to depression than another in the 'same circumstances' should be understood in the context of his or her personal history, which is unique, so that one is never really in the 'same circumstances' as another. The invocation of a supposed genetic predisposition is not only made in the absence of causal knowledge, but it diverts attention from knowledge of the contextual causes, which are indeed more plausible and remediable.

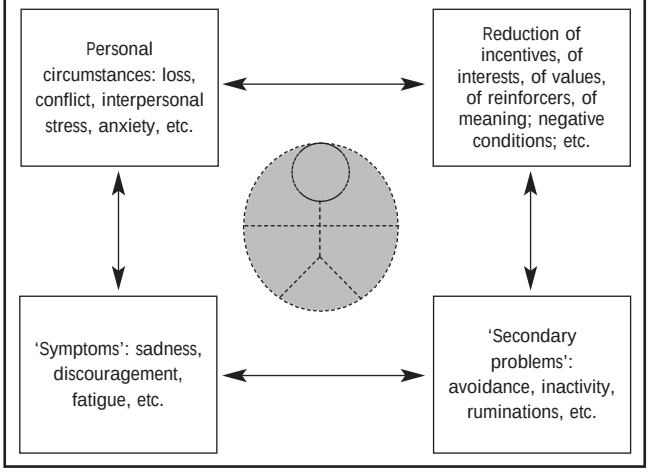
In any case, regardless of the clarity of the circumstances that have brought about the depression, depressed people tend to act in a way that may serve to maintain the depressive condition itself. The actions and reactions characterizing the depressed person play a significant role in depression, rather than being mere symptoms of a condition, as assumed by the current psychopathology (of a nosographic bent). Thus, according to BA, a large part

of the 'symptoms' of depressed people actually work as avoidance, which in effect makes them 'symptoms' that fulfil a function in relation to the environment. Looked at in this way, symptoms could be more appropriately considered as behaviours. Indeed, BA refers to symptoms in terms of 'behavioural avoidance'.

Behavioural avoidance takes a variety of forms, from staying at home, 'withdrawing' from one's normal activities to 'ruminations' or 'depressive modes of interaction' with others. In general, it could be said that 'depression' on the whole is a form of avoidance, even though it is not always obvious that clients' behaviours are avoidance behaviours. The client does what *feels* natural. Only when one analyzes the consequences of the behaviour can one begin to understand its function, in this case, that of avoidance. The decisive aspect is the function, rather than the form. The point is that the avoidance would not only be preventing depressed people from confronting the problems that have caused the current situation and opening up now possibilities for their life, but that it would also be perpetuating the vicious circle of depression.

But behavioural avoidance is actually a 'secondary problem' derived from the initial depressogenic circumstances, which do play a fundamental role in the depressive situation. Thus, BA is concerned both with the events that occur in a person's life, in this case the circumstances that bring about the depression, and with the responses to such events, in this case, behavioural avoidance. BA represents the depressive situation as interaction between diverse aspects of the context, as shown in Figure 1.

FIGURE 1
CONTEXTUAL MODEL OF DEPRESIÓN



Life events, then, may be associated with a reduction in positive reinforcement or life incentives, which may lead to 'secondary problems' of avoidance and to diverse 'depressive symptoms'. Note that the 'symptoms', often considered as the 'depression' itself, are no more than an aspect of an entire situation that ends up engulfing the person.

APPLICATION OF BA

For the application of BA, the contextual philosophy is more important than the techniques. In fact, the techniques are fairly common ones, though those applying them do require some degree of skill and should have a clear idea of the direction they are taking (Martell et al., 2001, p. 59). Below, we shall first of all consider some principles the therapist should bear in mind throughout the therapy. This will be followed by a consideration of some of the foundations underpinning the therapeutic application, and finally, by an explanation of the procedure (Hopko et al., 2003; Jacobson, Martell & Dimidjian, 2001; Martell et al., 2001).

