

BEHAVIORAL ACTIVATION INTERVENTION IN A PATIENT WITH DEPRESSIVE SYMPTOMATOLOGY

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This is a report on treatment for a 44-year-old man with depressive symptomatology. The intervention proposed was based on the Behavioral Activation (BA) perspective, which considers some types of depression as elaborate forms of avoidance. Treatment components included recovery of tasks that had previously been given up, reconsideration of life goals, extinction of avoidance behaviors, time scheduling and reengagement with domestic, creative work and social activities. After seven months of treatment, significant changes could be appreciated in pre-treatment measures (BDI-II, AAQ, ATQ, EROS, and BADS), as well as in the number and kinds of activities carried out. Depression was in full remission and the patient had resumed his productive work. Follow-up showed that the therapeutic benefits persisted for the next five months. In spite of the severity of the symptoms, the patient preferred not to take antidepressant medication, and so it was never used. The good outcomes obtained in spite of this circumstance and of the relative brevity of the intervention strongly support the model proposed from BA for these kinds of cases.

Key words: Behavioral activation, Depression, Case studies, Single-case experiment.

Se presenta el tratamiento de un sujeto varón de 44 años con síntomas de depresión. La intervención se organizó a partir del análisis propuesto por la Activación Conductual (AC), que contempla algunos tipos de depresión como formas elaboradas de evitación. Entre los componentes del tratamiento se incluyó la recuperación de tareas abandonadas, el replanteamiento de nuevos objetivos vitales, la extinción de conductas de evitación, la programación horaria y la recuperación de obligaciones domésticas, laborales y sociales. Después de siete meses de intervención se apreciaron cambios significativos en las medidas pretratamiento (BDI-II, AAQ, ATQ, EROS y BADS), así como en el número y el tipo de actividades desarrolladas. Tras este tiempo el cuadro depresivo podía considerarse remitido y el paciente había recuperado un trabajo productivo. Los beneficios terapéuticos se mantuvieron durante los siguientes cinco meses de seguimiento. A pesar de la gravedad del cuadro, el sujeto no deseaba tomar medicación antidepresiva, por lo que ésta no se empleó en ningún momento. Los buenos resultados obtenidos no obstante esta circunstancia y la duración relativamente breve de la intervención suponen un aval importante para el modelo de terapia propuesto por la AC para este tipo de casos.

Palabras clave: Activación conductual, Depresión, Estudios de casos, Experimento de caso único.

Recent years have seen renewed interest from clinicians in behavioral activation methods aimed at palliating depressive symptoms, including graded task assignment, goal setting scheduling, reinforcement of social contact behaviors or performance of gratifying activities (Kanter, Busch, & Rusch, 2009; Lejuez, Hopko, & Hopko, 2002; Martell, Addis, & Jacobson, 2001). In fact, there was always a place for these strategies in the most serious cases, but they were considered as part of an initial approach, and as a preparatory step for the use of cognitive techniques whose procedures, it was believed, would enable solid improvements in depressive conditions and the avoidance of relapses

(Beck, Rush, Shaw, & Emery, 1979). However, recent meta-analytical reviews (Cuijpers, van Straten, & Warmerdam, 2007) and experimental studies comparing different therapeutic approaches — antidepressant medication, cognitive therapy and behavioral activation therapy — (Dimidjian et al., 2006) have revealed that purely behavioral interventions are sufficiently effective and efficient for depressive conditions, even in the long term (Dobson et al., 2008).

At the same time as the really useful components of cognitive therapy were being studied systematically (Gortner, Gollan, Dobson, & Jacobson, 1998; Jacobson et al., 1996), a clinical approach to depression was being formulated that incorporated the analysis of the factors maintaining it. This approach recovered the explanatory model of Ferster (1973) and Lewinsohn's (1974) first model, but enlarged on them, stressing the functional character that should guide all case analyses (Hopko, Lejuez, Ruggiero, & Eifert, 2003; Jacobson & Gortner,

The original Spanish version of this paper has been previously published in *Clínica y Salud*, 2010, Vol. 21, No 2, 183-197

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2000; Jacobson, Martell, & Dimidjian, 2001). Thus, what eventually emerged is not a mere updated version of behavioral activation techniques, but rather a whole new therapy (Behavioral Activation, BA) which, put simply, can be defined as a procedure that is well structured but flexible, idiographic in nature and whose aim is for depressed patients to learn to organize their lives and change their environment so as to re-establish contact with sources of positive reinforcement. In view of this emphasis on functional analysis and of its contextual approach – and also in part because of some of the techniques it incorporates – BA has come to be classified within the so-called third generation of cognitive-behavioral approaches (Barraca, 2006; Hayes, 2004; Pérez-Álvarez, 2006).

