

Befriending versus CBT for Schizophrenia: A Convergent and Divergent Fidelity Check

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Abstract. Befriending (BF) has received attention as a beneficial part of mental health care. For example, when compared with cognitive-behavioural therapy (CBT) for schizophrenia, BF was found to be as effective as CBT in terms of initial symptom improvement (Sensky et al., 2000). Why was the BF apparently so effective? Was the BF really a discrete and powerful intervention? Or was it simply an unrecognized aspect of regular CBT? We addressed these questions by first observing BF's convergence with "social support" (a plausibly discrete treatment) and, second, by examining its divergence from CBT, drawing on archival data. For the convergence prediction we correlated the speech content of therapists' in 10 BF sessions from the Sensky et al. study with previously published social support data from stylists working with people with severe mental health problems in a psychiatric hospital (Milne and Netherwood, 1997). For the second prediction the same 10 BF sessions were compared with a sample of 10 CBT sessions, also from the Sensky et al. study. The results indicated that BF was indeed significantly correlated (converged) with social support ($r = 0.7; p < .05$), and also that it did differ (diverged) significantly from CBT ($p < .05$). As a treatment fidelity check, therefore, these findings indicate tentatively that the two treatments in the Sensky et al. (2000) study were appropriately implemented. As an analysis of effective interventions for schizophrenia, it cautiously suggests that "social support" merits serious attention, and is perhaps no mere placebo.

Keywords: Befriending, CBT, social support, schizophrenia.

Introduction

In a randomized controlled trial into the effect of therapy upon positive symptoms of schizophrenia, Sensky et al. (2000) found befriending (BF) to be equal to CBT at the end of the intervention. Such a finding has a number of possible interpretations, assuming that the obtained effect was valid. First, BF may be an active treatment, and not simply a convenient placebo control. Second, perhaps the two treatments were not actually distinct when implemented (particularly as the same therapists provided both interventions), so initially comparable results actually reflected similar treatments. Third, it is plausible that both treatments were actually different, but achieved initially comparable outcomes. The available evidence favours the latter hypothesis, especially as CBT was found to be superior to BF at a 9-month follow-up. The present study therefore analyses these interpretations.

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There is limited research on BF as an intervention. However, if one views it as a form of “social support”, there is larger body of empirical work testifying to its helpfulness (Milne, 1999). Social support usually refers to the way that people benefit psychologically from the emotional, informational, practical and companionship aspects of relating to others, normally family and friends. To illustrate, Caron, Tempier, Mercier and Leouffre (1998) found that psychiatric patients reported less satisfaction with all assessed aspects of social support than the general population, while Erickson, Beiser and Iacono (1998) were able to predict the course of schizophrenia from social relationships. Those suffering from schizophrenia and provided with a befriender perceived the support favourably (Bradshaw and Haddock, 1998; Newton, 1999). Equally, those with depression have demonstrated benefits from good interpersonal support (Harris, Brown and Robinson, 1999; Peveler, 1999).

Given the similarities between BF and social support, and the evidence base for the use of various forms of interpersonal support, we therefore hypothesize that:

1. The effective BF intervention in Sensky et al. (2000) was social support. This is a construct that has been reliably measured and manipulated previously (see Milne, 1999). Specifically, we predicted that there will be a significant correlation between the present BF data and archival social support data (our “convergence” hypothesis);
2. Second, we hypothesize that the BF treatment differs significantly from CBT, both as measured by the Support Observation Scale (SOS). This is our attempt at a “divergent” validation of the social support hypothesis (i.e. that CBT will not equate with BF, i.e. with the construct of social support). This is a more testing examination than assessing either convergence or divergence alone (Kazdin, 1998).

Method

Participants

The first hypothesis involved a comparison of the BF sessions from the Sensky et al. study with archival data.

Archival data. The archival data were drawn from the Milne and Netherwood (1997) sample: 20 adult female patients who resided in a psychiatric hospital participated, selected at random from those attending the hairdressing salon within the hospital. Precise diagnostic information was not available, but the majority were known to have a depression or a dementia, and fell in the age range 60–75. These data were the only set available to the authors which had been analysed with the relevant observation tool (SOS).