Principles to bear in mind throughout the therapy

1) *People are susceptible to depression for a variety of reasons*. The reference to 'susceptibility' suggests that depression is understood more as a possibility within human beings than as a deficit or dysfunction in relation to some supposed neuro-psychological mechanism. As regards the reference to a 'variety of reasons', it concerns life circumstances; these may not always be easy to identify, but this should not lead to the conclusion that depression has endogenous causes. In this context, it would be more appropriate to say that depression had life-related *reasons* than that it had biological *causes*.
2) *Behaviours for coping with the depressive situation play a decisive role in depression*. This refers to the fact that behaviours characteristic of depressed people exacerbate depression, prevent them from changing things by dealing adequately with life problems, and sustain a passive attitude that leads to a vicious circle. These 'depressive' behaviours would include feelings of sadness, pessimistic thoughts, reduction of activities, passive attitude, and so on. For BA, these behaviours, far from being mere symptoms of depression, constitute and contribute to the depressive condition. In particular, BA highlights the

avoidance role fulfilled by such symptoms or behaviours – the behavioural avoidance previously referred to.

3) *BA does not consist simply in increasing pleasant activities*. It is not a question of simply doing things for the sake of it (in hypomaniac fashion), nor of filling up time to keep oneself occupied, but rather of doing something functional, which makes practical sense for the person. The idea is that the consultant ends up becoming an expert in observing the relationships between the actions and consequences in everyday life, particularly the consequences related to the client's mood.
4) *Clients should be aware of the situation they are in and the consequences of behaviours on their mood*. BA teaches clients to observe what they do or fail to do so as to see why they feel the way they feel. It is a priority of BA to link what is happening to the person and their life circumstances.

Foundations underpinning the therapeutic application

a) *The main focus of the therapy are the client's behaviours and the context in which they occur*. The crucial question for the therapist is 'what circumstances are involved in how the client feels and responds to them so as to maintain the feeling' – of sadness, discouragement or whatever.
b) *The therapy tries to teach clients to be active, in spite of their emotional states*. The aim is for clients to act in accordance with objectives that will benefit them rather than in accordance with how they feel.
c) *The therapy needs to identify response patterns that could be maintaining the depression*. This involves analyzing, by means of daily records or other data, the client's characteristic patterns in everyday life.
d) *The therapy teaches clients to make functional analyses of their own behaviours, identifying their antecedents and consequences*. It represents, in general, a new perspective about oneself, consisting in understanding one's own behaviour in relation to the context, rather than being content with internal explanations referring to feelings or thoughts. It is not a question of invalidating or disputing the explanations given by clients in terms of internal causes, such as when they attribute their behaviour to 'low self-esteem', but rather of relating such 'causes' to manageable conditions of the context. Thus, with regard to 'low self-esteem', the therapist would not question this concept, but would rather say something like, 'Well, people understand different things by this term, and I'd like to know what it means for you. Could you tell me what sort of things are happening when you feel you have low self-esteem? Are there times when your self-esteem is high?' Once the internal explanations, which appeared self-sufficient, are related to the conditions on which they actually depend, it is possible to 'activate' the person in a way in which he or she can now create, change and improve his/her situation, including the 'self-esteem' component.

PROCEDURE

Presentation of the procedure of BA has to begin with a consideration of four objectives: behavioural avoidance, therapeutic context, disruption of routines and passive coping.

Behavioural avoidance. As already suggested, behavioural avoidance constitutes, as far as BA is concerned, the fundamental problem of depression. Given the circumstances through which one has *entered* into a depression, a secondary problem – in terms of time –, that of behavioural avoidance, emerges as the essential problem of the depressive situation. According to BA, depression itself is a form of avoidance. The avoidance we are talking about here is not a question of intentionality (as in saying that the client spends the day in bed to avoid going to work), but rather of functionality, insofar as the action in question does nothing to resolve the situation. A functional, pragmatic criterion is what prevails in BA. More specifically, behavioural avoidance maintains one out of contact with the conditions on which can depend an improvement, at the same time as potentially condemning one to a self-reflective vicious circle.

