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Introduction

The Development of Behavioral Activation

The past is never dead. It’s not even past.
—William Faulkner (1897–1962)

This book is about behavioral activation (BA), a psychotherapy that has been shown to be an effective treatment for depression and has shown potential for the treatment of other disorders as well. It is written with therapists from many different theoretical orientations in mind. BA is a standalone treatment, but it also is an important part of standard cognitive-behavioral treatment for depression. The principles we present will be useful for therapists who do not typically work from a cognitive-behavior therapy (CBT) framework and find they need greater structure with particular clients. BA has taken several forms over the past four decades and is a focus of renewed interest today following the results of recent clinical research. Yet, behind all research and scientific findings, there is a story. Journal articles present important data, but they do not always tell the story of the ways in which the studies are developed over the course of the actual lives and contributions of those who led the way in the development of these principles and this treatment. This book describes how to put the principles and strategies of BA into practice. Before we get there,
we want to share with you the history of the development and study of BA. Enjoy the story.

A Starting Place

There are many possible points in time to start this story. We begin with some memories of our colleague and mentor Neil S. Jacobson, who died in the middle of our work on BA in 1999. For Neil, doing science meant engaging skepticism. As Dimidjian (2000) recalled, Neil “accepted no theory of change, treatment model, or basic tenet or assumption without subjecting it to a rigorous, exacting empiricism” (pg. 1). He often challenged popular opinion and loyalties to particular models. Neil’s scientific skepticism was born not only of the enjoyment of a good fight but also of compassion. He wanted to find short-term interventions that provided lasting effects and could be easily disseminated among clinical communities.

Neil also criticized the prevailing treatments of depression as “defect models” because they located the cause of depression as internal deficits within individuals. In contrast, he sought to understand the person in the full context of the treatment of depression and encouraged us to look outside the individual in our effort to understand and treat depression. It was his supposition that the secret to alleviating depression lay in changing the conditions in people’s lives. In these ways, then, we begin our story of BA with skepticism and compassion, two essential ingredients for science to advance clinical change.

What Are the Active Ingredients of Therapy for Depression?

The theory behind BA owes its development to work that has been done over the past three decades on understanding and alleviating depression. Research on therapies for depression has focused most heavily on cognitive therapy (CT) for depression. Developed by Aaron T. Beck and his associates, CT is based on the assumption that the way people think about situations in their lives influences how they feel and what they do. When people are depressed, they exhibit problematic ways of thinking that increase their depression. CT focuses
on how to help people identify such depressive thoughts and beliefs, evaluate how these thoughts impact them, and make changes in such thinking patterns. The primary hypothesis in CT is that when people think more realistically they will feel better. The strategies used in CT are multifaceted and include three primary categories: behavioral strategies designed to change how people act in situations, cognitive strategies designed to change how people think about specific situations, and cognitive strategies designed to change the enduring central beliefs that people have about themselves, their future, and the world. The CT approach places particular importance on cognitive strategies. Although behavioral strategies are emphasized in the treatment of more severely depressed individuals, the goal of moving to cognitive change strategies is clear in CT. Beck and colleagues described the use of behavioral strategies in the seminal treatment manual for CT, explaining, “The ultimate aim of these techniques in cognitive therapy is to produce change in the negative attitudes” (Beck, Rush, Shaw, & Emery, 1979, p. 118).

Many studies have attested to the efficacy of CT, including some recent rigorous clinical trials (DeRubeis et al., 2005; Hollon et al., 2005). These studies, however, did not address some important questions. It seemed pretty clear that CT did work, but do we really know how it worked? What are the active ingredients of CT? Are all the strategies of CT needed to produce positive outcomes? Could the behavioral strategies of CT alone account for the success of cognitive therapy?

