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The Credibility and Acceptability of Befriending as a Control Therapy in a Randomized Controlled Trial of Cognitive Behaviour Therapy for Acute First Episode Psychosis

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Abstract. There is increasing evidence that cognitive behavioural therapy (CBT) is efficacious in treating psychosis. However, very little attention has been paid to the nature of the control treatments used in studies of this. Befriending has been used as a control treatment in several randomized control trials (RCTs) of CBT for psychosis as it is simple to learn and administer. The aim of the present study was to examine whether Befriending controlled for important non-specific aspects of therapy when compared to CBT in a RCT for acute first episode psychosis (FEP). These non-specific factors included time in, expectancy created by, and acceptability of therapy. Expectations and enjoyment of therapy were measured by questionnaire. Time in therapy and the number of drop-outs were also recorded. Results showed that Befriending was comparable to CBT on measures of expectancy, enjoyment of therapy and drop-out rate, but significantly different with regard to time in therapy. This suggests that Befriending is a credible and acceptable control therapy for FEP with modification to increase time in therapy sessions. Methodological issues are raised, and suggestions for future research are made regarding control treatments.

Keywords: CBT, first episode psychosis, control, Befriending, psychosis, non-specific factors.

Introduction

Several RCTs of CBT for psychotic disorders have found that CBT in combination with standard treatment (including medication) produces better outcomes on a variety of measures than standard treatment alone (Kuipers et al., 1997; Startup, Jackson and Bendix, 2004; Tarrier et al., 1998). However, it is necessary to ensure that these results are due to the specific effects of CBT rather than being due to people simply receiving increased amounts of treatment. Therefore, CBT should be compared with an appropriate control (Chambless and Hollon, 1998). RCTs of CBT for psychosis have utilised a variety of control treatments and have consistently found that CBT outperformed those control treatments (Drury, Birchwood, Cochrane and MacMillan, 1996; Sensky et al., 2000; Tarrier et al., 2004, 1998; Turkington and Kingdon, 2000).

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The choice of an appropriate control treatment is essential to the methodological integrity of a study (Baskin, Tierney, Minami and Wampold, 2003), but has received little attention in the psychosis literature. Befriending has been used twice as a control in RCTs of CBT for psychosis (Sensky et al., 2000; Turkington and Kingdon, 2000). It has great utility in a RCT since it is relatively easily learned by any experienced therapist, is atheoretical, and is manualized (Bendall, Killackey, Jackson and Gleeson, 2003). Nevertheless, the way in which it acts as a therapy has not been systematically evaluated. First used as an intervention for women with depression (Harris, Brown and Robinson, 1999), Befriending was modified for use in psychosis research (Sensky et al., 2000). In the current study, Befriending, based on the Sensky et al. model, was adapted for a RCT of cognitive behavioural therapy for acute FEP. Befriending consisted of talking about neutral topics that interested the client, including music, sport, books, cooking and pets. If the client found verbal interaction difficult, the client and therapist engaged in activities such as board games, walking, or playing sport. The therapist's primary goals were to keep the client engaged for the full duration of therapy and to keep the conversation or activity as close to a neutral, pleasant chat with a friend as possible. The therapist gently redirected the client away from emotionally loaded topics, such as symptoms or interpersonal problems, when they arose. Befriending was considered to be an ideal control in this trial because it was directive; thus, therapists had the ability to control the conversation and to redirect acutely psychotic clients from unstructured discussion of their psychotic symptoms, which may have been detrimental to them and may have erroneously increased the measured difference between CBT and the control treatment.

It has been traditionally considered that the function of a control condition in psychotherapy research is to account for all the factors that produce an effect but are not part of the theory of the active therapy (Rosenthal and Frank, 1956). The terms "common", "non-specific" or "placebo" factors have been used to describe these, but there is a lack of theoretical consensus and empirical research regarding the nature of these factors (Greencavage and Norcross, 1990; Shapiro and Shapiro, 1997). Nevertheless, many psychotherapy RCTs describe their control treatments as controlling for the common or non-specific factors including RCTs of CBT for psychosis (e.g. Sensky et al., 2000; Tarrier et al., 2004).

Some factors, however, have been investigated empirically and found to have an effect, regardless of the active treatment offered. One of these is time. Longer time in therapy has been related to better outcome in psychotherapy generally (Howard, Kopta, Krause and Orlinsky, 1986). Time in therapy has been the most commonly (and usually only) measured variable to check for equivalence across control and target treatment in RCTs of CBT for psychosis (Drury et al., 1996; Sensky et al., 2000; Tarrier et al., 2004). Tarrier et al. (2004) found that the number of therapy sessions was similar for their CBT group and supportive counselling control in a sample with early psychosis, but people who had supportive counselling received only 83% of the time in therapy that people with CBT received. Sensky et al. (2000) found that the Befriending and CBT groups did not differ significantly as regards the number of therapy sessions or total session time in a sample of people with chronic psychosis. In the current study protocol, therapies were matched for the number and duration of therapy sessions.