Today, BA has amassed extensive evidence of its efficacy, both in well controlled experimental studies (Dimidjian et al., 2006; Gawrysiak, Nicholas, & Hopko, 2009; Hopko, Lejuez, LePage, Hopko, & McNeil, 2003; Pagoto, Bodenlos, Schneider, Olendzki, Spates, & Ma, 2008) and in case studies (Bottonari, Roberts, Thomas, & Read, 2008; Hopko, Lejuez, & Hopko, 2004; Hopko, Robertson, & Lejuez, 2006; Santiago-Rivera, Kanter, Benson, Derose, Illes, & Reyes, 2007), and it has been incorporated in the most reputable psychological treatment manuals (cf. Dimidjian, Martell, Addis, & Herman-Dunn, 2008).

However, a problem that negatively affects the dissemination and development of BA as a therapy is the existence of two different intervention protocols: that of *Behavioral Activation* (BA) (Jacobson et al., 2001; Martell et al., 2001; Martell, Dimidjian, & Herman-Dunn, 2010) and that of *Behavioral Activation Treatment for Depression* (BATD) (Lejuez, Hopko, & Hopko, 2001; Lejuez et al., 2002; Lejuez, Hopko, LePage, Hopko, & McNeil, 2001). While the two types of intervention coincide in the essential aspects (self-monitoring of mood, graded task assignment, specific goal setting scheduling, etc.), some differences can be appreciated between them (duration of the intervention, structuring of the sessions, emphasis on positive or on negative reinforcement etc.) (for a detailed review see Barraca, 2009 or Hopko et al., 2003). Although the coexistence of the two protocols gives an image of diffuseness and generates doubts for the clinician who needs unified and well-tested guidelines, current efforts to integrate the two procedures (in the manual by Kanter et al., 2009, for example) are likely to provide the solution to this problem.

Despite the fact that BA has been used with Latino population (Santiago-Rivera et al., 2007), there is still no literature to facilitate the spread of knowledge about it among Spanish-speaking clinical psychologists; nor have there been any case studies carried out in Spain to complement the theoretical work already published (Barraca, 2009; Pérez-Álvarez, 2008) or the research on assessment instruments for BA (Barraca & Pérez-Álvarez, pending publication).

The goal of the present article is to fill this gap with a detailed presentation of an intervention carried out in the BA framework with a patient showing symptoms of depression. The presentation format employed here follows the recommendations of Virués-Ortega and Moreno-Rodríguez (2008) for the publication of clinical case reports in behavioral psychology.

PRESENTATION OF THE CASE

Identification of the patient and reason for the consultation

The patient is a man aged 44, married with two children. Although a lawyer by training, at the present time and for the past few years he has lived exclusively from the books he has written and the work deriving from them (the books themselves, lectures, working with the media, etc.). He has no family antecedents of mental illness. He reports a brief anxiety episode from some twenty years earlier which quickly subsided after treatment with anxiolytics.

A few weeks before coming to the therapist's consulting room he confessed to his wife about an extra-marital affair. As a result, there began a period of difficulty between them, in which both were weighing up the different options, and it was at this time that the patient started the therapy. Finally, a couple of months later, his wife decided to divorce him. From that time on, and despite initially seeming relieved, he began to fall into a state of deep distress, and greater passivity, and his creative work came to a standstill; nevertheless, he continued to fulfil his commitments not directly involving original creative work. It was his state of sadness, dejection and despair that then became the reason for the consultations.

Although, as a trained lawyer, the patient was well aware of this, it was explained to him that all the information provided would be treated with the confidentiality appropriate to this type of professional relationship.