Therapeutic context. For BA, as for other psychotherapies, the context of the therapeutic relationship is highly important. But BA not only requires an empirical collaboration like CT, in this case to put behavioural activation into practice in the extra-clinical context, but takes the therapeutic relationship itself as the actual therapeutic context, being akin in this respect to functional analytical psychotherapy (Kohlenberg et al., 1999). Thus, it is a requirement of the BA therapist to consider the function of the client's verbalizations as much as or even more so than their content. For example, the client's expression 'I feel lonely' may have the function of a 'mand', in Skinnerian terminology, which indeed

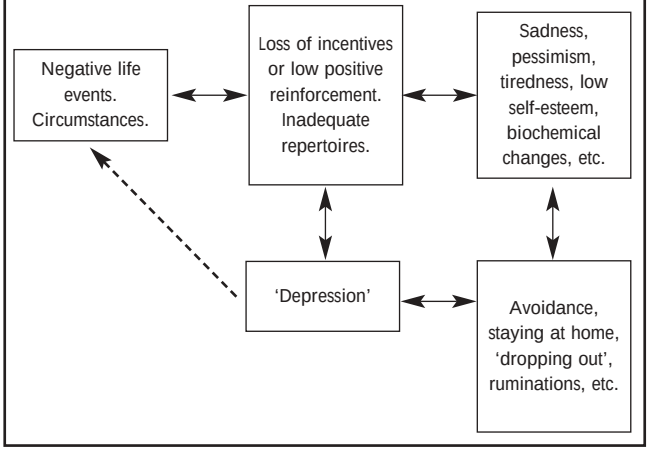
demands certain a social attention; it can have the function of 'magic mand' in Skinner's definition (1957/1981, p. 62), without this 'demanding' a particular response; or, finally, it can have the function of avoiding the subject that was being talked about. In general, it is better to stimulate conversations about practical activities than to encourage conversations about repeated complaints in relation to the client's life.

Disruption of routines. Disruption of the routines that constitute the functioning of everyday life tends to precede a depressive episode. Although such disruption is particularly recognized in bipolar depression, it is also important in other forms of depression. In any case, BA attempts to re-establish the interrupted routines or to establish others capable of stabilizing the client's everyday life pattern.

Passive coping. Given that passive coping is the accomplice of the depressive situation, BA proposes from the outset an active role for its clients. Instead of assigning to depressed people the role of passive patients, waiting to get well in order to act, BA proposes that they act in order to get well.

BA is an idiographic treatment, so that it does not follow a protocolized session-by-session procedure. In any case, its logic permits a structured application which is nevertheless flexible. Duration of the treatment is 20-24 sessions, even though there are briefer versions of the order of 6-12 sessions (Lejuez, Hopko & Hopko, 2001), and even self-application formats (Addis & Martell, 2004). The course of the treatment moves through a series of stages. It begins, like other psychotherapies, with the establishment of a collaborative therapeutic relationship,

FIGURE 2
MODEL OF DEPRESSION PRESENTED TO THE CLIENT



though the BA approach seeks to maintain a balance between attention to the client's preoccupations and adherence to the treatment objectives and techniques. In this line, the therapist demonstrates an understanding of the client's situation and asks questions that can lead to greater specification of the behavioural patterns that have become problematic. Given this context, the therapist shows the client how to analyze the depression in contextual terms, presenting a model of depression, often through the use of diagrams. The model of depression presented to the client situates on a diagram the different aspects of the depressive situation (Figure 2).