Another empirically supported "non-specific factor" is client expectations (Barker, Funk and Houston, 1988; Baskin et al., 2003; Bowers and Clum, 1988). It is widely known that the expectation of an outcome can produce an effect in the expected direction in a wide variety of psychological and physical conditions (Kirsch, 1990). Psychotherapies generally engender high levels of expectation by presenting a credible rationale for treatment and using

therapeutic techniques that have high credibility to the person receiving the treatment (Kazdin, 1980). However, rationales for control therapies have been found to be generally less credible than those for active treatments (Borkovec and Nau, 1972; Nau, Caputo and Borkovec, 1974). Meta-analyses have found conflicting results when investigating the credibility of the control condition in psychotherapy outcome studies. Some studies found that high credibility controls had a greater effect on outcome (Barker et al., 1988; Baskin et al., 2003), while others found no differences in outcome between high- and low-credibility controls (Bowers and Clum, 1988; Stevens, Hynan and Allen, 2000). These meta-analyses, however, used several factors to define credibility (including, for example, time and therapist experience). In the only meta-analysis of comparisons of psychological treatments and control treatments that specifically controlled for expectancy, the active treatments were found to be more effective than the expectancy controls, which in turn were more effective than no treatment conditions (Barker et al., 1988). Despite this evidence that client expectation is an important confounding factor in psychotherapy research, little attention has been paid to the role of the credibility of controls and expectation in RCTs of CBT for psychosis. The only study to directly address client expectations in CBT for psychosis found that there were no differences in outcome between a group given CBT and high expectations of a positive result, and a group given CBT and low expectations of a positive result (Tarrier et al., 1993). This study, however, did not address expectations in a control treatment. In another RCT of CBT for psychosis, participants were interviewed at 3 months post-treatment. The interview included questions that enabled an analysis of client expectations, although the authors did not describe their results as such (Durham et al., 2003). They found that participants were significantly more likely to find CBT "definitely helpful" than either their control treatment – supportive psychotherapy, or treatment-as-usual. This indicates that supportive psychotherapy may not have engendered the same kind of positive expectation as CBT, despite the authors' assertion (without empirical support) that supportive psychotherapy was highly credible. A recent meta-analysis of the credibility of control treatments categorized Befriending as a less credible therapy since it did not address problems, and thus could not engender the same kind of positive expectancy as a control therapy that did address problems (Baskin et al., 2003). This categorization was made without empirical support. In the current study, several strategies were instigated in order to create a high level of positive expectation in the Befriending group. Firstly, when the research project was presented to potential participants by the research assistant, they were told the name of both conditions, were given a brief description of each and told that both have been found to be efficacious in treating people with psychosis (as the Sensky et al. (2000) study found that Befriending was equally efficacious with CBT at end of treatment). Then, during the first therapy session when the therapist told the client which condition they had been randomized to, another introduction and rationale was given for Befriending. This is described in the Befriending manual as "We think it might be helpful to talk to a professional about the good things in your life, not just the difficult things" (Bendall et al., 2003, p. 14).

We also aimed to make Befriending highly acceptable to participants since engaging people with psychosis in therapy can be very difficult (Birchwood, Fowler and Jackson, 2000; Chadwick, Birchwood and Trower, 1996). Acceptability of treatment was included in this study since investigating whether Befriending was enjoyable to participants is essential in determining its utility. Two studies examined satisfaction with CBT in psychosis (Kuipers et al., 1997; Sensky et al., 2000). CBT was found to be satisfactory to clients where 80% responded as being "satisfied" or "very satisfied" with CBT (Kuipers et al., 1997). CBT

was found to be more satisfactory to clients (with a mean of 50 on a satisfaction scale with theoretical range of 7-70) than Befriending (with a mean of 43), but not significantly so (Sensky et al., 2000).

The aim of the current paper was to examine the credibility and acceptability of Befriending in a RCT of CBT for acute first episode psychosis. Credibility was operationalized as time in therapy and whether Befriending elicited the same degree of client expectancy as CBT. Acceptability of the therapy was measured by investigating the rate of drop-outs and client enjoyment of the therapy process. It was hypothesized that CBT and Befriending would not differ in any of these domains, which would indicate that Befriending was as credible and well-accepted as CBT for young people with first episode psychosis.

