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Behavioral Activation, an efficacious treatment for depression, presents a behavioral theory of depression—emphasizing the need for clients to contact positive reinforcement—and a set of therapeutic techniques—emphasizing provision of instructions rather than therapeutic provision of reinforcement. An integration of Behavioral Activation with another behavioral treatment, Functional Analytic Psychotherapy, addresses this mismatch. Functional Analytic Psychotherapy provides a process for the therapeutic provision of immediate and natural reinforcement. This article presents this integration and offers theoretical and practical therapist guidelines on its application. Although the integration is largely theoretical, empirical data are presented in its support when available. The article ends with a discussion of future research directions.

Keywords: *depression; Behavioral Activation; Functional Analytic Psychotherapy*

Recent interest in Behavioral Activation (BA) for clinical depression (Martell, Addis, & Jacobson, 2001) stems from several sources. The component analysis of Cognitive Therapy (CT; Beck, Rush, Shaw, & Emery, 1979) by Jacobson and colleagues (1996) suggested that the BA component of CT alone produced equivalent outcomes to the full CT package at the end of acute treatment (Jacobson et al., 1996) and at a 2-year follow-up (Gortner, Gollan, Dobson, & Jacobson, 1998). This grabbed the attention of prominent cognitive therapists (Hollon, 2000) and sparked the development of a full BA treatment package (Jacobson, Martell, & Dimidjian,

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2001; Martell et al., 2001). Current BA recently performed equivalently to Paroxetine and better than CT for moderate to severe depression in a large randomized trial (Coffman, Martell, Dimidjian, Gallop, & Hollon, 2007; Dimidjian et al., 2006).

Simultaneously, an alternate BA treatment was developed by Lejuez, Hopko, and Hopko (2002), referred to as Brief Behavioral Activation Treatment for Depression (BATD). BATD showed promise in a smaller randomized trial on an inpatient unit (Hopko, Lejuez, LePage, Hopko, & McNeil, 2003) and in several case studies (Hopko, Bell, Armento, Hunt, & Lejuez, 2005; Hopko, Lejuez, & Hopko, 2004; Hopko, Sanchez, Hopko, Dvir, & Lejuez, 2003; Lejuez, Hopko, LePage, Hopko, & McNeil, 2001). Cuijpers, van Straten, and Warmerdam (2007) recently published a meta-analysis of BA-related treatments that showed, with some exceptions (e.g., Hammen & Glass, 1975), that these treatments have performed quite well over several decades of research. A final source of interest in BA may be its inclusion in several descriptions of a growing "third wave" of behavior therapies that place less emphasis on cognitive change, revisit and elaborate on earlier behavioral theories, and emphasize mindfulness and acceptance processes (Hayes, 2004; Hayes, Follette, & Linehan, 2004). Currently, BA and BATD are being evaluated by several independent research groups for diverse problems, including posttraumatic stress disorder, depression in Latinos, depression in cancer patients, obesity, and addiction (Kanter & Mulick, 2007).

BA is based on early functional descriptions of depression by Lewinsohn (1974) and Ferster (1973) that emphasized basic behavioral principles, particularly positive and negative reinforcement (Hopko, Lejuez, Ruggiero, & Eifert, 2003). The current article offers an important clarification of how reinforcement is, and is not, incorporated into BA's model of depression and purported mechanism of action. This clarification expresses BA's strengths and exposes possible limitations. We then suggest an integration of BA with another behavioral treatment, Functional Analytic Psychotherapy (FAP; Kohlenberg & Tsai, 1991), to address an important limitation. In both BA and FAP, therapists are expected to learn the underlying principles rather than a session-by-session set of techniques (BATD, in contrast, offers more structure). The integration presented herein is offered in this spirit; in conjunction with the BA and FAP manuals it should provide a sufficient therapist guide to the delivery of FAP-Enhanced BA (FEBA). Although the integration is largely theoretical, we present empirical data in its support when available.

Behavioral Activation

A vast body of research supports the basic principle of reinforcement (Catania, 1998) that states that a given behavior will increase when followed by certain environmental changes. When this given behavior no longer produces these environmental changes or is punished, the behavior will decrease in frequency. Lewinsohn (1974) first described depression as such a decrease in behavior, with naturally elicited sequelae such as sad mood, anhedonia and other dysphoric emotional reactions because of losses of, reductions in, or chronically low levels of positive reinforcement. Lewinsohn's resulting treatment focused on pleasant events scheduling to increase rates of positive reinforcement and social skills training to increase the client's ability to obtain and maintain positive reinforcement (Zeiss, Lewinsohn, & Muñoz, 1979).

Current BA (Martell et al., 2001) retains this basic emphasis on activation and skills training strategies to increase contact with positive reinforcement but, based on Ferster's (1973) functional description of depression, adds a new emphasis on the role of negative reinforcement (i.e., escape and avoidance behavior) in depression. Specifically, negative events occur, these negative events produce aversive emotional responses, and the individual's repertoire becomes dominated by efforts to escape and avoid these aversive emotions. Such emotion-focused coping is often quite passive (e.g., staying in bed, withdrawing from or passively attending social situations, neglecting housework) or interpersonally or physically destructive (e.g., alcohol or drug use, excessive eating). Furthermore, most of these avoidance behaviors do not function to resolve the original problems or deficits that contributed to the negative events or lack of positive reinforcement in the first place. Thus, when an individual responds to the original negative events and resulting negative affective states with avoidance, a spiral into clinical depression may occur. This relation between avoidance and depression is supported by considerable research (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996; Ottenbreit & Dobson, 2004).

