



TAKE

5

to TUNE in

Facility Staff Information

This resource was (created, developed, compiled, etc.) while under contract with Center for Medicare & Medicaid Services, Baltimore, Maryland. Contract #HHSM-500-2016-NW00012C. The contents presented do not necessarily reflect CMS policy.

CONTENTS

Introduction 2

Talking Control 3

Set Up 3

Key Points 3

Guidelines 4

Successful Strategies 5

Tools/Resources

- Staff In-Service (suggested/optional format)*
- Staff Handout- Top 5 Ways Take 5 is Different*
- Session Tracking Form (optional)*
- Patient Invitation*
- Session in Progress card*
- Sorry We Missed You card*
- Pre Assessment Questionnaire*
- Post Assessment Questionnaire*
- Talking Control article*

Introduction

The 2016, “Take 5 to Tune In” project component has been included due to the success facilities have experienced in utilizing it to improve patient satisfaction with staff communication. “Take 5 to Tune In” creates opportunities in the dialysis facility for patients to experience positive staff interactions. In 2014, the average improvement in patient satisfaction with staff interactions for the participating facilities was 6%, exceeding the Network goal of a 5% improvement. Patients were more likely to be satisfied with their care when they believed staff:

- Listened carefully
- Showed respect for what they had to say
- Spent time with them
- Demonstrated that they cared about them as a person
- Made them feel comfortable asking questions about their care
- Explained things in a way they understood

The “Take 5 To Tune In” project has been recognized as a best practice by CMS due to the innovative approach used. The typical approach to addressing communication is providing a staff in-service on professionalism, communication, boundaries and listening. Although training is a part of the “Take 5 to Tune In” project, it builds in simple yet multiple opportunities for positive patient-staff interactions. This helps the staff build a positive relationship with patients and engenders trust. The approach is also innovative because typical staff-patient interactions are initiated by the staff with an agenda, whereas “Take 5 to Tune In” sessions provide patients with a voluntary, time limited opportunity to have a staff member’s undivided attention focused on a topic of their choosing. Previous facility participants in have shared that although they talk with their patients during each treatment, the sessions provided a unique opportunity because they were able to be completely focused on the patient. Participating patients reported it made them feel like staff wanted to get to know them as a person and not just about their medications, diet and treatment.

Talking Control

“Take 5 to Tune In” will utilize the strategy of talking control during staff interactions with patients to increase patient satisfaction with staff interactions. Taking control is a cognitive behavioral therapy technique focusing on moving towards patient-centered involvement in their care. Talking control is similar to “befriending” in that it provides companionship for participants by engaging them in patient-led “free-floating” conversations. The “talk” is controlled by staff by focusing on factual information while providing warmth and interest, but not focusing on underlying beliefs or emotional problems. The goal of each conversation is for the patient to have a positive experience rather than focusing on the content of the discussion itself. For example, if the patient shared that they had attended a wedding, the staff would not ask if that is why they had come in “heavier” than usual, but instead would ask about the couple or where the wedding was held.

Set Up

The following conditions will be established for each “Take 5 to Tune In” session:

- Encounters will be random with staff randomly selecting the patient and time
- Staff are seated at eye level at the chairside during a dialysis treatment
- A time limit is set at the onset (five minute minimum)
- Fellow staff members will provide coverage to allow staff to be fully engaged and free from distraction while participating in a session

Key Points

- Increased communication with patients
- Interaction rather than reaction
- Sharing rather than advising
- Valuing their ideas and challenges
- Create curiosity (Let it be a surprise who will visit and when)
- Keep to 5-10 minute time frame (determine with the patient prior to getting started)

Guidelines

Guidelines for Using Talking Control in “Take 5 to Tune In” sessions:

Staff will follow these guidelines during talking control sessions:

- Sessions are patient-led
- Staff shows enthusiasm and interest towards the patient
- Staff “lends a sympathetic ear” towards the patient allowing him/her to share their feelings but then steers the conversation away from more emotional topics
- Staff is non-judgemental
- Staff uses neutral tone, words and body language
- Staff focuses on neutral topics such as hobbies, news, or holidays
- Staff encourages the patient to talk about their family and friends
- Staff encourages the patient to talk about history, youth, or past events
- Staff uses self-disclosure in moderation (maintaining appropriate professional boundaries)

Talking control does not (staff will avoid):

- Set an agenda for the session
- Focus on a key problem to fix
- Apply specific techniques to change behavior
- Re-focus conversation to a specific topic
- Ask for feedback
- Have handouts or written materials
- Give specific suggestions for change
- Explore underlying belief systems
- Assign tasks for the patient to do later
- Give specific advice
- Provide specific plan of action for change

Successful Strategies

Issue/Concern	Strategies
Session Tracking	The facility puts each participating patient's name on a notecard and staff members randomly draw one to determine which patient they will be speaking with during their "Take 5 to Tune In" session. The staff member then uses the note card to document the date the "Take 5 to Tune In" session was completed and any other comments they have.
	Staff members randomly choose a patient (drawing from patient names) to speak with and then once the "Take 5 to Tune In" session is completed the staff member initials and dates the chart.
	The facility uses a grid system and reports that staff members are able to speak to 4-5 patients per month.
Patients not wanting to participate in a "project"	Facility staff will distribute an invitation to each patient to participate voluntarily. The invitation that has been developed is very simple and reinforces that the interaction is based on the patient's agenda. It is also clear that they can decide not to participate at any time.
	Start with a few willing patients and then obtain "buy in" from other patients. Participating facilities reported increased interest from patients after they would see their peers participating in the project.
Our patients don't want to talk	Facilities will be asked to determine if their patients are more likely to be turned off by a "formal" invitation. Facility staff can initiate a "Take 5 to Tune In" session randomly allowing the patient to choose to participate at that time or not. However, each patient who does participate must complete a pre-assessment form.
Staff buy-in	The Network will be available to assist with providing the in-service to staff. By providing the option for Network staff to facilitate the in-service, it will assist the facility leadership in gaining support from the team.
	Medical Directors have endorsed the project and engaged in it. Facilities reported physicians participating in "Take 5 to Tune In" sessions also.
Time constraints	The session time has specifically been set to address this concern. Participating facilities have shared that once the project was set up, completing the 5 minute sessions was easy to do and fit into the day.

Tools



Staff In-Service



Preparation/Materials Needed

- ☐ Set up training space. Training room can be set up in many different ways. The recommended arrangement is a circle or a U shape so participants can see and interact with one another
- ☐ Computer and large screen projector to play the power point presentation. If unavailable, the slides can be printed and distributed to the group.
- ☐ Blank flip chart for taking group notes. If no flip chart is available, then use 8 ½ x 11 inch paper or a dry-erase board.
- ☐ Sign-up sheet for staff to volunteer to participate

Welcome and Statement of Purpose

Trainer

states out loud:

*Welcome to the “**Take 5 to Tune In**” training. The purpose of today’s training is to share information about a new project to improve patient/staff communication and patient satisfaction. “Take 5 to Tune In” is based upon a project called “Getting Better” Health Awareness Patient Education Initiative which used talking control support therapy in a dialysis center.*

Let’s begin by reviewing the Network Power Point presentation which introduces the project and the concept of talking control.

You can review the presentation or review the printed power point presentation with your team.


Group Discussion

Trainer

states out loud:


What are some of your initial thoughts about the project and using talking control with our patients?

What do you think are some of the benefits of doing this in our clinic? (List on flip chart.)



Listen for and post any answers such as: patients will feel more comfortable, feel listened to, sense of community, spending time will improve communication when need to address concerns/education.


Let's review some of the recommended guidelines, let's list some of what you remember from the power point.