Assessment strategies

As assessment strategies we used the non-structured clinical interview, self-records and the following self-report instruments, widely employed in studies in which BA is the treatment of choice:

Beck Depression Inventory - II: The BDI-II (Beck, Steer, & Brown, 1996) is the latest edition of this instrument. In this case we used the version in Spanish calibrated with clinical and non-clinical samples (Sanz, García-Vera, Espinosa, Fortín, & Vázquez, 2003; Sanz, Perdigón, & Vázquez, 2003).

Acceptance and Action Questionnaire: The AAQ (Hayes et al., 2004) measures the degree of experiential avoidance, conceptualized from the Acceptance and Commitment Therapy model (Hayes, Strosahl, & Wilson, 1999). The version adapted to Spanish (Barraca, 2004) has obtained acceptable indices of internal consistency (Cronbach's $\alpha = .74$) and temporal stability ($r_{xx} = .71$) and has shown its validity with both general and clinical samples.

Automatic Thoughts Questionnaire: The ATQ (Hollon & Kendall, 1980) is a 30-item questionnaire developed with the aim of measuring the frequency of negative automatic thoughts (negative self-directed words/phrases) commonly associated with depression. The Spanish adaptation of the ATQ used here is that of Cano-García and Rodríguez-Franco (2002), which maintains the original four-dimensional structure (negative self-concept, hopelessness, poor adjustment and self-reproach).

State-Trait Anxiety Inventory: The STAI-T/STAI-S is a measure of anxiety, in its dimensions as a trait and as a state. In this case we used the version calibrated in Spain (Spielberger, Gorsuch, & Lushene, 1982).

Environmental Reward Observation Scale: The EROS (Armento & Hopko, 2007) is a brief instrument with 10 items developed for obtaining an objective self-assessment of the extent to which the environment is rewarding for the respondent. A high score indicates increased behavior and positive affect as a consequence of rewarding environmental experiences. The scale has good internal consistency (Cronbach's $\alpha = .85$) and test-retest reliability ($r_{xx} = .85$). There are also data on its construct validity (correlations with the Pleasant Events Schedule and BDI). The version used here is the

adaptation for the Spanish context by Barraca and Pérez-Álvarez (2010).

Behavioral Activation for Depression Scale: The BADS (Kanter, Mulick, Busch, Berlin, & Martell, 2007) is a 25-item questionnaire developed for measuring four basic dimensions for the BA model: Activation, Avoidant/Rumination, Work/School Impairment and Social Impairment. The version employed in this case is the adaptation to Spanish by Barraca and Pérez-Álvarez (pending publication).

The patient's scores on the scales were as follows: BDI-II = 32 (severe depression); AAQ = 39 (medium-high Avoidance); ATQ total = 44 (high general score); ATQ-I = 14 (high Negative Self-Concept); ATQ-II = 19 (high Hopelessness); ATQ-III = 3 (normal Adjustment); ATQ-IV = 8 (medium-high Self-reproach); STAI-E = 41 (high state-anxiety); STAI-R = 39 (high trait-anxiety); EROS = 21 (low environmental reward); BADS-I = 19 (low Activation); BADS-II = 19 (high Avoidant/Rumination); BADS-III = 15 (no Work Impairment); BADS-IV = 18 (medium-high Social Impairment)¹. The same instruments were applied again after the intervention, in the follow-up phase.

The purpose of the clinical interview was to obtain knowledge about the most relevant aspects of the case and set out the proposals for the functional analysis. Moreover, it was the most important method of determining the patient's state at the time of the first consultation, and also for assessing his evolution over the course of the treatment. Together with the patient, we tried in each session to arrive at a score of 0 to 10 to determine his mood that week. Although this type of estimation may be biased by subjectivity, it does provide quick and simple information with is of great use to the clinician; furthermore, these scores are useful in the assessment of chronic pain or anxiety (like the well-known "thermometers" for assessing fear level for certain phobic stimuli).

Finally, the patient was asked to keep self-records reflecting his everyday activities and the mood associated with each one. However, the patient only kept this up for one day; nor did he use diaries or e-mail, which had been suggested as alternatives.

¹Except in the case of the BDI-I, in which the categories are already designated, the score obtained was defined as *high* when it exceeded the mean by one standard deviation, and *medium-high* when the standard score (Z) lay between 0.5 and 1.