A series of studies have tried to address these questions. Zeiss, Lewinsohn, and Muñoz (1979) conducted one of the earliest studies, finding that depressed participants improved regardless of the specific components of the treatment. Their group of depressed outpatients received either cognitive restructuring, interpersonal skills training, or pleasant events scheduling. All of the treatments were successful in eliminating depression. Zettle and Rains (1989) compared three group therapies: complete cognitive therapy, partial cognitive therapy, and a contextual approach referred to as comprehensive distancing. All groups showed significant and equal reductions in depression over the 12-week treatment and 2-month follow-up. In 1989, Scogin, Jamison, and Gochneaur found that cognitively focused bibliotherapy and behaviorally based bibliotherapy were both superior to control conditions, but both interventions were of equal efficacy.
Perhaps the most widely influential of studies addressing the active ingredients of CT is the component analysis study published in 1996 by Jacobson and colleagues (Jacobson et al., 1996). In this type of study, the different components of a treatment are isolated and compared to one another in an aim to identify which parts of the treatment are causally active. Some 150 depressed adults enrolled in this component analysis study were randomly assigned to one of three treatments: (1) the behavioral activation component, (2) the behavioral activation plus cognitive restructuring of automatic thoughts component, or (3) the full cognitive therapy package, consisting of behavioral activation, cognitive restructuring of automatic thoughts, and cognitive restructuring of core beliefs.

The first condition (BA) allowed therapists to use the behavioral strategies such as activity scheduling, mastery/pleasure ratings, and graded task assignments, strategies we describe in much more detail in subsequent chapters. In the second condition (BA plus automatic thought restructuring), therapists could use the behavioral strategies and cognitive strategies designed to change how one thinks in specific situations. In the third condition, therapists could use any of the strategies used in the other conditions, and they could also work on changing core beliefs about the self, world, and future—that is, the full range of CT strategies as outlined in Beck et al. (1979) and subsequent treatment manuals (e.g., J. S. Beck, 1995).

The same therapists provided all of the treatments and, in fact, were strongly in favor of the full CT approach. They used cognitive conceptualizations for clients assigned to all of the treatment conditions and generally believed that utilizing the BA component solely was akin to doing therapy with one hand tied behind their backs. They felt discouraged when their patients were randomly assigned to the BA component condition, and their reactions paralleled those of most people in the field—namely, that participants in the BA (only) condition would show poorer outcomes.

What happened, though, surprised many! There were no significant differences among the three treatments, either in the acute treatment of depression or in the prevention of relapse across a 2-year follow-up (Jacobson et al., 1996; Gortner, Gollan, Dobson, & Jacobson, 1998). Results obtained from the BA component condition were comparable to those from the full cognitive therapy program. This finding caused quite a stir, and numerous notes of caution
were raised. Some rejected the findings, suggesting that the therapy had not been done properly and that the substandard quality of CT explained the pattern of findings (Jacobson & Gortner, 2000). Others were intrigued by the findings but believed that replicating them in another study was necessary.

The authors of the component analysis study thought there was much of value in the critiques and agreed that it was necessary to seek replication and to do so in a way that ensured the CT was performed as competently as possible. The results of the component analysis study galvanized our research group around some central questions as we continued to pursue this work. We began to wonder whether purely behavioral approaches had been overlooked in recent decades. Was the whole field missing something important that behavioral approaches might be able to offer in the treatment of depression?

**Back to Behavioral Roots**

The questions raised by the component analysis study spurred us to return to the literature. We started reading research studies that addressed behavioral approaches to depression. In some cases, these studies had been published decades ago. We requested papers from old journals in the libraries and dusted off old books from our shelves. As we read this literature, our thinking about BA evolved. We began to develop the basis for a behavioral treatment that was defined in its own right, not exclusively by the proscription of cognitive interventions as it had been in the component analysis study (Jacobson, Martell, & Dimidjian, 2001; Martell, Addis, & Jacobson, 2001).

As interest in BA for depression was revitalized by the component analysis study, the development of BA was also grounded in a long tradition of behavioral theory and research, much of which we realized had gone largely unnoticed in recent decades. In particular, BA builds on the foundation of the work of four important early pioneers: Charles B. Ferster, Peter M. Lewinsohn, Lynn P. Rehm, and Aaron T. Beck. While Ferster focused on the theory underlying the behavioral analysis of depression, Lewinsohn extended the theory and developed behavioral treatment methods for depression, Rehm emphasized the importance of reinforcement in the treatment of depression, and Beck made behavioral activation available to a
larger clinical audience by including it as an integral part of CT for depression. We discuss the contributions and influence of these forefathers of BA next.