One of these aspects is given by the life conditions antecedent to the depression. These antecedent conditions may consist in easily identifiable current or recent negative events or in predisposing biographical circumstances. Another aspect is the loss of incentive of things that were previously of interest and value – in technical terms, the low level of positive reinforcement. This aspect also includes the inadequacy of the behavioural repertoires necessary for maintaining or attaining worthwhile or valued goals. Another aspect distinguished is the 'depressive feeling' (sadness, low self-esteem, etc.) resulting from the previous aspects. We might include here possible neurochemical changes concomitant to the depressive state. Note that this aspect, often considered as the depression itself, is situated in the model as a sub-effect of the depressive situation and not, for example, as a self-defining cause or entity. A fourth aspect identified is the behavioural avoidance pattern, consisting in withdrawal from one's normal activities, involvement in other activities which only lead to the avoidance of situations, 'dropping out' in various senses, 'rumination', turning thoughts over and over with no resolution, and so on. Despite this aspect being, as stressed above, a 'secondary problem' of the depressive condition, it nevertheless plays a decisive role in the development and maintenance of the depression. The model also considers a fifth aspect called 'depression', perhaps so that the idea of depression becomes *situated* in the model, though this 'depression' is no more than one aspect within the circuit constituting the depressive situation. The reader will recall that depression would be a *situation* in which one finds oneself, and not a *thing* one has inside oneself.

The intention of the model is to provide an understanding of the circuit that comes to constitute the depression and to make the client see how to escape from

it. It is a question of understanding the 'trap' of depression and getting back on 'track' through 'action'. BA indeed uses these three words as acronyms: TRAP, TRAC(K) and ACTION, in order to transmit the essential idea of the underlying functional analysis.

TRAP stands for:

Trigger, to refer to negative antecedent events;

Response, to refer in this case to how one feels (e.g., 'depressed');

Avoidance-**P**attern, 'avoidance pattern', to refer to the pattern of avoidance one adopts ('staying at home', etc.).

It is understood that the *avoidance pattern* maintains the *response* of feeling depressed and impedes one from dealing with the *events* that *triggered* it (Figure 3). In order to get out of this trap, BA proposes an alternative path or 'track', TRAC.

TRAC stands for:

Trigger, as in TRAP;

Response, as in TRAP;

Alternative **C**oping, to refer to a new pattern of action that breaks the established avoidance pattern.

It is understood that the *alternative coping* blocks the avoidance pattern, interrupts the circuit that reinforces the depressive response and opens up the possibility of modifying the 'depressogenic' situation (Figure 3).

For its part, ACTION is another acronym that can be useful for some clients with a view to establishing new routines.

ACTION stands for:

Assess, in this case asking oneself whether what one does might not actually be maintaining the problem;

Choose, taking the decision to continue avoiding or to act in a resolutive way;

Try, the actions chosen;

Integrate, the new activities into one's daily routines;

Observe, the result, asking oneself if one feels better or worse after this activity and if it is in the direction of one's long-term goal.

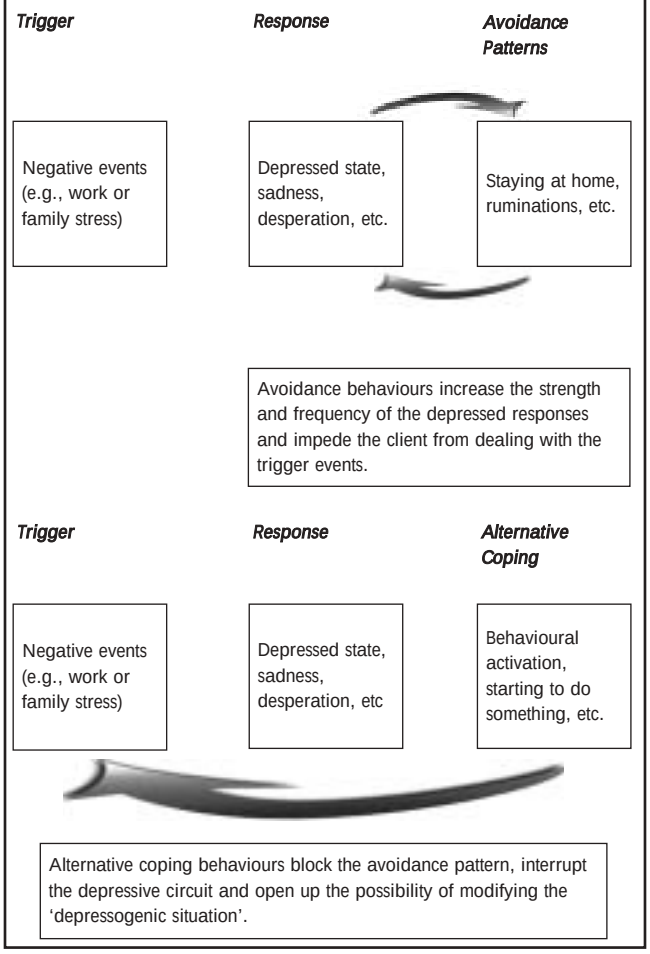
Never give up, keep on trying.