In BA (Martell et al., 2001) this basic model is presented to the client as the acronym *TRAP* (*T*rigger, *R*esponse, and *A*voidance *P*attern). *Triggers* are broadly defined, including sudden, major negative life events, stimuli related to past negative life events, or the accrual of smaller negative events over a long period of time. *Responses* to triggers are respondent behaviors or conditioned emotional responses and include some (but not all) of the symptoms of depression, including anhedonia, negative affect and crying, and loss of energy. Key to the model is that these responses are natural,

unavoidable, and not sufficient by themselves (in most cases) to constitute major depression or otherwise require clinical attention. Instead, the presence of *Avoidance Patterns* in response to these symptoms is emphasized. The goal in BA is to "get out of the *TRAP* and get on *TRAC*" (Martell et al., 2001, p. 102) by replacing the avoidance patterns with *Alternate Coping* behaviors that address the original triggers and bring the individual into contact with diverse and stable sources of positive reinforcement. The client in BA would be activated to get out of bed, leave home, go to work, and interact socially even when feeling sad, tired, worthless, indifferent, and hopeless.

Reinforcement

Thus, the key element in depression according to BA is lack of contact with positive reinforcement, and the mechanism of change is the establishment of such contact (Hopko, Lejuez, Ruggiero, & Eifert, 2003). This focus on reinforcement establishes BA as a member of a long line of behavioral treatments. As has been documented for several decades in this and other journals, behavioral researchers have explored a myriad of intricacies of how the timing and strength of reinforcement affect behavior (for a review, see Catania, 1998), which have been developed into successful interventions for a variety of presenting problems, including communication skills for autism-spectrum disorders and other developmental disabilities (e.g., Sallows & Graupner, 2005), toilet training and encopresis (e.g., Smith, 1996), self-injurious behaviors, ADHD (e.g., Ayllon, Layman, & Kandel, 1975), and repetitive habit behaviors (e.g., Woods & Miltenberger, 1995), to name a few. In general, these procedures can be summarized as following a protocol in which the target variable is identified and assessed, reinforcement is applied contingent on the occurrence of the target variable, and procedures for generalization are used. Almost all of the above interventions depend on the ability of the clinician to observe the targeted behavior as it occurs and apply reinforcement contingencies. It is a fundamental principle of these applied interventions that if the therapist has direct access to these contingencies and can manipulate them directly, treatment should be more efficient and more effective.

In BA, *how* the therapist achieves changes in client behavior that should lead to increased contact with positive reinforcement in the environment is very different from these traditional interventions. It is here that BA becomes less behavioral, relying instead on standard outpatient psychotherapy procedures such as the provision of instructions and homework assignments. For example, the client and the therapist collaboratively determine the new

behaviors to activate and a plan for when and how to activate. This plan may be written into an activity schedule or appointment book, or it may simply be remembered by the client. Essentially, the therapist says to the client, "Go do this and hopefully you will get reinforced."

Unfortunately, in this situation clients are given homework assignments to try out alternate behaviors but the therapist has no control over whether the environment will be reinforcing when the new behavior occurs. The therapist himself or herself may attempt to be reinforcing in session, by praising the client for doing homework assignments, but this reinforcement is unnatural (Ferster, 1967). For example, reinforcement from the therapist for completion of a homework assignment to call a friend is different from natural reinforcement provided by the friend for making the call. In fact, *different* behaviors, functionally speaking, may be being reinforced in the two situations. Homework completion is reinforced by the therapist in session (actually, it is *talk* about homework completion) but social engagement is reinforced by the friend. Furthermore, therapist reinforcement in this situation may be quite delayed, in that the call to the friend may have occurred several days before the therapy session. Because immediate reinforcement is more likely to lead to an increase or maintenance in behavior (Crow & Mayhew, 1976; Tarpy & Swabini, 1974), the delayed timing of therapist's attempts at reinforcement in standard BA may not be maximally effective. A problem with delayed reinforcement is that additional behavior is emitted between the desired response and the presentation of a reinforcer, potentially resulting in the reinforcement of these additional responses rather than the desired behavior alone (Reynolds, 1968).

An additional consideration is that there is no guarantee that the environment will reinforce the target behavior. For example, the client could make the call but the friend might not be home or return the call. Even if the friend takes the call, he or she may not successfully reinforce the client's activation. For example, the friend may be frustrated that the client has not called in such a long time and express this frustration, making the call far from reinforcing.

This issue is especially important when the case conceptualization calls for shaping new client behavior (e.g., behavior not in the client pretreatment repertoire) as opposed to the more traditional BA technique of increasing the frequency of antidepressant behaviors that are in the client's repertoire (Hopko, Lejuez, Ruggiero, & Eifert, 2003). Many depressed clients are unskilled at implementing more assertive or otherwise new behaviors (Libet & Lewinsohn, 1973), so much so that others in the client's environment may not recognize the improvement, may find the new behavior aversive, or even if they recognize the new behavior as improved and do not find it aversive

may nonetheless not change their response in such a way that it reinforces the new client behavior. Likewise, the client's environment will often fail at differential reinforcement. For example, the client may make the telephone call (an antidepressant behavior), but while on the phone the client may complain excessively and not listen to the friend's concerns (a depressive behavior), resulting in an overall aversive outcome (e.g., the friend prematurely terminating the call; cf. Coyne, 1976). Although the therapist may foresee and address these possibilities in session by practicing or role-playing, and trying not to give assignments until the target behavior is adequate for social reinforcement, ultimately the BA therapist provides the instruction and hopes that the environment essentially will do the right thing.