Clinical formulation of the case

The main problem behaviors emerged gradually but within a short period. Roughly a week after the separation from his wife, the patient began changing his timetable, going to bed later and getting up later. At the same time, he began to suffer from more pronounced insomnia, and in the little sleep he got he had nightmares. He also began to lose weight, up to 10 kilos, though this may have been partly explained by the fact that he had flu at this time lasting around two weeks. His self-statements started to become more and more negative (“my life has no future,” “I’ve lost the all the things that gave my life meaning: my family, my children,” “I’ve failed to keep what I most cherished: my integrity,” “my life is hardly bearable”).

At a cognitive level, other problems accompanied this process, such as his obsessive recall of happy times in his former life, feelings of guilt, and the recurring notion that he must have some “defect” which led him to commit the chain of errors that would explain the terrible situation in which he now found himself. In a similar line, he said his life lately was a sham, and that for many years he must have been harbouring “internal problems”, though nobody had warned him of it.

In the areas of social relations there was also a series of problems. Social contact in general was avoided, but he maintained relations with family and with people he had to see for work reasons. However, when he was with his parents he concealed how he was really feeling, so as to avoid making them suffer.

Most of these problems intensified whenever he spoke to his ex-partner about the divorce proceedings and the terms of the settlement. In their conversations there were continual reproaches over financial matters and in matters related to their children. He also fell into deeper despondency when his eldest daughter (aged 10) asked about the reasons for the separation.

It should be pointed out that although his expressions of distress were of great intensity (as reflected in the depression scores on the BDI-II and the ATQ), paradoxically, he kept up high levels of activity — even social activity — when his work involved talking to the media, giving lectures, taking part in discussions about his works, and so on. Likewise, he travelled a great deal, often driving himself. He mentioned that he felt incapable of keeping up this pace — even though he continued to do so, and to judge from the results, carried out all his tasks with great effectiveness. He understood the contradiction between what he said and what he did, but could not explain why. Nevertheless, it is also true

that his creative activities had come to a halt, and the patient did not consider himself capable of taking them up again; indeed, he put them off indefinitely.

The patient was also in a state of ambivalence about the possibility of using medication, since although he felt ill, he was afraid of becoming dependent on it, and in general, in his clearer moments, he was of the belief that his problems were not biological in origin.

To explain why the patient was becoming more and more depressed in spite of the fact that he continued to be highly active, and always acted responsibly with regard to his obligations — in contrast to what is customary in depressive processes —, it was decided to carry out a functional analysis to explore the relation between certain behaviors and his mood. This functional analysis followed, in general, the procedure proposed by the authors of BA to explain the onset and, principally, the maintenance of the depressive situation (Jacobson et al., 2001).

On the basis of this analysis it was hypothesized that, in principle, the trigger for the depressive state was the marriage break-up and the loss associated with it (financial problems, reduction in quality of life, poorer living conditions (home), less contact with his children, less time for himself, etc.). This situation had led to a series of responses typical of a depressed condition (insomnia, negative thoughts —“nothing makes sense”, “how could I have made so many mistakes”—, intense memories of his former happy life, doubts, weight loss, guilt, feeling ill, etc.). However, what was most interesting was the observation that this type of response was perpetuated through the maintenance of a series of avoidance patterns made up of his various activities (trips, lectures, working with the media, etc.). That is, although the patient complained about having to carry out all these activities, they provided him with a justification for not immersing himself in the creative work of writing his books. At the same time, his negative rumination, his insomnia, his lack of strength, his feelings of ineptitude and his distrust of man-woman relationships kept him from concentrating on creative work, gave him an excuse for not spending more time with his children, and prevented him from starting up a new intimate relationship. Thus, — as the BA model predicts — the depressive situation brought on certain symptoms, but could equally be seen as a pattern of behavior that maintained the situation itself. Certainly, the publication of a new book could be gratifying in the long term, but in the short term it obliged him to be deeply introspective, to work alone and to get in touch

with his own feelings. Similarly, meeting up once more with his old friends and re-establishing his social network, and even starting a new relationship could be tempting, but at the present time they reminded him of what he had lost, and especially his old stability. In sum, the hypothesis proposed was that the avoidance which involved a great deal of work activity, together with the depressive symptoms themselves, helped give rise to immediate negative reinforcement (escape from the unpleasant feelings produced by the marriage break-up), but obviously brought about ever greater fatigue, and impeded him in the long term from acceding to more beneficial positive reinforcers.