Method

Participants

Participants were recruited from ORYGEN Youth Health (OYH), Melbourne, Australia, into a RCT of CBT for first episode psychosis between August 2001 and September 2003. Research assistants approached consecutive patients admitted to OYH within 4 weeks of their registration with the service. Exclusion criteria were an inability to speak English, intellectual disability or psychosis due to a medical condition. Consenting participants were randomly allocated to either CBT or Befriending and to one of two clinical psychologists who delivered both interventions. Participants received up to 20 sessions of therapy over 14 weeks for approximately 45 minutes each session. Participants in both conditions received case management and medical follow-up as usual. The outcomes and a full description of the sample of this study are described in detail elsewhere (Jackson et al., submitted).

Interventions

Befriending therapy has been described in detail in the Introduction. For further details see the Befriending manual (Bendall et al., 2003). ACE (Active Cognitive Therapy for Early Psychosis) therapy drew on the cognitive work conducted with positive symptoms (Chadwick et al., 1996; Fowler, Garety and Kuipers, 1995; Kingdon and Turkington, 1994), and the more developmental and integrative approach to treating the experience of FEP developed at OYH (Henry, Edwards, Jackson, Hulbert and McGorry, 2002). In addition, ACE incorporated interventions based on general cognitive behavioural therapeutic principles as many clients presented with symptoms and issues other than psychosis that they experienced as distressing. In this way ACE is a therapy that is formulation-driven, cognitively-based, symptom-focused, and also addresses wider issues in the lives of clients such as quality of life, and integration of the experience of psychosis. A fuller description of ACE can be found in the ACE manual (Bendall, Killackey, Marois and Jackson, 2005).

Symptom and functioning measures

After giving informed consent, participants completed a baseline assessment interview with a research assistant to obtain demographic, quality of life and illness information. Major measures included the Structured Clinical Interview for DSM-IV-TR Axis 1 Disorders – Patient Edition (SCID) (First, Spitzer, Gibbon and Williams, 2001), Brief Psychiatric Rating

Scale (BPRS) (Ventura et al., 1993) and the Scale for the Assessment of Negative Symptoms (SANS) (Andreasen, 1984). These were repeated mid-way through, at the end of treatment, and after 1-year. CBT was found to outperform Befriending at mid-treatment on all measures of symptoms and functioning, and at 12-weeks on a smaller range of measures. Most of these effect sizes did not reach statistical significance, possibly due to the small sample size in each condition.

Time

The number of sessions and the number of minutes in each session for each participant were recorded by the therapist.

Rate of drop-out

Drop-outs were defined as clients who told their therapist that they did not want to continue with therapy or unexpectedly left the country or state. Clients who formally withdrew were asked why they chose to withdraw.

Satisfaction questionnaire

A brief questionnaire was developed by the therapists as a check of 1) expectancies and 2) acceptability of treatment. It should be noted that the questionnaire has not been psychometically validated at this time. There have been differing opinions as to when a check of expectancies should be carried out. Barker et al. (1988), in their meta-analysis of expectancy control therapies, categorized acceptable expectancy checks as those that asked participants to rate the usefulness of the therapy after hearing the treatment rationale but before the start of therapy. Bowers and Clum (1988) rated high credibility control treatments as those where clients rated their expectancies as the same as the active treatment at the end of therapy even though the effectiveness of therapy may have confounded expectancies. In the current study, the expectancy check was conducted after therapy was completed so as to include the two aspects of expectancy considered to be important: rationale and ongoing credibility (Kazdin, 1980). This confounds potential differential treatment outcome with satisfaction (Bowers and Clum, 1988). However, it was decided that it was important to capture clients' expectancies of ongoing treatment despite the confounding problems, since the ongoing credibility of Befriending was unknown and has been questioned (Baskin et al., 2003). The research assistant asked the participants to complete a simple satisfaction questionnaire, either after the end of therapy, or at 1-year follow-up. The scale consisted of a series of questions, with each response rated on a 5-point Likert scale. The reason for the varying completion times was that, initially, participants were given a more complex treatment alliance measure, the Agnew Relationship Measure (Agnew-Davies and Stiles, 1998), but this was found to be too complex for many of them to complete. Subsequently, the ACE satisfaction questionnaire was introduced at the completion of therapy as a much more simple measure. Those clients who had already completed the end of treatment assessment were given the questionnaire at the 1-year follow-up. Three questions were asked to assess client expectancies. These were: (1) "The therapy with {therapist name} was helpful." (2) "My therapist, {name}, was not helpful." (3) "The therapy with {name} made me feel better." Question (4), "I did not enjoy the therapy with

{name}", assessed enjoyment of therapy. A final question, (5) "The number of therapy sessions was... (e.g. too many, not enough)", was asked to investigate clients' satisfaction with the length of therapy.