Sensky et al. study – patients. Twenty cases were drawn from patients recruited as part of Sensky et al.’s (2000) original study. In the original study, patients were recruited from clinical services in London and the North of England. Patients were aged 16–60, had a diagnosis of schizophrenia and had suffered from medication-resistant symptoms for at least 6 months. Participants who attended at least 6 sessions were considered to have engaged in treatment. Patients were referred by mental health clinicians, and were assigned to one of the two treatment groups (BF or CBT), using a simple randomization process. These two samples therefore have some striking differences, such as their respective genders, ages and diagnoses.

For the present study, in order to have a comparable and “fair” test between the interventions, participants were drawn from those with the best outcomes as defined by reduction in the Comprehensive Psychiatric Rating Scale (CPRS) score (Asberg, Montgomery, Perris, Shalling and Sevall, 1978). Patients must have improved by at least 50% at the end of the intervention, representing a clinically significant improvement in general mental health. This is because any such changes to patients’ CPRS scores at the end of therapy are most likely to be due to the intervention, and also to a “high fidelity” manipulation of the given intervention. In practice, due to missing session tapes, it was not possible to obtain the top 10 for the BF group. BF patients were therefore selected from the top 15 best responders, with a reduced CPRS score criterion of 25% or more improvement. Once participants had been selected, therapy sessions were taken randomly from each patient’s data set. One therapy session per patient was used. Sessions used were mid-therapy period, defined as sessions 5–15. This ensured that the patients were at similar stages in their respective interventions. There were 8 males and 2 females in the BF group, and 5 males and 5 females in the CBT group.

Therapists

In the Sensky et al. study patients were seen individually by one of the two therapists. Each therapist offered BF or CBT, according to the patient’s randomly assigned group. The therapists were both experienced psychiatric nurses and had undergone recognized training in CBT. Although flexible to the needs of the patients, sessions were approximately 40–50 minutes long and were weekly, fortnightly and then monthly. The aim was to complete the patient’s course of therapy within 9 months. Therapists’ sessions were audio taped, and the tapes were used for analysis in the present study. In this study, the contents of the audio tapes of BF and CBT were coded by the authors after conducting inter-rater reliability work (see below).

Design

The design was mixed: for the first, “convergence” prediction a correlation was conducted between the sample of Sensky et al. (2000) BF data ($N = 10$) and the archival social support data ($N = 20$). Second, a cross-sectional comparison between two conditions in the Sensky et al. study CBT ($N = 10$) and BF ($N = 10$) was carried out, to determine whether there was any divergence between the two conditions on the observation scale (hypothesis two). The social support scale was the Support Observation Scale (SOS: Milne and Netherwood, 1997). This involved a time sampling analysis of the therapists’ speech content for each intervention.

Procedure

CBT interventions followed the treatment manual developed by Sensky et al. (2000). The approach was based on a collaborative, normalizing understanding of the development of symptoms, and worked towards reducing distress and disability through conventional CBT methods (e.g. voice diaries, re-attributions, and activity scheduling).

In BF, the therapist was instructed to be empathic and non-directive. Psychotic or affective symptoms were not tackled in any explicitly therapeutic way. Rather, the session focused on

neutral topics, such as hobbies and daily activities. BF was therefore designed to differ from CBT in verbal content and objectives, but to provide patients with approximately the same amount of therapist contact as the CBT group. Twenty therapy sessions ($N = 10$ for BF and $N = 10$ for CBT) were randomly selected and then coded for their full length (i.e. a total of approximately 6½ hours per intervention). Momentary time sampling of the therapists' utterances was carried out by the first and second authors, using a published observational instrument (the SOS, see below), following the establishment of acceptable levels of inter-rater reliability. The social support data had been coded in the same way by the SOS's authors. These two raters were not blind to conditions or the hypotheses. A correlation was then computed between the SOS data sets for each of the BF and stylist (social support) groups. For hypothesis two, the between-group analysis compared the SOS data for the BF and CBT groups.

Materials

The instrument used to assess the contents of the interventions was the Support Observation Scale (SOS; Milne and Netherwood, 1997). This is an observational measure of social support. Its 21 items comprise four subscales: Companionship (4 items); Emotional support (5 items); Informational support (6 items); Practical aid (4 items); and Other (2 items). Milne and Netherwood (1997) reported acceptable reliability with the SOS (Kappa values between 0.67–1.00; exact percent agreement ranged from 80–100%), and acceptable divergent validity (demonstrated by a significant difference between two groups known to differ with respect to the verbal content of their speech).