*Charles B. Ferster*

Ferster (1973) postulated that a decrease in certain types of activity and an increase in other types characterized depression. Ferster focused in particular on the increase in escape and avoidance behaviors and as a result suggested that depressed persons received fewer rewards from their activities. He proposed a few reasons why this might be the case. First, he suggested that depressed people might not engage in productive activities frequently enough, which lessens the effectiveness of the reinforcement of such activities. Second, he suggested that depressed individuals might engage in behavior that was motivated by attempts to escape from aversive feelings, which “prevented positively reinforced behavior” (p. 859). Thus, depressed people’s behavior may be controlled primarily by negative reinforcement as opposed to positive reinforcement. In other words, actions serve the purpose of reducing an aversive state rather than allowing the person to engage the environment in such a way that the behavior is naturally rewarded and positively reinforced.

All behavior occurs in a particular context, and behavior is reinforced by its consequences. These are the *contingencies* of behavior. Ferster (1973) emphasized the ways in which a depressed client’s limited interactions with his or her environment can result in a diminished ability to learn from contingencies. The focus on one’s internal state of deprivation as opposed to a focus on observing one’s environment, according to Ferster, is “a serious impediment to an improvement of the depressed person’s view of the world. The depressed person may not be able to emit enough potentially reinforceable behavior to discover the differential reaction of the environment, depending on the kind of performance that is emitted” (p. 39).

As we readily acknowledge, the current BA model is grounded in many of Ferster’s early ideas. His work provided a sound behavior-analytic framework for looking at the *function* of behavior rather than just its form. BA was intended as a flexible treatment tailored to each individual client. The BA model does not assume that any particular class of behavior is necessarily reinforcing for a client, such
as increasing pleasant events. Rather, the BA model uses functional analysis (discussed throughout this book) to increase behaviors that have the greatest potential to help the client interact with an environment and that provide consequences that will positively reinforce antidepressant behavior. The emphasis on the function over the form of behavior remains a major contribution of the early work of Ferster to BA.

Peter M. Lewinsohn

Lewinsohn’s theory of depression was consistent with many of the elements proposed by Ferster. Lewinsohn highlighted the importance of the lack of positive reinforcement in depressed patients’ lives. Specifically, he conceptualized depression as a result of a lack, or low rate, of “response-contingent” positive reinforcement (Lewinsohn, 1974). Response contingent means that reinforcement is dependent on the individual’s actions. For example, if a person in a relationship tries to make conversation and the partner ignores the attempt (does not provide response-contingent positive reinforcement) or rebuffs it as “clingy” (punishes), the individual will eventually stop making attempts at conversing with the partner and feel sad about the relationship. It follows that this person is less likely to make conversation over time, and, in other words, conversation behavior may become extinguished. This lack of positive reinforcement is hypothesized to limit behaviors that typically result in rewards from individuals’ lives, which can cause or maintains dysphoria. Lewinsohn (1974) also pointed out that low rates of response-contingent positive reinforcement can operate in contexts that may seem surprising; for instance, he explained that job promotions can lead to loss of social reinforcement (e.g., losing peers in the transition to a managerial position) or that achieving a goal for which one has worked long and hard (e.g., attaining an academic degree) may turn out to be a weak reinforcer for the individual. He explained, “It is not the absolute amount of attention or other ‘goodies’ received that is critical but the fact that the environment provides consequences sufficient to maintain the individual’s behavior” (p. 180). Clearly, Lewinsohn believed that the subjective experience of environmental rewards trumps their face value in determining their subsequent impact on behavior and mood.
Lewinsohn and colleagues eventually revised their model to explain how negative life events affect some people and not others. Lewinsohn, Hoberman, Teri, and Hautzinger (1985) suggest that negative life events decrease the likelihood of adaptive behaviors for vulnerable individuals who may lack the skills for coping with the events. These disruptions and the accompanying dysphoric mood lead to the individual’s becoming excessively self-focused and self-critical. There is also a decrease in motivation, and the vulnerable individual withdraws from social contacts. Thus, there is a downward spiral into further depression as the individual deactivates in response to the disruption.