Results

Sixty-two participants were randomized into the trial. Two participants withdrew from the therapy component of the research after they had been allocated a therapy condition but before they were informed as to the therapy condition they had been allocated. The results in this study were based on the 60 participants who were aware of the therapy condition to which they had been allocated.

Satisfaction questionnaire

Forty of the 60 participants (66.7%) responded to at least one item on the questionnaire. Twenty-one of those were in the ACE condition and 19 were in the Befriending condition. Non-responses ($n = 20$) occurred because: participants were unable to be followed up ($n = 7$); participants were not given the questionnaire by research assistants in error ($n = 7$); participants failed to return their questionnaire ($n = 5$); or the participant's mental state prevented completion of the questionnaire ($n = 1$).

Representativeness of responders. The representativeness of responders to the satisfaction questionnaire was assessed by comparing the respondent group to the non-responders on a range of sociodemographic and illness characteristics using chi-square tests and independent sample *t*-tests, as appropriate. All statistical tests were two-tailed. There were no significant differences found as regards gender ($p = .69$); age ($p = .84$); age of onset of psychosis ($p = .90$); positive symptoms ($p = .67$); or quality of life ($p = .91$). Most importantly, there did not appear to be any differences between the ACE (67.7% response) and Befriending (65.5% response) groups in terms of response rates ($p = .86$).

Time of completion of questionnaire. Twenty-two (13 ACE and 9 Befriending) respondents completed the satisfaction questionnaire at the 12-week assessment and 18 (8 ACE and 10 Befriending) at the 1-year follow-up assessment. The questionnaire responses were examined as a whole to determine whether there was any systematic bias in the responses of those who completed the questionnaire at 1-year compared with those who completed it at 12-weeks. In particular, we were interested in whether those who completed the questionnaire at 1-year may have given less extreme or more generally positive answers than those who completed it at 12-weeks because of retrospective self-report. The patterns of responses across all questions were inspected for the group who completed the questionnaire at 12-weeks and the group who completed at 1-year, and no systematic differences between the groups were found. Both groups tended to answer more positively than negatively.

Questionnaire responses of ACE and Befriending groups. Each questionnaire item was then analysed individually with regard to differences between the ACE and Befriending groups. Because the questionnaire items were ordinal and the distribution was non-normal, parametric analyses such as t-tests were not used. Non-parametric tests such as the Mann-Whitney *U*-test were not appropriate either, as this technique relies on ranking the data values and there were only 5 points to rank. Because of this, similar agreement categories were grouped together

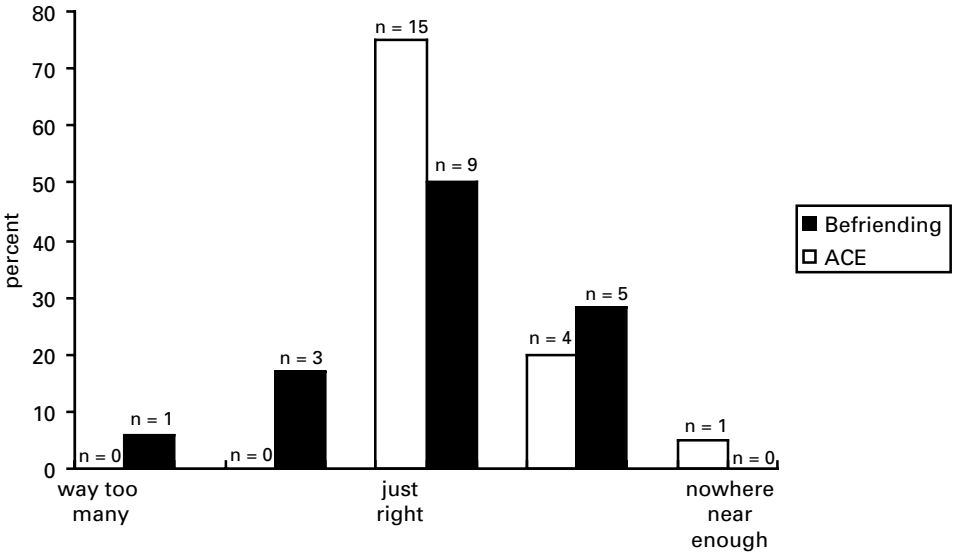

Figure 1. Number (and %) of people responding to question 5: "The number of therapy sessions was. . ."

and the resultant data were cross tabulated with treatment status. Due to the number of cells with small expected frequencies, exact *p*-values were computed rather than asymptotic chi square statistics and their associated *p*-values. This analysis revealed no significant differences between the ACE and Befriending groups on any of the five questionnaire items (Item 1: $p = .89$; Item 2: $p = .54$; Item 3: $p = .33$; Item 4: $p = .68$; Item 5: $p = .08$). Graphs of responses to each question for the ACE and Befriending groups are presented in Figures 1–5 as they give more specific information regarding the differences in the response patterns in the two groups. The bars show the percentages of responses to each item on the five-point scale.