To be clear, there is nothing wrong with the provision of instructions to clients, as instructional control is effective (Galizio, 1979; Lowe, 1979). However, clinical instructional control interventions did not evolve from basic behavioral principles, do not uniquely define behavioral interventions (Hayes, Kohlenberg, & Melancon, 1989), and may in fact result in rigid behavioral repertoires that are less sensitive to the actual contingencies (Catania, Shimoff, & Matthews, 1989; Hayes, Brownstein, Haas, & Greenway, 1986). From the standpoint of behavioral theory—and its historical strength providing immediate reinforcement to strengthen target behavior—such instructions are the weak link in the chain of BA's proposed mechanism of action. BA's model of depression focuses on reinforcement contingencies but its therapeutic process focuses on provision of instructions. Although it could be argued that some specific BA techniques—such as the involvement of others in the provision of consequences for activation compliance, behavioral contracts with the therapist, or therapist provision of social consequences for positive out-of-session behavior (i.e., cheerleading)—do not rely on instructional control, even these techniques lack a mechanism for provision of in-session, natural, and immediate reinforcement. Theoretically, addition of such a mechanism should make the treatment stronger.

Functional Analytic Psychotherapy

FAP (Kohlenberg & Tsai, 1991) may provide a solution to this weak link. The key to FAP is the identification of in-session target behaviors, known as clinically relevant behaviors (CRBs), to which natural reinforcement is contingently applied live by the therapist. FAP distinguishes two types of CRBs. CRB1s are in-session occurrences of client repertoires that have been specified as problems according to the client's goals for therapy

and the case conceptualization, and CRB2s are corresponding in-session improvements in those repertoires. Understanding CRBs requires an appreciation of functional response classes with varying topographies; some occur in session in relation to the therapy process and the therapist and some occur out of session in relation to friends, family, significant others, and so forth.

The rationale for FAP is quite simple and represents an application of basic behavioral theory to outpatient psychotherapy. It is this: Given a therapeutic relationship of value to the client, therapist contingent responding to naturally block, ignore, punish, or otherwise extinguish CRB1s and reinforce CRB2s should lead to decreases in the frequency of CRB1s and increases in the frequency of CRB2s. Data suggest that in successful FAP, CRB1s decrease in frequency over the course of therapy and CRB2s increase (Busch, Callaghan, Kanter, Baruch, & Weeks, 2007; Callaghan, Summers, & Weidman, 2003). In FAP, the therapeutic relationship is a genuine, real interpersonal relationship in which therapists amplify their private reactions to provide natural feedback to clients contingent on the occurrence of targeted behavior (Follette, Naugle, & Callaghan, 1996). Assuming that contingent responding is natural and that CRBs targeted are members of the same response classes as are outside-of-session problems and improvements identified in the case conceptualization as goals for therapy, then generalization of gains made in therapy to the outside should occur naturally. Additional generalization strategies are discussed below.

Integration: FAP-Enhanced Behavioral Activation

Although FAP has been suggested as a stand-alone intervention, it may be more promising as an enhancement to existing interventions, especially interventions that are already empirically supported. There are several reasons for this. First, FAP does not specify what the therapist should do in session when CRBs are not occurring. In other words, how does the FAP therapist discuss or intervene on out-of-session behavior, other than relating it to in-session behavior? Second, FAP does not offer a full theory or model of depression (or any other disorder); it simply specifies a behavioral process that could occur between a therapist and client. Thus, FAP has little to say about depression per se independent of its integration with another treatment that offers such a model. Thus, because both BA and FAP are behavioral treatments that focus on reinforcement as the key mechanism of

change and in addition BA provides a full behavioral theory of depression with linked treatment techniques, they provide a perfect integration that solves these dilemmas for FAP and may increase the effectiveness of BA. BA focuses on out-of-session behavior and the goal is to activate new client behaviors in the natural environment to contact stable sources of positive reinforcement. FAP focuses on in-session behavior and the goal is to naturally reinforce improved behaviors *as they occur* in the therapeutic relationship. Thus, the integration of FAP and BA, referred to as FAP-Enhanced Behavioral Activation (FEBA), uses BA's TRAP model and case conceptualization but, rather than relying on instructions to achieve activation of new behavior, attempts to activate new behaviors in the therapeutic relationship, naturally reinforce these behaviors in the therapeutic relationship, and generalize these improvements to the natural environment. At this point, standard activation strategies and assignments are used.