In these ways, Lewinsohn’s work contributed the importance of understanding the contingencies in the individual client’s life. Lewinsohn and Libet (1972) found that depressed individuals might be more vulnerable to the ups and downs of everyday life. Depressed individuals also respond more to an aversive stimulus than do non-depressed individuals. Just as some people have a lower tolerance for physical pain and will become highly distressed at a twisted ankle while others will continue to walk around with the same level of injury, depressed individuals are likely to be more reactive to the pain of life—emotional as well as physical—than those who are not depressed. Lewinsohn (1974) suggested that desensitization to aversive situations might be a useful therapeutic tool.

Importantly, Lewinsohn and colleagues (Lewinsohn, 1974; Lewinsohn, Biglan, & Zeiss, 1976) were the first to incorporate activity scheduling into the behavioral treatment they developed for depression. In this approach, they assessed the frequency and range of pleasant events in a client’s life. They developed activity schedules, breaking the week into hourly segments, and asked clients to plan pleasant activities in their week. Over time, clients increased their activity and engaged in behaviors that they either wished to do or had once done but had stopped since becoming depressed. Lewinsohn and colleagues also developed a self-report measure, the Pleasant Events Schedule (PES), to assess pleasant events occurring in an individual’s life over the past month (Lewinsohn & Graf, 1973; Lewinsohn & Libet, 1972; MacPhillamy & Lewinsohn, 1982). The PES lists 320 events for which individuals are asked to rate the frequency and the degree to which each event was “pleasant, enjoyable, or rewarding.”
Lewinsohn’s work has profoundly influenced the BA approach that we describe in this book. His research on both behavioral models of depression and behavioral interventions established the foundations on which the current BA approach was built. Specifically, his emphasis on the importance of understanding reinforcement contingencies has informed our emphasis on the use of behavioral assessment to guide treatment planning and targeting. A general aim of BA is to help the client to activate in ways that will increase the likelihood that his or her behavior will be positively reinforced. Lewinsohn’s focus on aversive control has also shaped our emphasis on helping clients to take action and solve problems in order to live richer lives, even at times in the midst of negative feelings. His understanding of the excessive self-focus of depressed individuals informs our approach to treating the process and function of depressive rumination. Finally, the strategies he used clinically, such as monitoring weekly activities and scheduling ongoing activities, are the mainstays of BA practice and procedures.

**Lynn P. Rehm**

While Rehm’s model of depression included components that are considered more cognitive, such as selective attention to negative events (Fuchs & Rehm, 1977), it was also distinctly behavioral. Rehm (1977) emphasized the importance of reinforcement in depression and proposed a self-control model of depression and therapy for depression. Rehm’s model used Kanfer’s (1970) definition of self-control as “those processes by which an individual alters the probability of a response in the relative absence of immediate external supports” (Rehm, 1977, p. 790). The self-control model postulates a feedback loop consisting of self-monitoring, self-evaluation, and self-reinforcement. An example of self-monitoring would be a student’s keeping track of her grade-point average. Self-evaluation is a comparison between an estimate of performance and an internal standard. Stated simply, the student has observed that her grade-point average has been a 4.0 and may evaluate a grade of 3.5 as failure because it doesn’t meet her standard. If she typically downloads a few favorite songs when she gets a 4.0, she may not reward herself in the same way for the 3.5. Comparisons of one’s behavior, however, are predicated on the attribution that the cause of a behavior is inter-
nal, that is, “I did not work hard enough.” A perception of internal control is required in order for one to attempt self-control of behavior, that is, “I can do better than this.” Also, one must be able to reinforce oneself for behavior that does not meet with immediately rewarding consequences—for example, the student rewards herself by downloading music, although the longer-term consequences of getting high grades is that she graduates with honors and increases her chances of future success.