Treatment

Selection of the treatment

In view of what was revealed by the functional analysis, it was decided that BA was the most suitable treatment. Of the two possible intervention protocols, those of BA (Martell et al., 2001) and BATD (Lejuez et al., 2001), the former was chosen because of a series of factors that appeared especially pertinent in this case. Specifically, as regards the BA protocol: (1) it emphasizes the role of negative reinforcement in the maintenance of depressive states; (2) it makes use of a more extensive set of strategies, and not only the gradual incorporation of tasks, a circumstance already present in this case; (3) it takes into account cognitive depressive manifestations, such as rumination, also strongly present in this patient; and (4) there is empirical evidence of its efficacy in similar cases where there were also anxiety symptoms and there was no recourse to antidepressant medication (Cullen, Spates, Pagoto, & Doran, 2006; Santiago-Rivera et al., 2008).

Application of the treatment

On the basis of the functional analysis the treatment goals were determined and the application began. The goals set were as follows: (a) *Behaviors to be activated*: (1) Maintaining fixed hours (for going to bed, getting up and working from home; from the first day of treatment he would start by fixing those for bedtime and getting up); (2) Going back to writing his latest book and keeping it up (first for one hour a day at least, until reaching five hours); (3) Spending time with his children at least once during the week and on alternate weekends, when it is his turn to see them; (4) Getting back in contact with his group of friends on alternate weekends (when it is not his turn to be with the children); (b) *Behaviors to be extinguished or moderated*: (1)

Participating in book presentations, giving lectures, going to conferences, making trips, etc., in connection with his works (it was agreed on a gradual reduction over the following months, leading eventually to just one such activity per month); (2) Working with the media (it was agreed that by the end of a period of four months he would only be working in stable fashion with three newspapers or TV/radio channels); (3) Cognitive rumination (using the *mindfulness* technique – focusing on the task in hand – he would try to ignore these thoughts and appraise their function: did they activate him, or facilitate passivity and avoidance?).

In order to carry out this intervention plan, it was explained to him first of all what the functional analysis involved and why some behaviors that were in principle positive and active (lectures, discussions, trips, etc.) needed to be gradually reduced because they constituted elaborate forms of avoidance; at the same time, he was explained how important it was to undertake tasks that were cognitively challenging – such as creative work – or delicate and tiring – such as spending more time with his children and meeting up with friends – but which, in the end, would fill his life with meaning again and offer a way out of the present situation. It should be understood that creative activity had shaped this patient's life, and the rest of his work followed from that vocation.

As set out in the BA model, the achievement of these goals must occur in gradual fashion, since the depression situation is difficult to unpick. Moreover, given that undertaking the activities indicated could not be expected to provide rapid relief of the depressive situation, but rather quite the contrary, it was essential that he commit himself to maintaining this approach over a more or less extensive period. As is customary in BA interventions, once incorporated in the treatment, the behaviors to be activated and to be extinguished or moderated were maintained permanently.

The application phase of the BA therapy lasted a total of seven months (with 22 sessions), after an initial month which served as an assessment period (5 sessions), somewhat longer than usual due to the need to gather information on the patient's life circumstances and to deal with some doubts about the setting-up of the functional analysis. Just after the end of the treatment, 5 follow-up sessions were programmed at increasing intervals (the first two were 2 weeks apart, followed by one at 3 weeks, 1 month and 2 months). In these follow-up sessions the self-report instruments were reapplied, a relapse prevention program was carried out, and it was

explained to the patient about the need to continue with an observation process similar to that shown to him in the sessions (functional analysis) in relation to new life situations with the potential to trigger depression (e.g., he was taught to identify patterns of avoidance so as to respond with activation behaviors). The schedule of the sessions is shown in Table 1. As proposed in the BA approach, the incorporation of the strategies and goals was gradual, and this can be seen in the table.