On the assumption that what is most important is the contextual philosophy, BA boasts a range of other techniques, in addition to the functional analysis through the TRAP, TRAC and ACTION schemas. Among them, perhaps the most important is the continuous monitoring of activity, by any means (systematic records, diaries, narratives, etc.), so that clients can relate what they *feel* with what they *do* and what is *happening in their environment*.

In a similar line, continuous assessment may take place through, for example, an inventory such as that of Beck. Likewise, BA may involve a rating of the 'mastery and pleasure' of activities, always with the aim of providing opportunities for bringing into play actions that might possibly be reinforced by the contingencies of the natural social environment. Other common techniques are:

- assignment of graded tasks,
- verbal rehearsal of the tasks proposed,
- management of situational contingencies,
- rehearsal of behaviour,
- shaping of activation strategies by the therapist,
- training for overcoming social skills or other deficits,
- relationships therapy,
- 'attention to the experience' or *mindfulness*,
- acceptance, etc.

FIGURE 3
THE 'TRAP' OF DEPRESSION AND THE ALTERNATIVE 'TRACK'



The therapy also considers techniques that may involve temporary relief, such as distraction, restricted contact, avoidance, or medication, with a view to improving the conditions in which one will deal with the situations that eventually have to be faced.

Of all the techniques used in BA, of the most noteworthy is 'goal-directed action' (Martell et al., 2001, pp. 116-119), a revised version of George Kelly's 'fixed-role therapy' and Alfred Adler's 'acting as-if' (Pérez Álvarez, 1996, p. 154). Clients are instructed to behave in accordance with a self-proposed goal or in a way consistent with how they would like to feel or be perceived by others – for example, as though they had 'high self-esteem'. The new role is designed and trained and it is proposed to the client that they act *as-if*, in this case, they had 'high self-esteem'. BA uses this technique of acting in accordance with a goal more than with a feeling, so as to demonstrate to clients that their behaviour can have an effect on how they feel and how others interact with them. After all, depressive behaviour contributes to a person's depressed feelings and creates a depressing atmosphere, which extends to others' interaction with that person. Beyond this justification, moreover, behaving *as-if* corresponds to a 'Quixotic principle' or 'Quixote effect' according to which feigning and pretending a (temporary) way of being can actually forge a full-blown and more permanent way of being, way of life or character (Pérez Álvarez, 2005; Pérez Álvarez & García Montes, 2004). This can work both for good and for ill: for good insofar as behaving *as-if* makes one capable of overcoming insecurity, and for ill insofar as such as *as-if* can lead to a neurotic character or style, as Adler would put it. Thus, for example, if one has to 'feigning' and 'pretending' that one is more depressed than one actually is to obtain a 'sicknote' and 'justify' it to others, one may end up actually 'forging' a depression, including the social environment generated.