FEBA parallels a similar use of FAP to enhance CT that showed promising results in a nonrandomized comparison to CT (Kohlenberg et al., 2004; Kohlenberg, Kanter, Bolling, Parker & Tsai, 2002). To demonstrate FEBA, we will present FAP's five rules (Kohlenberg & Tsai, 1991) and discuss how they may be used in BA. An important theme is that to do FEBA one first does BA and uses a BA case conceptualization, with additional consideration for how BA treatment targets may be noticed in the context of an intense, intimate therapeutic relationship. When CRBs are observed, a shift into FAP techniques occurs. When successful, these techniques result in in-session, immediate, and natural reinforcement of CRB2s. Standard BA techniques are then used to activate these behaviors in the outside environment, resulting in environmental reinforcement and generalization of in-session gains.

Rule 1: Observe CRB

Rule 1 in FAP is simply to notice and observe CRBs. In FAP, CRBs are defined idiographically based on the case conceptualization, so in FEBA, CRBs may be conceptualized in terms of BA treatment targets. In other words, CRBs in FEBA are occurrences of BA treatment targets (e.g., TRAPs, TRACs, and other behaviors) during the therapy session and in the context of the therapeutic relationship. This leads naturally to an increased focus on intimacy and problems with intimacy, as the FAP therapeutic relationship has many functional parallels with outside intimate relationships (e.g., issues of trust, disclosure, confidence, and mutual caring).

Intimacy and CRB. Problems with intimacy are often associated with depression (Hammen & Brennan, 2002; Zlotnick, Kohn, Keitner, & Della Grotta, 2000). Generally speaking, avoidance of intimacy leads to either no intimate relationships or unsatisfying intimate relationships—either way there is a dearth of positive social reinforcement. Similarly, avoidance of conflict within intimate relationships stalls growth and problem solving. In FEBA, clients are taught to identify avoidance in these areas and to invoke alternate, intimacy-enhancing behaviors instead. Clients are asked to tell others how they truly feel (for many clients, direct expressions of positive, loving feelings are as difficult as or more difficult than expression of negative, critical feelings). FEBA therapists tell their clients that when they can express their thoughts, feelings, and desires in an authentic, caring, and intimate way, they will be more likely to find true intimacy and this will be antidepressant. Other BA treatment targets as per Martell et al. (2001) are now discussed in terms of the therapy process and therapeutic relationship.

Routine disruption and acting according to a goal or plan. Major life changes (e.g., job loss, moves, marriage, or divorce) often precede depression. Secondary problem behaviors (e.g., sleeping late, skipping meals, not calling friends) can further disrupt the client's routine and worsen negative moods. Routine disruption may be seen in session as inconsistent attendance, inconsistent homework completion, changing meeting times, showing up late to session, or not writing future sessions in an appointment book. BA sessions are quite structured, typically beginning with agenda setting and homework review, followed by coverage of the topics on the agenda and then review of the session. This in vivo routine can also be disrupted; for example, a client who is sleeping poorly may have trouble staying on the agenda or may impulsively attempt to shift from a topic on the agenda to a discussion of sleep medications. In BA, to counter routine disruption, clients are encouraged to act according to goals or plans and establish routines. This may be seen as a CRB2 in session if the client successfully sets and follows the session agenda, or if the client completes homework assignments on schedule.

Avoidance patterns. Avoidance patterns may be quite ubiquitous in the therapy relationship. Clients may miss or arrive habitually late to session. Missing session is of course difficult to target as the client must show up for any targeted work to occur, but conceptualizing it as a CRB may be helpful. During session, clients may avoid difficult topics, begin to show some emotion but then make a joke or change the topic, or stay on superficial material. For example (Kohlenberg et al., 2002), consider Jim, a client

who becomes silent during an interchange and when questioned, eventually responds, "Oh, I don't know, nothing important." This may be a CRB1 in that this client may avoid talking and feeling about troubling topics by using such dismissive phrases in his daily life, preventing resolution of the troubling issue and interfering with the formation of more satisfying relationships. Gentle inquiry into "nothing important" may prompt a CRB2, which in this case may be the client identifying and expressing his feelings of discomfort to the therapist. The simple question, "Are you avoiding something right now?" may be enough to identify an avoidance CRB that would otherwise go undetected.

Rumination. Excessive rumination predicts the onset (Just & Alloy, 1997; Nolen-Hoeksema, 2000), length (Umberson, Wortman, & Kessler, 1992), and severity (Nolen-Hoeksema, Parker, & Larson, 1994) of depression. According to BA, rumination is a form of passive avoidance and some forms of client talk during session may be seen as rumination. For example, it is easy when working with a depressed person for the therapist to listen for long periods of time to the depressed person's tales of woe and misery. Although this speech is public and rumination is largely private, the functions may be similar. In other words, such behavior, either public or private, may function as avoidance of distress related to more active attempts at problem solving. Because such active problem solving may increase anxiety and distress, a rumination repertoire may have developed because it appears superficially like problem solving but does not elicit the same intensity of aversive affect (see Kanter, Busch, Weeks, & Landes, in press). Therapists may identify rumination as a CRB and target it directly, gently letting the client know that it affects the therapeutic relationship negatively (e.g., it is boring), is not a good use of therapeutic time, and blocks attempts at effective problem solving during the therapy hour.