According to this model, depression is accounted for by deficits in self-control behavior, specifically in “(1) selective monitoring of negative events; (2) selective monitoring of immediate as opposed to delayed consequences of behavior; (3) stringent self-evaluative criteria; (4) inaccurate attributions of responsibility; (5) insufficient self-reward; and (6) excessive self-punishment” (Rehm, 1977, p. 795). Depressed persons selectively attend to negative feedback, and their behavior elicits immediate reinforcement at the expense of important delayed reinforcement. When people are depressed, they make external attributions of causality and set stringent standards for self-evaluation. Finally, according to the self-control model, depression is characterized by relatively low rates of self-reinforcement and relatively high rates of self-punishment. The depressed individual is more susceptible to mood fluctuations occasioned by external events rather than self-reward to supplement and maintain behavior regardless of external environmental events. Deficits in self-reinforcement result in a reduction of sustained effort and a tendency to engage in behavior that is immediately reinforced. Such deficits in sustained effort and responses to immediate consequences may encourage high frequencies of behaviors that function as avoidance behaviors, which are discussed at length in later chapters. Furthermore, excessive self-punishment may result in unduly inhibited thoughts, speech, or actions, or in excessively negative self-statements and evaluations. Rehm’s work has been influential in extending the understanding of the nature of reinforcement and the need to look at the client’s predilection to benefit from short-term (versus long-term) rewards.

Aaron T. Beck

In 1979, Beck and colleagues published *Cognitive Therapy of Depression*. This text and its dissemination profoundly changed the land-
scape of mental health service delivery for depression. The empirical support for cognitive therapy and cognitive-behavioral therapies for depression has led to CBTs becoming one of the strongest empirically supported treatments for depression. In essence, it is the gold standard of brief treatment for depression. In his cognitive therapy approach, Beck integrated BA strategies in a larger cognitive framework. Although this cognitive-behavioral approach eclipsed the purely behavioral approaches that preceded it, it also helped to formalize core BA strategies and make them widely available. In this way, Beck promoted the value of BA more than many pure behaviorists.

Beck’s model of cognitive therapy for depression specifies that treatment should begin with activation—particularly with more seriously depressed clients—prior to monitoring and modifying specific beliefs. Moreover, behavioral strategies are optimally integrated throughout treatment as a key means of exploring and evaluating cognition.

One of the primary contributions of CT to behavioral strategies includes the ways in which CT has formalized a method for activity monitoring and scheduling. In CT, clients record activities on an activity schedule and are asked to record whether the activity gave them a sense of pleasure or mastery (accomplishment). Therapists assist clients in developing a rating scale for mastery and pleasure. J. S. Beck (1995) suggests having clients develop a 0–10 rating scale, identifying specific behaviors that would give them a sense of accomplishment or pleasure at the various poles of the scale and along the continuum. Thus, the client can use his or her scale as a guide for rating how much mastery or pleasure an activity allowed. For example, a client may select “brushing my teeth” as providing zero sense of accomplishment, “making the bed” may be rated as a “5,” and “mowing the backyard” as a “10” on his or her individualized scale. Similar anchors for pleasure may be generated. Using this as a guideline, when the client engages in an activity such as dusting furniture in the den, he or she can compare dusting to the three tasks on the scale and determine if it is closer to making the bed (a “5”) or mowing the backyard (a “10”) and rate it accordingly.

Behavioral techniques in CT always serve the ultimate goal of changing how people think since belief change is considered to be essential for lasting improvement in behavioral or emotional prob-
lems. In contrast, this is a distinct difference in BA, where activity is encouraged hopefully to bring the client into contact with positive reinforcers that will maintain or increase further antidepressant activity. Both CT and BA ask clients to engage in behavioral experiments. However, in BA the client is asked to conduct experiments to evaluate the outcome, impact on mood, impact on goals, and so forth. In CT, clients are asked to conduct “experiments” in order to test their depressive assumptions and expectations. Despite the differences, the development of CT provided an essential foundation for the development of the current model of BA. In addition to the overlap in specific strategies, as noted above, BA also adopts an emphasis on structuring sessions that is characteristic of CT. Nonbehavioral psychotherapists are more likely to make use of activation strategies, thanks to the work of Aaron T. Beck and his associates. This is all to the benefit of depressed clients, for whom simple activation procedures appear to be a necessary treatment for reduction of symptoms.