During the process of implementation of the therapy there were some breaks due to holiday periods and to the patient's need to travel with his work. Although he was doubtful at first, his commitment to the relevant tasks and the correction of some strategies facilitated the inclusion of the elements that followed. As his mood settled down and his confidence grew after a few months, when the time came to extinguish the last behaviors (e.g., ignoring the content of depressive rumination and focusing on direct experience) it had become easier and the patient had fewer reservations.

Factors related to the therapist

The sessions were run by a single therapist, author of the present article. This therapist completed his degree in 1992 and took a Masters in Clinical and Health Psychology between 1992 and 1994, obtaining his doctorate in 1997. He is qualified as a Specialist in Clinical Psychology and a Specialist in Psychotherapy (EFPA). The sessions took place in the therapist's private consulting room.

The therapeutic relationship can be considered good. The patient adhered to the treatment program and tried to fulfil its requirements, even though he failed to

adequately fill out the self-records prescribed at the beginning of the intervention. It is important to mention that the patient had had negative experiences with psychiatrists and that this circumstance could have initially affected his confidence in any therapeutic process. Later on, the patient gave the therapist books of his own as presents, and was prepared to make the sessions more frequent when this was suggested to him because of a dip in his mood, and to give the necessary continuity to the treatment. The therapist showed interest in the books he was given, and discussed them in the session. The patient's cultural activities were of genuine interest to the therapist, and this was probably reflected over the course of the treatment. The patient did not cancel any of the scheduled sessions, and always notified the therapist well in advance if he was obliged to change times or dates. He also attended the follow-up sessions, despite the longer intervals between them.

Study design

The case reported here has an AB design. While with such a design it is not possible to be completely certain that the changes are due solely to the application of the BA therapy, it should be mentioned that during the intervention there were no changes in the family, work or general contextual circumstances of the patient, making it more likely to be the therapeutic strategies that explain the improvements obtained.

Data analysis

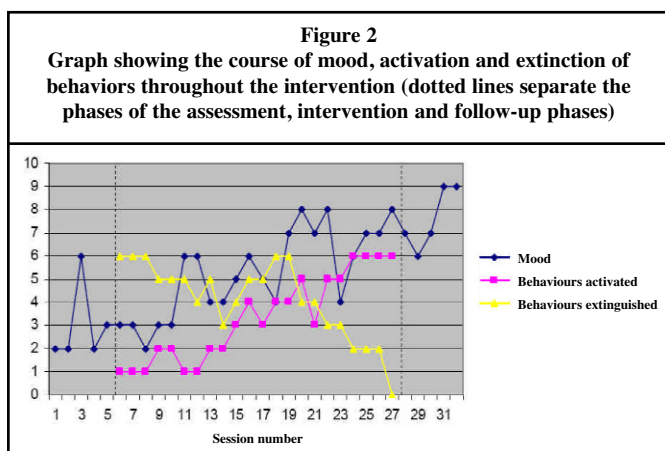
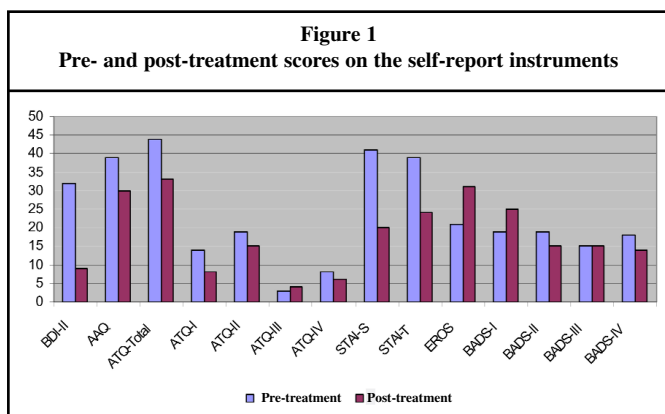
With the aim of obtaining measures that would indicate possible changes resulting from the intervention, in the follow-up all the self-report