Time in therapy

The mean number of sessions for the ACE group was 9.00 ($SD = 4.93$) and the median was 9.00. The mean number of sessions for Befriending was 7.21 ($SD = 5.17$), and the median was 6.00. A *t*-test showed that the difference between the means was not significant ($p = .18$). The mean time in therapy for the ACE group was 385 minutes ($SD = 238$), with a median of 354 minutes. The mean for the Befriending group was 276 minutes ($SD = 261$), and the median was 174 minutes. The data were positively skewed in the Befriending group hence a Mann-Whitney *U*-test was performed instead of a *t*-test. This revealed a statistically significant difference between the groups ($p = .04$), showing the ACE clients spent more time in therapy.

Figure 1 shows responses to the questionnaire item regarding satisfaction with the length of therapy. It shows that 75% ($n = 15$) of people in the ACE therapy found the length of therapy to be "just right" compared with 50% ($n = 9$) in the Befriending group. Only participants in the Befriending group reported that there were "too many" or "way too many" therapy sessions (22%, $n = 4$). While the differences in this question did not reach statistical significance ($p = .08$), there do seem to be differences in the pattern of responding, with only people in the

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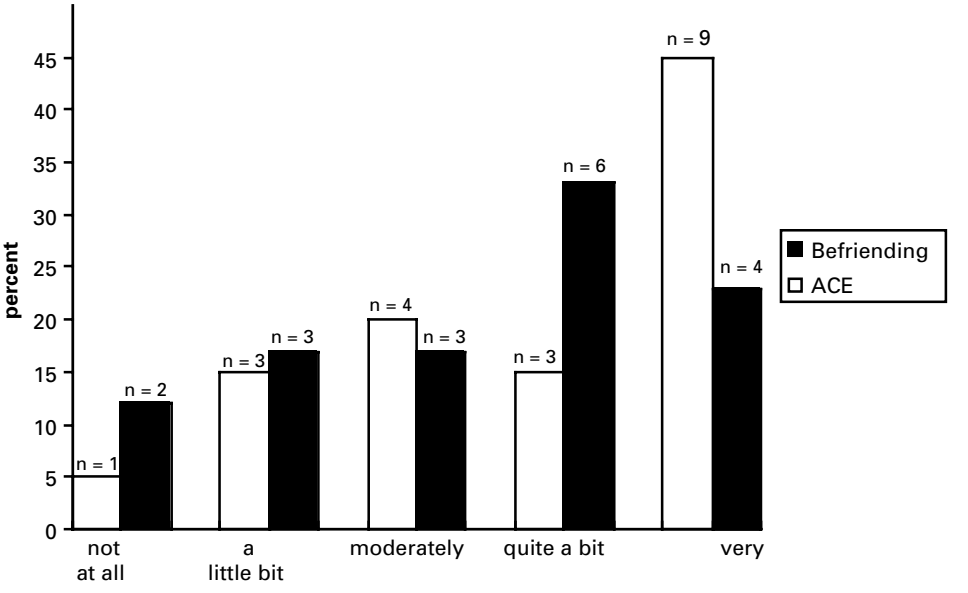

Figure 2. Number (and %) of people responding to question 1: "The therapy . . . was helpful."

Befriending group wishing to receive less therapy, while ACE responders were highly satisfied with length of therapy or wished to have more therapy.

Expectancies

Three questionnaire items were used to measure expectancies.

Item 2: The therapy with {therapist name} was helpful. Figure 2 shows that there was no striking difference between clients' appraisal of the helpfulness of their therapy in either condition. A greater percentage of people did find ACE "very helpful" (45%, $n = 9$) compared with Befriending (22%, $n = 4$). However, this pattern was reversed in those who found the therapy "quite helpful" with 33% ($n = 6$) of Befriending clients but only 15% ($n = 3$) of ACE clients finding their therapy "quite helpful". Similar (and low) percentages of people in each group found both therapies to be "not" or "only a little helpful".