The Empirical Evidence Base for BA

The contemporary model of BA was put to a rigorous test in a clinical trial at the University of Washington (the Seattle study). This study was important because it addressed some of the major limitations of the earlier component analysis study. It compared BA not only to CT but also to antidepressant medication. Previous research had suggested that psychotherapy (specifically CT) was not efficacious among patients with moderate to severe major depression (Elkin et al., 1989). Treatment guidelines had been issued suggesting that, although less severely depressed patients may benefit from psychotherapy, moderately to severely depressed patients required antidepressant medication for successful treatment (American Psychiatric Association Workgroup on Major Depressive Disorder, 2000). Thus, the study compared BA to the most widely studied psychotherapy, CT, and the current standard of care, pharmacotherapy. Experts in each of the treatment modalities collaborated on the study, ensuring that highly respected cognitive therapists and pharmacotherapists were involved in the planning, execution, and analysis of the study. Throughout the study, these advocates for each treatment were charged with overseeing the quality with which their preferred treatment was being implemented.

Specifically, BA was compared to CT and to antidepressant
medication (paroxetine) in the context of a placebo-controlled trial with 241 depressed adults. The results of this study were provocative. The analysis focused on how the treatments compared between the two groups of interest: the less and more severely depressed patients. The acute outcomes of patients who received BA were comparable to those who received antidepressant medication, even among more severely depressed patients. Patients assigned to BA tended to stay in treatment longer than those assigned to pharmacotherapy. BA was also superior to CT in the acute treatment of more severely depressed patients. There were no differences among treatments for the less severely depressed patients. Longer-term follow-up data showed indications that the benefits of BA were as enduring as those of CT in helping patients prevent relapse or future episodes of depression. Participants who had responded to pharmacotherapy relapsed at greater rates when withdrawn from their medications than participants who had prior BA or CT (Dimidjian et al., 2006; Dobson et al., 2008).

Like all studies, the Seattle study was not without its limitations. In retrospect, we might have prescribed the antidepressant medications in a different way to help people stay in treatment longer. We also would have enrolled more patients so that we could have had a larger sample to adequately run all of the statistical analyses we preferred. And, like any study, the findings need to be replicated at other places by other people. There are important questions that we are pursuing with our current research. In this way, the story of BA, with which we started, is ongoing even today. Although no one study can answer all the important research questions, we did learn from the Seattle study that BA has promise in the treatment of depression. Moreover, our excitement about the results is bolstered by a number of other lines of converging results.

**Related Activation Treatments for Depression**

The theory and conceptualization of BA are finding support in other related activation-based interventions for depression. Many of the central concepts in BA, such as activation, scheduling activities, and engaging in problem solving rather than passive ruminating, are critical to these related approaches as well. The findings supporting these related approaches have influenced our thinking about BA and have provided independent support for the central tenets of the BA approach to depression.
**Brief Behavioral Activation Treatment for Depression**

During the time that the Seattle study was being conducted, Carl Lejuez and colleagues (Lejuez, Hopko, LePage, Hopko, & McNeil, 2001) conducted a similar line of research into what they referred to as behavioral activation treatment for depression (BATD) independent of the research being done in Washington. In several small studies they have also found that activating depressed clients is an effective treatment for depressed inpatients (Hopko, Lejuez, LePage, Hopko, & McNeil, 2003), depressed cancer patients (Hopko, Bell, Armento, Hunt, & Lejuez, 2005), and clients with comorbid depression and anxiety (Hopko, Lejuez, & Hopko, 2004). These researchers have utilized a brief form of activation that consists exclusively of activity monitoring and scheduling. Clients are asked to develop a list of activity goals for the week and then to note on each day whether they attempted the activity or not and if they achieved their goal for that activity. This approach is highly compatible with BA and again provides a converging line of evidence for the importance of activating depressed clients.