Table 1
Schedule of the sessions

	Assessment phase	Treatment phase	Follow-up phase
<i>Session number</i>	1 2 3 4 5	6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27	28 29 30 31 32
Interview	* * * *	* *	
Self-reports	* *		* *
Explanation of functional analysis and intervention plan	*		
Activation of behaviors			
1 ^a		* *	
2 ^a		* *	
3 ^a		* *	
4 ^a		* *	
Extinguishing/reduction of behaviors			
1 ^a		* *	
2 ^a		* *	
3 ^a		* *	
Prevention of relapses			* * *
Confronting other depressive situations (functional analysis)			* * *

instruments administered at baseline were re-applied. Also, given that the patient did not fill out the self-records prescribed at the outset, it was necessary to use other strategies for assessing the effectiveness of the therapy. Specifically, the therapist estimated, together with the patient, his mood during that week (on a scale of 0 to 10). A record was also kept of how far the patient fulfilled the tasks assigned as goals of the intervention (behaviors to activate and behaviors to extinguish or moderate).

Bearing in mind the nature of these measures, it was considered that the presentation of the results would be clearer in visual format. Figure 1 shows the differences between pre- and post-treatment measures for each of the self-reports applied. Figure 2 shows in integrated form the data from the scale for estimating mood throughout the entire therapy and follow-up (five months later), together with the fulfilment (in numbers) of the tasks to be activated, reduced and extinguished, which was recorded week-by-week in each session according to the information provided by the patient.



Effectiveness and efficacy of the intervention

The results of the intervention can be seen on observing the notable differences between the majority of the scores on the self-reports prior to and subsequent to the intervention phase (see Figure 1). Score on the BDI-II fell from 32 (severe depression) to 9 (absence of depression). On the AAQ, the patient's score decreased from 39 to 30. In this case, it should be borne in mind that for the Spanish adaptation of the instrument the mean score in general (non-clinical) population is 34.61 (SD = 5.43) (Barraca, 2004). On the ATQ the general score fell from 44 to 33, and in all four dimensions: (1) Negative Self-Concept from 14 to 8; (2) Hopelessness from 19 to 15; (3) Poor adjustment from 3 to 4; and (4) Self-reproach from 8 to 6. On the STAI there was a substantial change in both dimensions of the instrument, from 41 to 20 in state-anxiety and from 39 to 24 in trait-anxiety, which represents a change from Pc 95 to 55 in the first case and from Pc 97 to 70 in the second on the scale for adult males (Spielberger et al., 1982). On the EROS there was another significant change, from the initial 21 points to 31. On the original instrument the mean for the general male population is 29.61 (SD = 4.20) (Armento & Hopko, 2007). Finally, in the first dimension of the BADS (Activation) the patient's score increased from 19 points to 25, and in the second dimension (Avoidant/Rumination) from 19 to 15; in the third (Work Impairment) there was no change (15 to 15) and in the fourth (Social Impairment) the score fell from 18 to 14. In this case the mean values reported by Barraca and Pérez-Álvarez (pending publication) for the respective subscales are 21.36 (SD = 8.93), 14.55 (SD = 6.67), 16.37 (SD = 8.09) and 14.87 (SD = 10.17).

Figure 2 reveals the notables changes in mood and the fulfilment of both the activation of target behaviors and the extinction of the avoidance patterns detected. Although it is difficult to determine the magnitude of these changes, particularly at the beginning of the treatment (indeed, the intervention had to start without having achieved the desired baseline stability), the graph suggests significant improvements resulting from the intervention. This would correspond with the proposals of the BA model, whereby the gradual disappearance of the avoidance behaviors and the cessation of the reinforcement of the depressive behaviors leads eventually to an improvement in mood.

In addition to these measures, it should be stressed that the patient expressed his satisfaction with the therapy and reported feeling fully recovered. He stated that he felt clearly ready to cease the treatment, and was

prepared to provide information subsequently if it were required for longer-term follow-ups, as was indeed the case. Given that he had never stopped working or meeting other people, these comments are an important testimony to his improvement.

The BA intervention method, which emphasizes the importance of assimilating the functional analysis, and therefore, of understanding the relation between certain activities and one's mood (Dimidjian et al., 2008), provides a guarantee that the improvement in mood will be maintained over time, and in the case reported here this is also borne out by the data from the follow-up, in which the patient's mood after five months was actually better than it was straight after the treatment phase.