EMPIRICAL EVIDENCE

The first empirical evidence on BA comes from the study of the breakdown of the CT components in which, the reader will recall, the 'behavioural activation' component showed an efficacy equivalent to that of the complete therapy (Jacobson et al., 1996). It should be borne in mind that CT is of proven efficacy, and is in fact currently the psychological therapy of reference for others (Pérez Álvarez & García Montes, 2003).

Following that research, BA as a therapy in its own right was tested in various studies. Thus, a study with hospital inpatients with major depression showed that BA applied in a brief format over two weeks with three 20-minute sessions per week was significantly more effective than supportive psychotherapy (Hopko, Lejuez, LePage, Hopko & McNeil, 2003). BA has also been tested in group format with major depression in a public mental health context, showing its efficacy in a waitlist-group design (Porter, Spates & Smitham, 2004). Another study showed BA to be effective both in patients who are taking antidepressant medication and those who are not, in an application of between 6 and 10 sessions (Cullen, Spates, Pagoto & Doran, 2006). There are also case studies on BA applied to depression with additional complications, and which again show its efficacy (Hopko, Bell, Armento, Hunt & Lejuez, 2005; Hopko, Lejuez & Hopko, 2004; Hopko, Robertson & Lejuez, 2006; Hopko, Sánchez, Hopko, Dvir & Lejuez, 2003; Lejuez, Hopko, LePage, Hopko & McNeil, 2001; Mulick & Naugle, 2004; Ruggiero, Morris, Hopko & Lejuez, 2005).

However, the most important study providing evidence in favour of BA, and probably the most rigorous of those carried out up to now in the field of depression, is that already cited, by Dimidjian et al. (2006). This study compared BA with CT and with antidepressant medication in a randomized design with control-placebo groups in 241 adult patients with major depression. Although all the treatments were effective with less severe depression, BA was superior to CT with more severe depression, equalling the efficacy of medication. Moreover, BA showed a lower drop-out rate than medication. This means that 'patients', here considered as active agents, are more committed to BA than to medication, despite the latter apparently being a more convenient form of treatment. If in addition to this we consider the side effects that tend to be associated with medication and the relapses that tend to occur when patients come off it, all things considered BA emerges as the best treatment option.

In sum, the empirical evidence shows that BA is a psychological treatment of proven effectiveness for depression. All the indications are that it is more effective than CT itself and just as effective as medication, currently the therapy of reference against which other therapies are tested. The empirical evidence also shows BA to be an efficient treatment in cost-benefit terms. For a start, BA is more parsimonious than CT; by comparison with medication, fewer people appear to give up BA, so that

reaches more clients, not to mention the data in relation to relapses and side effects; furthermore, BA has also shown its efficacy in brief formats, of the order of 6-10 sessions, and is suitable for group application to 6-10 participants. It will be recalled that its efficacy has been proven in a variety of contexts, including that of public mental health services. There is also preliminary evidence from case studies suggesting the efficacy of BA for other conditions, such as post-traumatic stress disorder (Mulick et al., 2005; Mulick & Naugle, 2004), anxiety disorder (Hopko et al., 2004; Hopko et al., 2006) and borderline personality disorder (Hopko et. al., 2003).

It should be stressed that this efficacy shown by BA was measured using instruments associated with CT and medication, the typical scales of Beck and Hamilton. Nevertheless, BA also has its own scale (Kanter, Mulick, Bush, Berlin & Martell, 2007). It is assumed that the efficacy of a depression therapy should be measured not only in negative terms of *reduction of symptoms*, but also in positive terms of *personal improvements* (environmental changes, life orientation, clarification of values, carrying out of activities, achievement of objectives, and so on).