Item 3: My therapist, {name}, was not helpful. Figure 3 shows the majority of people "disagreed" or "mostly disagreed" with the statement that their therapist was unhelpful regardless of what therapy they received (ACE - 95%, $n = 19$; Befriending – 83%, $n = 15$). Only 1 (5%) ACE participant and 3 (17%) Befriending participants agreed in any way with the statement. This indicates that those receiving ACE and Befriending found their therapists to be similarly helpful.

Item 4: The therapy with {name} made me feel better. Figure 4 shows that almost all participants found that the therapy made them "feel better" at least to some degree (ACE-95%, $n = 19$; Befriending – 89%, $n = 16$). More people found that ACE made them feel "very" much better (35%, $n = 7$) than Befriending (11%, $n = 2$). There seems to be no striking difference in how each group responded to this question.

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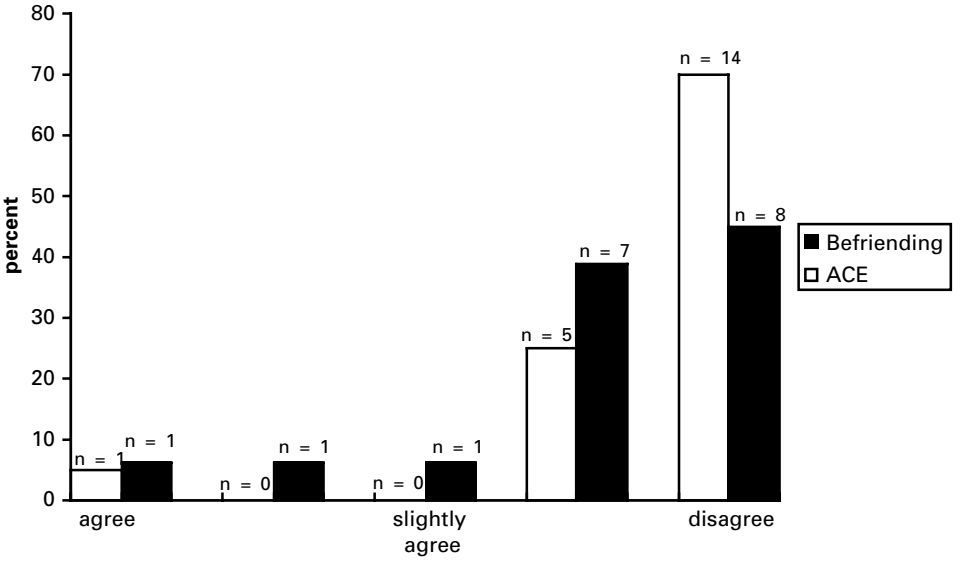

Figure 3. Number (and %) of people responding to question 3: "My therapist. . . was not helpful."

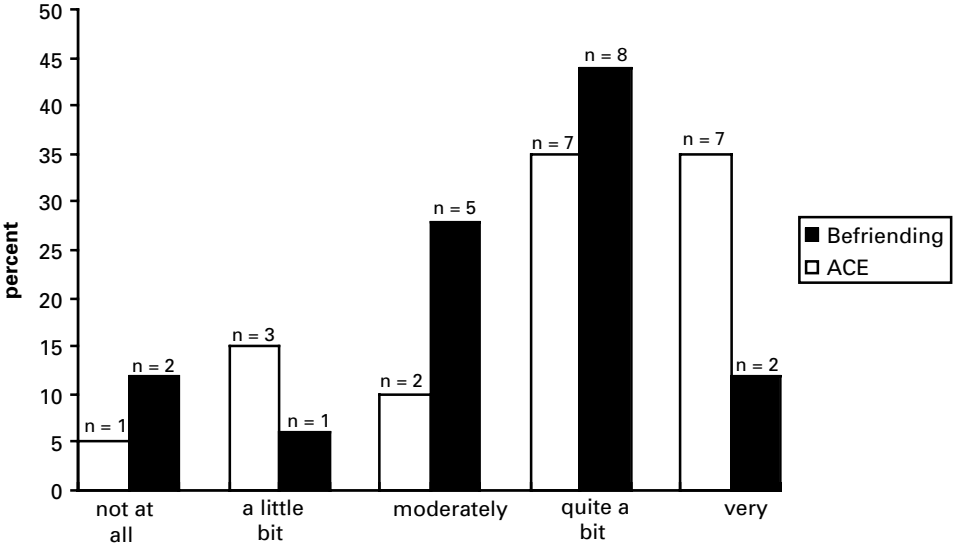

Figure 4. Number (and %) of people responding to question 4: "The therapy. . . made me feel better."

