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An Uncontrolled Evaluation of Group Behavioural Activation for Depression

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Abstract. Behavioural Activation is a contemporary contextual psychological treatment for depression. The outcome of a series of five treatment groups involving a total of 42 patients presenting to a psychotherapy department with self-reported depression is reported. Three of the treatment groups were delivered by two cognitive behavioural psychotherapists, two of the groups were delivered by a single cognitive behavioural psychotherapist and a trainee with no previous experience of the approach. The results suggest that group Behavioural Activation is an effective and tolerable treatment as indicated by BDI-II, CORE scores and the low drop-out rate. The methodological limitations of the findings are discussed.

Keywords: Behavioural activation, behaviour therapy, functional contextualism, acceptance, depression.

Introduction

Behavioural Activation (BA) is a contemporary contextual treatment based on a behaviour analytic view of depression as an understandable response to difficult life circumstances (Martell, Addis and Jacobson, 2001). Behaviour analytic approaches look at depression in terms of a person's interaction with their environment, in particular rates of reinforcement. Based on Ferster's (1973) account of depression, BA highlights reduced rates of positive reinforcement and higher rates of negative reinforcement as central to the maintenance of depressive symptoms. The latter refers to the actions people take that provide some relief from symptoms (or stop them worsening), such as avoidance and rumination, but that lead to decreased repertoires of responding and reduce opportunities to engage in meaningful, valued action. BA has been shown to produce comparable results to a full cognitive therapy treatment (Jacobson et al.,1996; Dimidjain et al., 2006). Although BA strategies are a feature of cognitive therapy for depression there are some important differences to note. In BA the issue is one of function rather than form. When applied to the thinking patterns often seen in depressed clients, the goal of BA is not to change or replace these thoughts, but to help the client develop an understanding of how these thinking patterns may or may not be helping them. The goals of BA are to help clients understand their own patterns of responding to depressed mood, and to choose to activate themselves in a valued direction. In particular, patterns of avoidance and rumination are highlighted and their effect on mood and behaviour explored. This is achieved through

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the use of activity logs, graded task assignment, identifying alternative methods of coping, problem solving, and other methods to decrease unhelpful patterns of negative reinforcement, and increase behaviour that is likely to be positively reinforced. This paper aims to describe the outcomes of five consecutive groups delivered in an NHS out-patient setting.

Method

Any client referred to the psychotherapy service for treatment of depression, and found suitable for cognitive behavioural psychotherapy, was offered the BA group; no clients were excluded. Suitability is routinely decided by the assessing therapist based on i) the evidence for the effectiveness for CBT for the client's presenting problem; and ii) the client's willingness to undertake CBT. A 10-session group intervention was structured around materials from a self-help manual (Addis and Martell, 2004), and developed into a treatment protocol (available within an online supporting paper). Each session lasted 1 hour 45 minutes (including a break) and included a review of the previous week through paired and whole group discussion, followed by a presentation and therapist facilitated discussion of the week's theme. Examples of weekly themes include "Understanding Depression", "Learn your patterns and start to change them", and "Taking ACTION: The first steps towards change". Based on our understanding of the approach and recent developments in contextual behavioural psychotherapies, we chose to include material on acceptance and values. Acceptance was introduced as an alternative to change, and values helped to provide a context for the strategic selection of activity, and to help clients develop a whole life view to developing pragmatic solutions to identified problems. The first three groups reported were delivered by the same two cognitive behavioural therapists and groups four and five by one of these psychotherapists with a trainee therapist. All groups were conducted in a secondary care mental health out-patient setting. All clients are routinely asked to complete the BDI-II and CORE-OM pre-, mid- and post-intervention. Data collected were anonymized and exported to MSExcel for analysis.

Results

A total of 54 clients enrolled for the groups, out of 80 that were offered places. Five clients did not attend the first session and so no pre-group data are available for these individuals. A further five clients dropped out of the group after commencing and two did not complete post-group measures. As such, pre-post data are available for 42 completing clients. On entry to the group there were 21 men and 28 women, with a mean age of 42.5 yrs (*SD* 10yrs), and a mean BDI-II score of 30.2 (*SD* 12.0; range 5–48). Although within the philosophy of functional contextual psychotherapeutic approaches symptom reduction is not a primary goal (rather the client is encouraged towards living a more rewarding and valued life), it is interesting to note that, for the majority of clients, some reductions in BDI-II scores are evident (see Table 1). As can be seen, the group intervention appears to be effective in improving self-reported symptoms of depression for a large proportion of clients. At post-treatment the mean BDI-II score was 17.9 (*SD* 13.1; range 0–46). Clients with severe depression pre-group 12 (52%) reported only minimal or mild symptoms at post-group. Similarly, of those clients with moderate depression pre-group, 8 (89%) reported minimal or mild symptoms post-group. When CORE-OM scores were analysed it was observed that post-group 14 (33.3%) of clients had made statistically reliable and clinically significant change (Figure 1).