Passivity as CRB. Avoidance patterns often involve passive coping, in that depressed individuals attempt to avoid further negative emotions and merely react to what comes without actively addressing their values and goals. As with avoidance in general, this form of avoidance will limit contact with positive reinforcers, thus BA directly targets passivity by attempting to break avoidance patterns and provide the client with goals to work toward outside of session. To the degree that passivity characterizes the client's behavior (or lack of behavior) in daily life, it will undoubtedly characterize his or her behavior in the therapy relationship. For example, a client may agree with all of the therapist's suggestions and advice but demonstrate no real enthusiasm or follow-through. The client may present

no ideas or topics for the session agenda and may passively follow the lead of the therapist, stating "You're the expert" or something similar. Without recognition of passivity as a CRB, such lack of active responding may either (a) extinguish the therapist's active therapeutic stance, resulting in a progressively more passive therapist, or (b) prompt the therapist to become more active, taking responsibility from the client for change and doing all the in vivo work for him or her. Both responses are problematic.

All of these behaviors may be seen in the therapeutic relationship, and these are particularly powerful opportunities for activation of intimacy-enhancing repertoires. Unlike other relationships, the therapy relationship may be a training ground for such behavior, as the therapist may offer genuine and compassionate feedback to the client about the way he or she affects the therapist. In many cases, the difference between an intimacy-enhancing client behavior and an intimacy-defeating client behavior may not so much be *what* was said but *how* it was said. For example, subtleties of voice tone, eye contact, facial expression, body posture, and timing all interact to influence how someone will respond to a particular disclosure. These subtleties may be targeted in therapy as a CRB, as the therapist may be more sensitive and more patient with the client in shaping changes in subtle behaviors or qualities of behavior compared to others in the client's environment.

Assertiveness. In conjunction with avoidance patterns and passive coping, depressed individuals often lack appropriate assertive behaviors that are frequently necessary for successful, active problem solving and goal-directed action. Assertiveness CRBs may be seen in session in many forms. In general, if assertiveness is conceptualized as a treatment target for a particular client, then any appropriate client request to the therapist may be an instance of CRB2, and avoidance of such a request may be a CRB1. Such requests may be quite simple, such as the client asking to change the session time or open a window if it is hot inside the room.

Such requests may be trickier if the request appears countertherapeutic. For example, in standard BA, the therapist may work on assertiveness via role-plays, which clients often find aversive. Consider a client who states, "I really dislike role-plays and would prefer not to do it right now." In this situation, the standard BA therapist may re-present a rationale for the importance of role-plays and proceed to do the role-play. However, in FEBA, the therapist would consider whether the client response was a CRB1, a CRB2, both, or neither. It easily could be both. A client request to not engage in role-play may be a CRB2 in terms of assertiveness and a

CRB1 in terms of avoidance. The therapist must weigh the relative strengths of each CRB and prioritize these targets sensitively. It may be the case that a therapist would choose to reinforce the CRB2 in this situation, which we discuss below.

Rule 2: Evoking CRBs

Rule 2 in FAP is to evoke CRBs. The goal is for the client's TRAPs and TRACs to occur during therapy. It is important to note that the therapy process, setting, and relationship often evoke CRBs naturally, in which case the therapeutic task is to notice their occurrence (Rule 1) and then proceed (to Rule 3) without having had to explicitly evoke CRBs (Rule 2). For example, setting an agenda, therapist vacations, negotiating fees, therapist mistakes, silences, client affect, a client doing well, positive feedback from the therapist, therapist physical or emotional qualities, and homework assignments may all naturally evoke CRBs.

In addition to noticing CRBs that occur naturally during the course of therapy, FEBA therapists strategically evoke CRBs. In general, the therapist prompts the client to engage in new behavior. Strategically evoking CRB2s often occurs in the presence of a naturally evoked CRB1 and consists of asking the client to do something different in that moment. For example, the therapist may notice that the client seems uncomfortable on a warm day and has glanced at the window. The therapist may prompt a CRB saying, "If you are warm, did you consider asking me to change the temperature or open a window?" In essence, the therapist is explicitly evoking a weak assertiveness repertoire in session with a simple prompt for an assertive request. Such prompts may be faded after the behavior has come under more natural stimulus control.

As another example, consider Vicky, a client who identified assertiveness as a CRB and who was telling her therapist about an interaction she had at work, when she had difficulty explaining to a colleague that she could not stay late to complete a project. The therapist responded, "So how would that feel to you, to say something like that to me? We could do it in here, like at the beginning when I'm trying to arrange the agenda. And it wouldn't even have to be very important to you. In fact, that might be a good way to start. So if I say, "Let's talk about your activity chart now," you could say, "Well, what if we talked about that later—I'd like to talk about something else instead." How would that feel to you?"

In these examples, prompts by therapists for clients to be assertive can be seen as in-session parallels to assigning outside-of-session assertive

activities. The obvious advantage of the in-session assignment is that the therapist has control over what consequences follow relevant behavior. Furthermore, the therapist may shape approximations to the desired behavior (e.g., a weak but still improved attempt to change the agenda from the client) that would go unreinforced at best or punished at worst by the outside environment. Thus, in-session therapist prompts for CRBs may occur earlier in therapy than corresponding outside activation assignments, so the therapist has a chance to ascertain that the behavior is reinforceable outside and to shape improvements to reinforceable behavior. Also, in parallel with the fading out of highly structured out-of-session activation assignments that occurs in later BA sessions (Hopko, Lejuez, Ruggiero, & Eifert, 2003), direct prompts for in-session CRB2s can be faded out by the FEBA therapist as the CRB2 comes under appropriate stimulus control.