Enjoyment

The questionnaire item "I did not enjoy the therapy with {name}" was used to measure enjoyment of therapy. Figure 5 shows that 90% ($n = 18$) of ACE and 78% ($n = 14$) of

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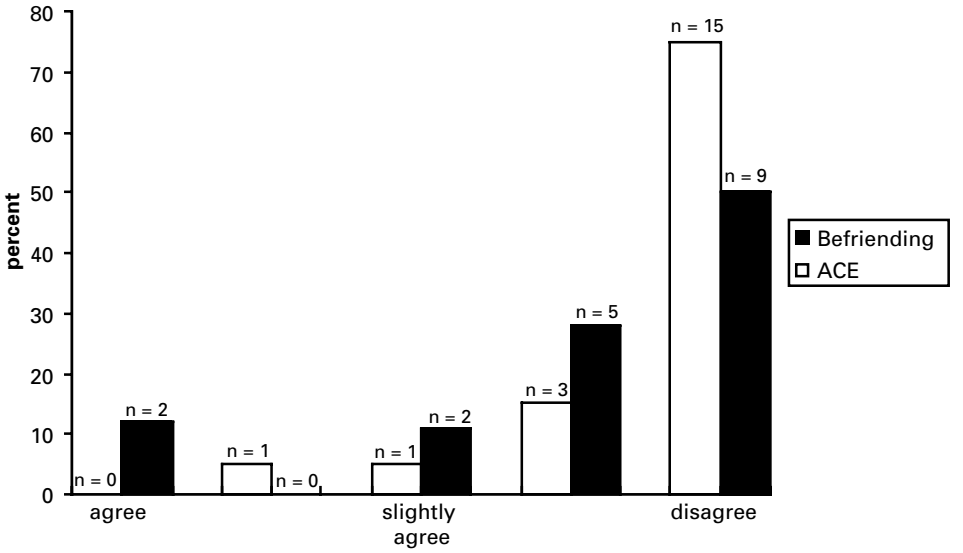

Figure 5. Number (and %) of people responding to question 2: "I did not enjoy the therapy. . ."

Befriending participants "disagreed" or "mostly disagreed" with Question 3 "I did not enjoy the therapy. . .", while 10% ($n = 2$) of ACE and 22% ($n = 4$) of Befriending participants agreed with it in some way. This indicates no striking differences between enjoyment of therapy in ACE and Befriending.

Rate of drop-out

Nine participants (15%) dropped out of the therapy trial. Three participants were categorized as dropouts because they unexpectedly left the catchment area of the service (two went overseas and one moved interstate). All of them were in the Befriending condition and all left the service after one session of Befriending. The remaining six told either the research assistant or their therapist that they did not want to continue with the therapy.

Of the six remaining, three were in Befriending and three were in ACE. Table 1 shows the number of sessions completed before withdrawal and the stated reason for withdrawal.

Discussion

Time in therapy

Participants in both therapies received a similar number of therapy sessions. However, people in Befriending received shorter therapy sessions and were less satisfied with the length of their therapy. These results are similar to Tarrier et al.'s (2004) RCT of CBT for first episode psychosis who found that the number of sessions was similar to CBT but total amount of time in therapy was less in the control condition (supportive counselling). On the other hand, the results were different from the Sensky et al.'s (2000) RCT of CBT for chronic psychosis.

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Table 1. Therapy condition, number of sessions and reasons for withdrawal of therapy drop-outs

Person	Therapy	Number of sessions	Reason for withdrawal
1	ACE	3	Did not want to talk anymore, too many questions, too confronting
2	ACE	2	Has too many workers and feels she doesn't need therapy
3	ACE	1	Felt he was better and did not need therapy
4	Befriending	5	Was not getting anything out of therapy
5	Befriending	1	Did not want to do therapy any more
6	Befriending	5	Was not happy he was in Befriending

The authors found that session number and total time in therapy were matched in the Befriending and CBT conditions. This may indicate that young people with first episode psychosis are able to be engaged for longer on a more task-focused therapy such as CBT, while they tolerate the less task-focused supportive counselling and Befriending for shorter amounts of time. Anecdotally, we found that it was often difficult to have Befriending clients "chat" for 45 minutes if they were symptomatic. In the interests of maintaining engagement, the therapy session was sometimes cut short. In this way, manipulating the length of the therapy sessions was a tool for maintaining engagement in Befriending, in a way that it was not in CBT. This was partially solved by engaging the client in activities such as going for walks, playing board or outdoor games although *anecdotally*, this seemed to work more successfully when client-therapist gender was matched rather than un-matched. That fewer participants found the number of sessions in Befriending "just right" (50%) compared with ACE (75%) is possibly also reflective of differences in the two therapies. Befriending did not enable the therapist to take control of the therapy package as a whole and any planning was made from week to week. In CBT on the other hand, the therapist can mould the aims and goals of the therapy to fit the time available. That 22% of clients found Befriending involved too many sessions may indicate that the therapists were attempting to match for time at the expense of following this natural course of Befriending therapy. The current study and the Tarrier et al. (2004) study highlight the importance of measuring both number of sessions and total time in therapy, especially in FEP, since both studies using a first episode sample found significant differences in total time in therapy.