DISCUSSION

The improvements observed in this patient after the intervention provide substantial support for the model proposed by BA therapy in the case of mood disorders. Nevertheless, it is important to point out that the choice of this therapy was based not so much on the depressive symptomatology as on the functional analysis carried out. In particular, the insistence in BA on appreciating the functionality of the behavior and not anticipating the nature of the avoidance behaviors was key to an understanding of the situation. On the face of it, the patient led a very active life, but his "depressive situation" was highly intense because all his efforts were at the service of avoiding commitment activities and behaviors, and gave him an excuse to not tackle tasks that were emotionally difficult. Therefore, a conventional treatment exclusively involving the programming of gratifying everyday activities incorporated little by little, like that proposed by Lewinsohn and cols. (Lewinsohn & Graf, 1973; Lewinsohn, Muñoz, Youngren, & Zeiss, 1978; Zeiss, Lewinsohn, & Muñoz, 1979), would probably not have been effective.

On the other hand, therapy of a cognitive nature might have focused on the need to modify beliefs (such as those relative to being ill, to having some kind of defect or to his life having lost meaning), given the lack of empirical evidence; however, this would not have helped an understanding of the fact that these thoughts — this "depressive rumination" — could be at the service of avoiding other activities associated with the patient's feelings of loss and change vis-à-vis his family circumstances. The BA approach still has the goal of eliminating the patient's distorted cognitions, but the idea is for these changes to occur as a consequence of the activation itself (Kanter et al., 2007; Lejuez et al.,

2001; Martell et al., 2001), and when they are addressed in session, it is to consider not the truth or falsity of their content, but rather their function: Do they serve to bring about the goals set or to make them less accessible? How much time do they take up? What other things could be done instead of ruminating? (Martell et al., 2001). In fact, in the case of this patient, the decrease in score on the second dimension of the BADS (Avoidant/Rumination) is an indication of cognitive change as an indirect product of the activation.

The case presented here was intended to illustrate the model proposed by BA and the intervention deriving from it in a patient who was probably somewhat unconventional as regards his depressive process, but perhaps precisely because of this, more useful for helping us to understand what is new in the contributions of this therapy. As we have seen, what is important is not so much the application of a protocol with solid experimental support, but rather the fact that it highlights the potential value of functional analysis in cases in which there is the possibility of more sessions for an individualized approach (as is the case in a private consultation). Nevertheless, it is true that for other types of context, such as the institutional one, the more parsimonious protocol proposed by BATD would be a more justifiable choice.

The present clinical case study has a series of limitations that should be borne in mind. To begin with, it is true that the lack of self-records hindered a complementary assessment of the case. Moreover — as stressed by the authors of BA themselves — such records constitute an important means of helping the patient to understand the functional analysis, and hence, a valuable element in the prevention of relapse. Nevertheless, it is no less true that patients suffering from severe depression often have little motivation to keep such self-records, especially if they also have negative previous experience of this activity. In this case their absence did not prevent the intervention being carried out successfully, and in any case, this circumstance should not be an obstacle to the dissemination of the information about this study in the scientific context. In addition to this limitation, it should be noted that there is a scarcity of studies on some of the self-report instruments employed, in particular on the EROS and the BADS; despite their showing adequate psychometric properties, there are no validation studies on them for the Spanish population apart from those mentioned in this article. Even so, it was considered useful to include them in the patient's assessment given

that they are designed specifically for BA treatment. Finally, there remains some doubt about the exclusiveness of the effect of the intervention as the source of the patient's improvement, since the design used was AB in an environment with scarce control (external private consultation). We should bear in mind that certain changes, particularly those related to anxiety levels, can sometimes be explained by a process of habituation to the therapeutic situation, among other possible factors.

Behavioral Activation is a highly promising therapy. Its principles are well understood by cognitive-behavioral therapists and its methods are more accessible than those of other third-generation therapies, such as Acceptance and Commitment Therapy, Functional Analytic Psychotherapy or Dialectical Behavior Therapy. In its short life, BA has amassed considerable experimental support in highly controlled studies. Even so, it is essential for it to maintain a strong presence in the literature, and for the flow of case studies to continue, since it is these which do most to encourage clinical psychologists to incorporate it in their practice. Ideally, future research on clinical cases with BA should try to add other, more complex designs (such as ABAB, ABCB, or multiple baseline) that would allow greater confidence on interpreting the changes obtained after the therapy.

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