In general, to the degree that the case conceptualization identifies avoidance and passivity as CRB1s, the therapist may pay particular attention to the way the therapeutic workload is shared by the client and therapist. Is the therapist doing most of the talking, trying to cajole, entice, or simply plead with the client to get active? This may be in-session avoidance and passivity, and the therapist may be reinforcing it unintentionally by taking responsibility for change from the client. The FEBA therapist may choose to evoke new behavior by pointing out this dilemma to the client, as in, "I notice that I have become increasingly active in our sessions, seemingly in response to your passivity. But if I am not active, we may just sit here silently for the hour and get nothing accomplished." Functionally, this response serves to evoke improved behavior, but may also function to block problem behavior. As this block may be experienced as punitive by the client, it is important that the prompt for new behavior is clear. For example, the therapist may continue to prompt CRBs by saying, "I know this is hard for you, but we really have to break this pattern between us. What small step can you take, right now, that would be in the service of you becoming more active and taking more responsibility for our process?" A client may respond to this with additional CRB1; for example, the client may complain about how difficult the situation is or how tired he or she feels. This may be more passivity, which again should be blocked and additional prompts for CRB2 supplied. The goal is to not stop until CRB2s occur.

Broadly speaking, although almost any CRB may be evoked during the course of therapy, the therapy relationship in FEBA may be established as a context that evokes CRBs specifically related to intimacy. Given an appropriate case conceptualization, an FEBA therapist may place emphasis on a client's being able to express what is difficult for him or her to express

to the therapist. Furthermore, FEBA therapists may express caring or other feelings, tell clients what he or she sees as their strengths, and make requests themselves (e.g., I want . . ., I need . . ., I would like . . .). Such therapeutic behavior may establish a context in which similar behavior from the client would not be unusual and models the behavior for the client.

For example, Monica's case conceptualization described a pattern of behavior that included avoidance of intimacy. In session, Monica would often avoid intimacy with the therapist by making jokes about herself. The therapist clarified with Monica that the joking behavior functioned as a CRB1 when she responded affirmatively to the question, "Is your joking in here with me similar to what you do when you get uncomfortable after your husband tells you he loves you?" The therapist then described to Monica how the joking behavior functioned to push him away and then evoked a CRB2 by asking her if there was something different she could do that would be more effective in bringing their relationship closer. The therapist encouraged Monica to more directly discuss with him how she was feeling, what about their interaction made her uncomfortable, and what she wanted from him.

The ultimate goal is for the therapeutic relationship to function, to the degree possible, as a real intimate relationship that is as similar as possible to the kind of intimate relationships the client desires. Of course, obvious limits on what occurs in the therapy relationship apply, and these limits are discussed explicitly with the client. For example, the therapist may say to the client, "I do want us to have a close, genuine, and real relationship, but there are important differences between our relationship and other intimate relationships you may have. First, nothing sexual will ever occur between us. Second, our relationship will always be in the service of your treatment goals; we will not focus on my problems or my issues, unless for some reason focusing on them will further your goals." Such clear demarcation of the boundaries of the therapeutic relationship may occur repeatedly throughout treatment.

Rule 3: Reinforcing CRBs

Rule 3 in FAP is to naturally reinforce CRBs. One of the most important benefits of FEBA over standard BA is that the therapist has control over the provision of reinforcement for target behaviors. Thus, the behavior therapist providing FEBA may be sensitive to issues of shaping and schedules of reinforcement that may be important in establishing new behaviors. This is quite simple in theory. At first, even gross approximations to the behavior should be reinforced every time they occur. Over time, the threshold for a

behavior to be reinforced can be adjusted so that eventually the client is only reinforced for very precise and skillful instances of the desired behavior, and the reinforcement schedule can be thinned and adjusted to approximate the schedule that might occur outside of session.

The nature of reinforcement in FEBA is tricky, as FAP highlights natural rather than arbitrary reinforcement processes. According to Ferster (1967) and Kohlenberg and Tsai (1991), natural reinforcement benefits the person being reinforced, whereas arbitrary reinforcement uniquely benefits the person doing the reinforcing. Moreover, natural reinforcers, in contrast to arbitrary reinforcers, are characteristically and reliably present in the reinforced person's natural environment outside of the therapy setting. According to Skinner (1982), "By contriving relatively unambiguous social contingencies, the therapist builds a repertoire that will be naturally effective in the client's daily life" (p. 5). Thus, FEBA therapists are discouraged in using arbitrary reinforcement and are encouraged to provide natural reinforcement instead.

In some cases this can be quite simple but nonetheless represent a novel move for a therapist. For example, assertiveness is naturally reinforced in daily life by compliance with the assertive request. Thus, if the therapist has observed an assertive CRB2, the therapist should give the client what he or she asked for, to the degree possible. For the client who was warm and was prompted to ask that the window be opened, this may be as simple as opening the window. For others, this may involve rescheduling a session or changing the session time. Such natural responding contrasts with more arbitrary but perhaps more common responding. For example, a therapist may say, "That is really assertive of you to ask me to open the window. Good job!" but not actually open the window. This form of reinforcement is discouraged in FEBA.