Expectancies

It has been suggested that Befriending may not engender high expectancy since it does not include discussion of the client's problems (Baskin et al., 2003). This suggestion might appear to have some merit, particularly for therapists who see the expression and discussion of problems as the basis for combating them. Furthermore, these therapists may assume that their clients would share that view. In fact, both the therapists who provided Befriending in the current study (SB and EK) were similarly sceptical as regards the expectancy created by Befriending. Yet, while piloting the treatment, they discovered that Befriending was well

accepted as a therapy by their clients. The current study addressed this issue empirically. The three questionnaire items measuring client expectancy all yielded similarly high levels of expectancy across the two groups. This suggests that participants were similarly convinced of the utility of both interventions at the end of treatment even though Befriending did not involve discussion of problems. The high level of positive expectancy for Befriending may have been due to the research team's work to present a clear rationale for the efficacy of Befriending throughout the therapy process. Future meta-analyses of control treatments should categorize Befriending (when presented with a clear rationale) as producing high expectancy based on this result. Befriending appears to create more positive expectancy than supportive psychotherapy, the only other empirically tested control treatment in psychosis (Durham et al., 2003).

Acceptability

The dropout rates were similarly low across both treatment conditions and clients rated their enjoyment of their therapy similarly, indicating that both therapies were well accepted by participants. This supports Sensky et al.'s (2000) finding that rates of satisfaction were similar across CBT and Befriending. Befriending was found to be well accepted by young people, some of whom had severe symptoms. This may have been because it was a directive therapy and so the therapist could actively manage a session if young people had prominent psychotic, depressive or anxiety symptoms. This may have made therapy more comfortable for them, rather than forcing them to take the initiative, which is expected in a less directive control treatment (such as supportive counselling).

Clients in the current study also came from an ethnically and culturally diverse background and many had little knowledge of the therapeutic process or the concept of talking through problems. Befriending afforded an advantage in this case because activities could be used if participants found it difficult to talk, thus maintaining engagement. This form of control treatment may be helpful in other disorders, particularly acute, serious mental health problems, or with adolescents or young people.

Limitations

The study was limited by problems with the client satisfaction self-report questionnaire. Only 67% of participants completed the questionnaire. A 61-71% response rate to satisfaction-type questionnaires has been found in other studies of CBT for psychosis (Kuipers et al., 1997; Sensky et al., 2000). Therefore our data are very comparable to those studies. The questionnaire also yielded skewed responses to all items in the direction of overall satisfaction with both kinds of therapy. This meant sample sizes in many cells were too small for statistical analysis and the percentages in each cell were examined. This did allow for detection of differences in the pattern of satisfaction responses between the ACE and Befriending groups, even though they did not reach significance. This shows that, despite low numbers, "clinically" significant differences in satisfaction were able to be detected using this design. The study is also flawed by the collection of satisfaction data at two time points. Ideally, the satisfaction questionnaire should be completed at the end of treatment. However, results showed that participants who completed the questionnaire at 1-year follow-up answered in a similar way to those who completed it directly after therapy.

Conclusion

This study did not assume that Befriending controlled for the common or non-specific factors in general, as do the majority of studies using control treatments (e.g. Sensky et al., 2000; Tarrier et al., 2004). Instead, it empirically examined Befriending for its ability to control for some of the important factors that have been shown to confound RCTs of CBT. The results suggest that Befriending is a good control for client expectations, drop-out rate, and enjoyment of therapy when compared with CBT in early psychosis. Befriending failed, however, to match CBT in terms of time, with the Befriending sessions being significantly shorter than the CBT sessions. Future studies using Befriending as a control should adapt it to make the average therapy session longer, possibly by introducing more activities. In future, authors of RCTs using control treatments should empirically examine factors that they wish to control for rather than assuming that any control treatment will control for the non-specific factors. This would serve two functions: to make RCTs more methodologically sound, and also to contribute to the knowledge base surrounding the nature and functioning of control treatments which is seriously lacking at present. This is particularly important in the area of CBT for psychosis where the evidence-base is not as yet clear, and control therapies are widely used.

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