TOWARDS THE DEMEDICALIZATION OF DEPRESSION

In the year 2000, Jacobson and Gortner wondered whether the 21st century might see the demedicalization of depression (Jacobson & Gortner, 2000). The answer depended on a study in which BA was tested in relation to CT and antidepressant medication, according to a challenging methodological design. Thus, for example, CT would be applied by a *Dream Team* of cognitive therapists, so that there could be no suggestion of a lack of commitment to the therapy. Likewise, the medication would be applied with all the necessary psychopharmacological rigour. For its part, the contextual character of BA would be maximized. The study in question is none other than that already cited, by Dimidjian et al. (2006).

In the light of the data, the reply would be that depression can indeed be demedicalized. What does this mean in the current state of affairs? First of all, the reopening of an alternative to the deficit models of depression that dominate clinical discourse, be it in terms of brain chemistry (typically, 'serotonin imbalances') or of psychological mechanisms (typically, 'cognitive schemas'). These deficit models represent the triumph of the illness model among mental health professionals, a model that was once contested by clinical psychologists but is now embraced by the majority of them, insofar as CT is the psychological treatment of reference. Indeed, the illness model of depression is incorporated in clinical conventions even by those who advocate psychological treatment.

The alternative would be a contextual model which, as we have seen, begins by helping clients to understand the problem presented in relation to their personal circumstances and to what they do in response to them (rather than as something that 'happens' or is 'faulty' inside them). Given the current climate, it is especially relevant to resituate the 'patient' with respect to his or her own problem, since it is common for people to conceive themselves precisely as patients suffering from the supposed illness of depression – a notion propagated in popular clinical culture and promoted in professional practice. Since this conception is derived not from scientific findings but from cultural tendencies largely promoted by the pharmaceutical industry, it is open to question, and, as proposed here, to replacement by one in which people would take the initiative for solving their own problems as active agents seeking help in accordance with the nature of those problems – which would be the type of help provided by BA. For a discussion of the contextual perspective in clinical practice, see, for example, Costa and López (2006) or González Pardo and Pérez Álvarez (in press).

At the very least, patients/clients should be informed of these therapeutic findings, which suggest an alternative to medication and to the consideration of their problem as an illness. It goes without saying that this notion does not in any way belittle depression or ignore the suffering it involves. What it does is situate depression in the context of life problems and give back to the patient the role of agent expropriated by the illness conception.

Clinical professionals should also be informed of how, moreover, it is their duty to take note of findings such as these, coming out of duly controlled and published studies. If the 'ongoing training' of clinicians were to include – as its merits demand – the contextual alternative, the demedicalization of depression would be possible, since its current medicalization is more than anything an institutional question. 'How institutions think' determines whether things develop in one way or in another. In any event, change in clinical conventions is not only a question of 'ongoing training', but rather, and above all, of 'initial training', of the way professionals are educated before they begin their careers in the field. If the

clinicians of the future do not know how to conceive of people's problems other than in terms of molecules or minds, apart from the fact of their ignorance of other approaches, they may well be subject to a sort of 'Charcot effect', whereby they will find in patients what they themselves prescribe (Pérez Álvarez & García Montes, in press). It is even easier for those who think in terms of molecules to be subject to this effect, since patients tend to be formatted through the same concepts, notions and marketing as those which influence the training and education of the professional themselves.

Finally, a health system that is not content with mere statistics, that is concerned with the ever-rising cost of antidepressants (which, the reader will recall, has tripled in 10 years), and that is also interested in offering the most effective and efficient solutions for its users, should consider the contextual alternative represented by BA. It is a case not only of acknowledging, as we have seen, the better alternative represented by psychological treatments for depression (Pérez Alvarez & García Montes, 2003) – an alternative also recognized, indeed, by the London School of Economics (LSE, 2006; see also InfoCop, 2006), which recommended the British National Health System to take on five thousand clinical psychologists over the next seven years – but also of highlighting within the psychological treatments the most efficacious and efficient alternative, which would appear to be BA, and which the US National Institute of Mental Health has already begun to consider at least as a simpler form of CT (NIMH, 2005, p. 92).

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