For other clients, responding to assertiveness CRB2s may be more complicated. Consider the client who assertively mentioned that he does not like role-plays. On one hand, this may be a CRB2 in terms of assertiveness and should be reinforced. On the other hand, this also may be a CRB1 in terms of avoidance of uncomfortable social interactions and should not be reinforced. In general, reinforcing a CRB2 may be seen as the priority, but the therapist should try to minimize the degree to which the response also reinforces a CRB1. In this example, the therapist might say, "OK—what would you like to do instead? But let's not avoid the topic completely, because it wouldn't be helpful for you if we just never did things that you'd rather avoid. How can we honor your request to not do role-plays but still make sure we're actively working on this issue and not avoiding?" A collaborative discussion could then occur.

Therapist reinforcing responses often include amplification of private reactions, including showing caring, telling the client how the therapist feels about him or her in the moment, and nonverbal displays of interpersonal connection. For example, consider David, a client who has just demonstrated a CRB2. After avoiding talking about his grief over the death of his mother for months, the client has broken down and started crying about her. Furthermore, the client's marriage has been disrupted, partly because of his inability to express his grief, which his wife desires. At this moment, the FEBA therapist asked himself a series of questions: "How am I feeling toward this client at this particular moment?" "Am I feeling close, intimate, connected, supportive, or am I feeling distant, bored, disconnected?" "Would expressing my own reaction function to reinforce or punish this client's behavior?" and "How likely is it that my reaction in this moment would be typical of his wife? In other words, would she feel the same as I do and express those feelings?" Because the therapist felt closer and more connected to the client after the disclosure, believed that the client would respond positively to a therapist disclosure, and had previous interactions with the client to know that the wife would likely feel and respond similarly, the therapist decided to amplify his feelings: "You showing me your feelings right now makes me feel as close to you as I ever have. It connects me to you in a deep way."

Responding to CRB1s. A final consideration under Rule 3 is how to respond to in-session avoidance behaviors and other instances of CRB1. Although not every instance of avoidance will be noticed and responded to, in general the goal when avoidance occurs is to block it and prompt CRB2. Blocking avoidance is a form of punishment and should not be taken lightly. For most clients, simply pointing out the behavior as it happens is sufficiently aversive and no additional or explicit punishment need occur. For example, in many cases a sufficient response to an avoidance CRB1 is, "It looks like you are hoping to avoid this topic. I know it is hard but can you be more active right now? Let's face this thing."

Rule 4: Observing Your Effect on the Client

Rule 4 in FAP involves the therapist's observing his or her effect on the client and does not need much modification from FAP to FEBA. By definition, the client has only experienced reinforcement if he or she exhibits the target behavior with increased frequency, intensity, or both. Therefore, it is essential that the therapist assess the degree to which his or her behaviors that were intended to reinforce actually functioned as reinforcers, and that

behaviors not intended to reinforce did not accidentally function as reinforcers. By continuing to pay close attention to the function of one's own behavior, the therapist can adjust his or her responding as necessary to maximize the potential for reinforcement.

Rule 5: Generalization Strategies

In FAP, the original Rule 5 was to provide functional descriptions of client behavior to the client and was intended to facilitate the generalization of in-session gains to the client's daily life. Simply put, when working on target behaviors in session, it is important for the therapist to draw parallels between in-session and out-of-session behavior in terms of functional similarities. Weaving between focusing on in-session and out-of-session behaviors will also increase the ease with which clients understand how the in-session work is related to their goals for therapy. Drawing parallels and weaving also increase the client's attention to the similarities between in-session and out-of-session work, increasing the likelihood of generalization.

In FEBA, generalization strategies also are considered more broadly. In fact, all standard BA activation techniques function as generalization strategies in FEBA. The key shift is that activation assignments flow directly from in-session work. Consider the following homework assignments based on the examples provided thus far:

- Jim, who used a dismissive phrase with the therapist to avoid an intimate disclosure and then was prompted to identify and express his feelings of discomfort to the therapist, would be given the homework assignment to be more directly expressive to his wife.
- Vicky, who had difficulty asserting herself at work and with the therapist and was prompted to act assertively in therapy, would be given the assignment to directly tell her coworker that she could not stay late when asked. Vicky also may be given assignments to assert herself at home with her husband, perhaps asking him for more help caring for the children.
- For Monica, who tended to joke when she became uncomfortable, which functioned as avoidance of intimacy, the homework assignment may consist of having her not joke with her boyfriend when she is uncomfortable and instead verbalize to him how she is feeling.
- David, the client who avoided and finally talked about his grief over the death of his mother, would be activated to talk with his wife about this event. He may also be encouraged to actively grieve in other ways, including looking through photo albums, visiting his mother's grave, or calling his mother's old friends.

An important component of such homework assignments is that the therapist explicitly parallels in-session therapist reactions with expected reactions of outside others. For example, consider David's therapist who told David that he felt closer to him after David's disclosure. The therapist might also state, "I am telling you this is because I am genuinely feeling it and I really believe that if you open up in this way to your wife, she will feel the same. Do you think you are ready to do that this week? If she reacts the way I just did, it could be a very powerful experience between the two of you and may bring you much closer together." If David agrees to this assignment, standard BA techniques would be used, including scheduling the activity at a specific time and place, discussing obstacles to completion of the activity, and discussing how engaging in the activity would be an example of a TRAC rather than a TRAP.