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Table 1. Change in BDI-II scores pre–post group by level of symptom severity

Severity of depression (BDI-II score)	Number (%) at start	Minimal at end	Mild at end	Moderate at end	Severe at end
Minimal (0–13)	2 (4.8)	2 (100)	0	0	0
Mild (14–19)	8 (19.0)	5 (62.5)	2 (25)	1 (12.5)	0
Moderate (20–28)	9 (21.4)	5 (55.6)	3 (33.3)	1 (11.1)	0
Severe (29–63)	23 (54.8)	5 (21.7)	7 (30.4)	2 (8.7)	9 (39.1)
Total	42 (100)	17 (40.5)	12 (28.6)	4 (9.5)	9 (21.4)

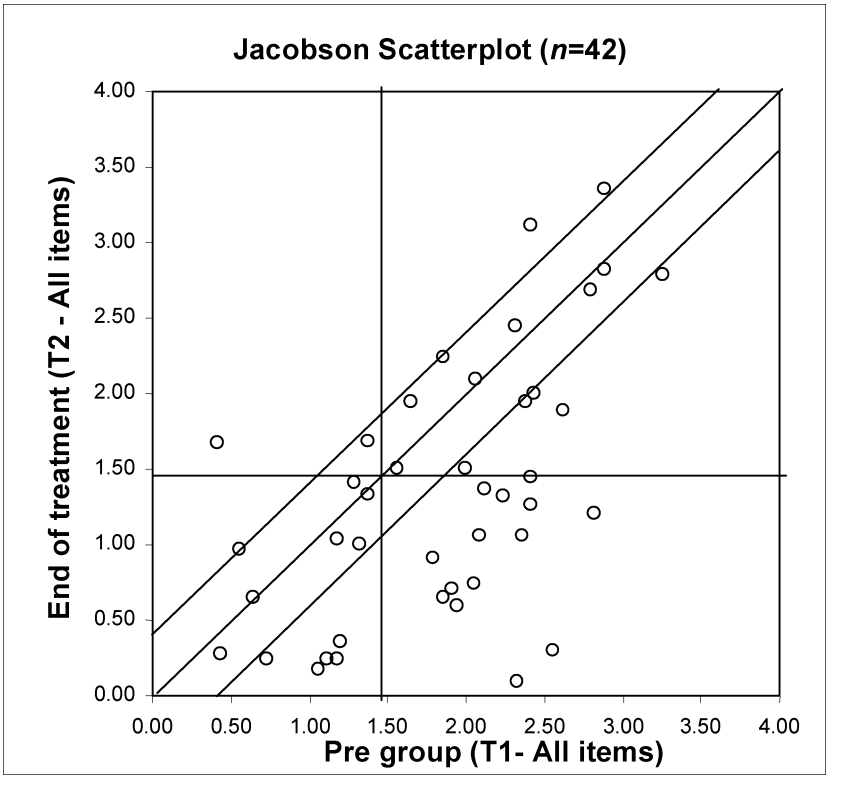

Figure 1. Jacobson scatterplot of statistically reliable and clinically significant change pre–post BA group

Discussion

The results of this uncontrolled evaluation of Behavioural Activation delivered in a group setting highlight a number of important findings. Most importantly, the group appears to be an effective intervention with one-third of patients making a statistically reliable and clinically significant change on the CORE-OM. Also, the group appears to be equally effective for all levels of depression, when using the BDI-II to categorize severity. Although no follow-up data were collected, at individual interview 4–6 weeks post-group with one of the group facilitators,

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only 10 (19%) patients requested further individual therapy. There was no blind assessment of outcome or acceptability of the group model as this intervention was delivered in a real world setting, and continuity of care is an essential aspect of NHS service delivery. No patients requested an alternative approach, despite other secondary care services and models of psychotherapy being described in the final group session, suggesting that the approach is credible even for patients who made relatively little improvement. Furthermore, the tolerability of the approach appeared high, with only five clients in total (9%), or one per group, failing to continue in treatment. This suggests some degree of acceptability of the intervention to clients, but other factors such as satisfaction and client views on the materials were not assessed in this study.

It is evident that group delivery of Behavioural Activation is possible. The treatment approach used in the groups was based on Addis and Martell's (2004) self-help manual, with the addition of some theoretically congruent techniques from another functional contextual psychotherapy, Acceptance and Commitment Therapy (Hayes, Strosahl and Wilson, 1999). In this regard, the groups cannot be considered a test of the self-help book. Participants were informed that the book formed the basis of the work, and were encouraged to purchase it at their own expense. An important point here is that the intervention did not include any attempts at thought challenging, as would be carried out in traditional cognitive approaches to depression. Rather, the thinking typically seen as a part of depression, most often rumination, was examined from a functional perspective, with participants encouraged to examine the effect of rumination on their ability to engage in meaningful, positively reinforcing activity.

There are several methodological limitations that may pose a threat to the internal validity of the findings. Level of severity of depression was assessed using the clients' self-report of their symptoms using the BDI-II, rather than establishing a diagnosis using a structured clinical interview. There was no control or comparison group, and participants were self-selected for inclusion and were not randomized. No follow-up data were collected so no conclusions about the longer term effectiveness of this approach can be made. Similarly, no account was made for participating clients' use of medication throughout the group, although our client group will have typically been taking anti-depressant medication for an extended period prior to referral to secondary care services. The results may also be confounded by the social interaction effect of being in a group. We would hypothesize that this is an important and active ingredient in the delivery of this intervention but that the outcomes achieved reflect the result of a combination of the group effect and the techniques of BA. However, future research should include measures of group interaction and therapeutic relationship in both active and control groups. Nevertheless, the groups have been delivered and evaluated in a real world setting, which therefore may enhance the generalizeability of the results. Future randomized controlled investigations would provide more robust empirical evidence of the effectiveness of Group Behavioural Activation, when compared with alternative individual and group treatment approaches.

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