**Problem-Solving Therapy**

Problem solving is a mainstay of BA and has a history of evidence as a treatment for depression (Gotlib & Asarnow, 1979; Nezu, 1987). The problem-solving approaches, for the most part, consider the individual client, define the problems experienced by the client, set targets for treatment, and then implement therapeutic techniques that have empirical support in the treatment of various problems or skill deficits (Biglan & Dow, 1981). Problem-solving therapy has been shown to be an efficacious treatment for depression in primary care settings as well and can be conducted by trained psychiatrists, psychiatric nurses, or general practitioners (Mynors-Wallis, Gath, Davies, Gray, & Barbour, 1997).

**Similarities to Newer Behavior Therapies**

BA has been developed during a time when cognitive-behavioral therapies are being transformed. Interest in more purely behavioral approaches is increasing, and thoughts are being dealt with in dif-
ferent ways than the original cognitive therapies proposed by Beck and others. Several new therapies have a focus that is very consistent with BA. The accumulating evidence for these approaches adds to the weight of data suggesting that activation is a key ingredient in the clinical change process and that BA represents part of a larger shift back to behavioral roots that have been underemphasized in the past two decades.

Dialectical behavior therapy (DBT) was developed for the treatment of highly suicidal clients diagnosed with borderline personality disorder (Linehan, 1993). The therapy consists of a number of component skills that are taught to clients to assist them in regulating their moods. One of the core skills utilized in DBT is referred to as “opposite action,” in which clients are taught to act in ways that are opposite to the action urges of emotions that they want to change. For example, a person who feels angry at a slow parking garage attendant and has a strong desire to curse may act in an opposite manner, smiling and saying in a warm and friendly tone, “Thank you, have a great day.” BA, in many ways, is “opposite action” for depression. The urge in depression is often not to act, or to escape or avoid; activating goes against that urge.

Acceptance and commitment therapy (ACT), developed by Hayes and colleagues, is another approach with accumulating support that shares similar treatment targets to BA (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Hayes, Strosahl, & Wilson, 1999). Specifically, ACT emphasizes that clients break patterns of experiential avoidance and make a commitment to action that will help them attain a life that they value. This attention to values was underemphasized when we wrote the original manual for BA (Martell et al., 2001), but is a useful idea to incorporate when treating clients. In an early version of ACT, Zettle and Rains (1987) evaluated comprehensive distancing (CD) versus CT. CD focused on letting go of efforts to change negative thoughts and acting effectively even in the presence of negative thoughts. Zettle and Rains (1987) reported evidence of promise for CD.

David H. Barlow, considered one of the most influential psychologists of the late 20th century, has noted similarities in treatments across several disorders (Barlow, Allen, & Choate, 2004). Barlow and colleagues (2004) noted that a common strategy that has been utilized in a number of treatments is to modify action tendencies in response to emotional dysregulation. They state:
In modifying the behavioral action tendencies driven by fundamental emotions, the first step is to provoke the emotions in as far as possible…. Adopting strategies that encourage experience of the emotion without engaging in the associated action tendencies (accepting the emotion) is a very basic strategy in this regard. When applied to specific disorders, emotional and behavioral activation, especially in situational context, becomes a particularly powerful tool. (pp. 223–224)

Barlow and colleagues emphasize the value of a “unified” approach to the treatment of mood and anxiety problems. It is possible that BA may be a core ingredient of a range of efficacious treatments and, as such, may have value as a transdiagnostic approach. Such possibilities, however, are purely speculative at this time and require rigorous research to examine the potential promise and limitations of BA across a range of presenting problems.

Summary

The history of BA is ongoing. The earlier development of behavioral and cognitive-behavioral treatments for depression continues to inform current research. Our return to the behavioral basics to develop a straightforward treatment for depression that acknowledges the problematic lives with which many depressed people struggle has been part of a wider resurgence of behavioral treatments. BA is consistent with other newly developed behavioral interventions as the fields of behavior therapy and CBT continue to evolve. Having reviewed the story of how BA developed, the evidence that supports its use, and how it fits into the grand scheme of contemporary behavior therapy, we are now ready to turn to the core principles and strategies of BA.