Discussion and Future Directions

The integration presented herein resolves a mismatch between the behavioral theory behind BA—which emphasizes the need for clients to contact positive reinforcement—and the therapeutic techniques of BA—which rely on provision of instructions rather than therapeutic application of reinforcement. To nonbehaviorists this may seem trivial, but to behaviorists the provision of reinforcement is the sine qua non of behavioral interventions and its importance is backed by decades of basic and intervention research. We suggest that the current integration makes BA more behavioral, but more importantly, may make BA more effective for specific populations. In fact, the authors of BA were very familiar with FAP as both were developed at the University of Washington and the authors admittedly did not emphasize the therapeutic relationship in the BA manual (Martell et al., 2001). In its final chapter, they noted, "As the use of activation strategies alone in the treatment of depression takes greater hold in the therapeutic community, a combination with FAP may result in a stronger contextual treatment" (p. 185).

Current BA, in its unmodified form, performed very well in a recent trial (Dimidjian et al., 2006), perhaps leaving little room for improvement. However, FEBA may be better suited to target chronic and pervasive interpersonal difficulties and other severe behavior deficits that accompany depression. As interpersonal problems function as risk factors for relapse (Barnett & Gotlib, 1988), FEBA may improve long-term outcomes over standard BA. Furthermore, given the emphasis in FEBA on building basic

interpersonal repertoires that would not be easily shaped in the outside world, it may be useful for clients with comorbid depression and personality disorders. The recent BA trial enrolled very few clients with personality disorders, so current BA's efficacy with these clients is largely unknown. In fact, FEBA is consistent with recent American Psychological Association guidelines for the provision of treatment for personality disorders (Critchfield & Benjamin, 2006) that emphasized not just the importance of a strong and collaborative therapeutic relationship but one that serves as a fundamental mechanism of therapeutic change. CT has been modified to incorporate the therapy relationship in this way to target personality disorders (Beck, Freeman, Davis, & Associates, 1990), but this treatment is not based on behavioral principles and thus may be less amenable to integration with BA.

FEBA also may be useful for clients with chronic forms of depression who are likely to have interpersonal problems, and for depressed clients in ongoing but problematic intimate relationships. An interesting application may be for the combination of depression and marital distress, as marital distress increases risk for depressive relapse (Hooley & Teasdale, 1989), and couple therapy appears to hold an advantage over individual therapy in improving relationship functioning and satisfaction (Beach & O'Leary, 1992). FEBA, because it specifically targets interpersonal behaviors in individual therapy and aims to generalize improved behavior to the outside relationships, may be useful when the nondepressed member of a distressed couple cannot or will not participate in couple therapy. Research on FEBA in this area may be beneficial.

An existing study in which experienced CT therapists learned FAP techniques (referred to as FAP-Enhanced CT or FECT), suggests that FEBA in turn may be equally promising. In the FECT study (Kohlenberg et al., 2002), FECT appeared to be incrementally more efficacious than standard CT (79% of the FECT participants responded to treatment, i.e., experienced a more than 50% decrease in depression symptomatology, vs. 60% of CT participants). Furthermore, FECT participants experienced significant improvements in their interpersonal functioning compared with CT participants. Two findings additionally provide some evidence for FAP's mechanism, contingent responding to CRB, in FECT. First, in the FECT study, therapeutic progress was significantly related to rates of FAP interventions (Kanter, Schildcrout, & Kohlenberg, 2005). Second, single-subject data have suggested that FAP interventions, when added to CT, can result in specific improvements in target variables immediately after the therapist begins contingent responding to these variables (Kanter et al., 2006).

Some potential complications and limitations to adding FAP to BA should be discussed. A strength of standard BA is that because of its straightforward rationale and corresponding set of techniques, it may be easier to train and disseminate than other empirically supported treatments for depression, such as CT (Hollon, 2000). FEBA undoubtedly will be more difficult to learn and implement as it requires a more sophisticated understanding of behavioral principles than does standard BA and requires a variety of skills associated with a potentially intense focus on one's own reactions in the context of a therapeutic relationship.

In fact, in the FECT study described above, CT therapists had some difficulty implementing FAP techniques at the high rates expected (Kanter, Schildcrout, & Kohlenberg, 2005). Training BA therapists to conduct FEBA may be significantly easier than training CT therapists to conduct FECT. The marriage between an out-of-session set of techniques (BA or CT) and an in-session set of techniques (FAP) is much more compelling in FEBA versus FECT because BA and FAP integrate well theoretically. Cognitive therapists, in contrast, entered the FECT training situation with a preexisting theoretical stance that did not match FAP's behavioral theory and focus on reinforcement.

Likewise, the intense focus on the therapeutic relationship produced by FEBA, if not executed competently and sensitively, may be aversive to clients, resulting in some clients who would have remained in a pure BA treatment dropping out of FEBA (cf. the second FECT case published in Kanter et al., 2006). FEBA treatment development should be sensitive to this possibility. It is also possible that adding FAP to BA may distract the therapist from the simple activation instructions in BA that have been empirically supported, thus attenuating its effectiveness rather than enhancing it. To the extent, however, that FEBA proves to be effective for some clients who would not benefit or gain less benefit from standard BA, therapists already trained in BA may increase their effectiveness by learning additional FEBA techniques.

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