Results

Inter-rater reliability between the two raters of the BF and CBT tapes using the Support Observation Scale (SOS) was acceptable (86%). The present BF data were correlated with the archival social support data. For each condition the mean SOS score per individual item was used, and a significant correlation was obtained ($r = 0.7$). This finding indicates that the BF intervention was similar to "social support", as per our first "convergence" prediction.

Next, to test whether the CBT intervention was also "divergent", the SOS was applied to the CBT tapes and the results compared. BF material scored significantly higher than CBT for total frequency of SOS items (Mann-Whitney $U = 71$; $p < .05$). This indicates that the two interventions diverged, as we had anticipated and as the original authors had intended. Figure 1 displays the mean frequency of the therapists' utterances in the BF and CBT interventions. It indicates that BF was characterized by comparatively high frequencies of "positive social interaction", "expression", and "self-disclosure" (i.e. SOS items 1, 4 and 8). These items belong to the "Companionship" and "Emotional support" sub-scales of the SOS. Typical examples are statements like "we can talk that through together" and "that must have been upsetting for you", respectively. In contrast, CBT material was characterized by high incidences of "informational reassurance" and "requesting information" (i.e. SOS items 12 and 14). Typical examples of these items would be: "those symptoms are a common part of this kind of problem", and "can you tell me more about that?", respectively. These items belong to the "Informational support" sub-scale of the SOS.

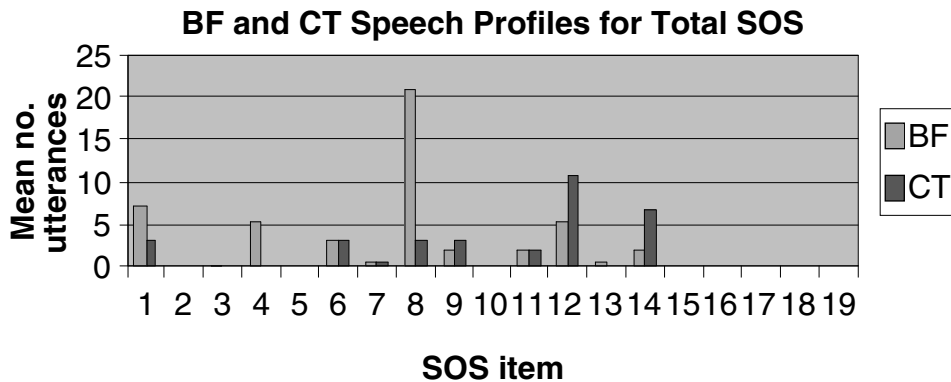


Figure 1. Mean frequency speech profiles for the 19 items* of SOS

*Item 20 and 21 “nothing” and “other” were removed from calculations as they are not classified as social support. However, CBT showed a significantly higher incidence of this item (i.e. 75% of mean utterances) compared to BF, for which “other” accounts for 10.36% of mean utterances. This strengthens the conclusion that CBT speech profiles were different to that of social support.

Discussion

These results suggest that the two interventions were manipulated with fidelity and that they had distinct treatment profiles, ones that concurred with their theoretical rationales. Furthermore, it seems that the BF intervention was a form of social support, and not (for instance) a diluted version of CBT.

It is consistent with prior research that BF, construed now as social support, was an effective short-term intervention (see, for example, Erickson, Beiser and Iacono, 1998). This bolsters the case for the use of befriending, and the potential for CBT practitioners to work with voluntary organizations and others who supply befrienders to those who suffer from schizophrenia. This might be studied in future research as part of an optimal “social therapy” form of CBT treatment (Milne, 1999).

However, these are speculations at this stage, ones that simply draw out in a novel way the potential significance of the role of social support in our work. The important limitations of this small study make it premature to draw firm conclusions about best practice. For instance, there were small (both hypotheses) and clearly different samples (hypothesis one). We also only applied the construct of social support in this analysis, and conceivably others may prove more appropriate. In a future study it would furthermore be useful to check the administration of CBT by such means as rating adherence and “competence” (Waltz, Addis, Koerner and Jacobson, 1993).

The initial comparability of the outcomes of these two interventions, despite their seemingly divergent processes, poses an interesting question: what are the properties of BF that made it equal to CBT? This pilot study suggests a need for further exploration of this interesting finding.

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