Listen for and post any answers such as:

- Patient-led
- Focus on enthusiasm and interest toward the patient
- Lend a sympathetic ear
- Allow patient to share feelings
- Non-judgmental
- Use self-disclosure in moderation
- Use neutral tone, words and body language
- Encourage the patient to talk about history, youth, past events, reminisce
- Encourage to talk about family and friends
- Focus on neutral topics: weather, hobbies, news

What are some of the things that talking control does not do: (List on flip chart.)



Listen for and post any answers such as:

- Set an agenda for the session
- Focus on a key problem to fix
- Apply specific techniques to change behavior
- Re-focus conversation to a specific topic
- Ask for feedback
- Have handouts or written materials
- Give specific suggestions for change or advise
- Explore underlying belief systems
- Assign tasks for the patient or a plan of action

Trainer

states out loud:

We are now going to take some time to review professional boundaries. Since this is new and patients could ask personal questions we need to be prepared to respond in a professional manner. We also need to make sure as professionals we don't overstep any boundaries. In the dialysis setting, we see our patients more often than most health care settings so it can become easy for boundaries to blur.

*Read: **Professional boundaries** define the effective and appropriate interaction between professionals and the public they serve. Boundaries exist to protect **both** the professional and the client/patient.*

One way to tell if you are maintaining appropriate boundaries is to stay in the "Zone of Helpfulness". Let's review the Zone of Helpfulness, what are the components that are in "the zone"? What is included in being "under involved"; what is included in being "over involved"? (List on flip chart.)



Listen for and post any answers such as:

- Zone of Helpfulness: Staff teach patients about:
 - About dialysis
 - How to self-cannulate
 - Machine Set-Up
 - Tips to manage fluids
 - About home options
- Under Involved
 - Ignoring health information the patient provides
 - Keeping information from the patient
- Over Involved
 - Driving the patient to a store
 - Hanging out outside of dialysis
 - Loans or gifts

Trainer

states out loud:

During "Take 5" sessions you may feel compelled to share something as a natural part of the conversation, other times you may have to redirect (control the talk) patients away from too personal.

Here are some questions to ask yourself before you "self-disclose":

- Why am I sharing this information with the patient?
- Will it help him/her, or is it more about me?
- Is this information more like something I would share with a friend? Or with an acquaintance?
- Am I having an emotional reaction to the topic? If so, sharing is too personal.

Let's review a possible scenario. Which of the questions are ok to answer and which may be overstepping boundaries?



You are having your "Take 5" session with a patient and they ask you, identifying information about your family. Answer the questions in general terms to your comfort level.

How many kids do you have? *"I have two kids, how many kids/grandkids do you have?"*

How old are they? *"I have a toddler and a high schooler... what was it like for you when your kids were little?"*

Are they boys/girls? *"I have a boy... what about you..."*

Where do they go to school? *"They go to the "school district" or "they go to college in Nebraska."*

What activities do they do? *"My daughter is doing soccer again... what about your kids did/do they play any sports?"*

The general rule would be if you would feel comfortable sharing this with someone you just met or would consider an acquaintance then you could share it. When in doubt, don't disclose, redirect the patient. With talking control you are "controlling the talk" to refocus the patient on themselves.

If you need to redirect, what neutral topics could you focus on? (List on flip chart.)



Listen for and post any answers such as:

- Hobbies
- General information about their children/grandchildren
- Sports teams
- Weather
- News
- Upcoming holidays

Practice

Trainer

states out loud:

One way to alleviate any hesitation about volunteering is to practice and become more comfortable with the process. It's really very simple, as shared in the Power Point presentation, it's similar to an "oral Facebook" or "befriending" within a professional setting. You are "controlling" the talk to drive information sharing from the patient.

I'd like to ask for a volunteer to practice a "Take 5 to Tune In" session with me.

You can choose to use one of the examples from the power point.

"I can't remember to take my pills but it doesn't matter anyway. They do no good."

Replace: "You have to take your pills."

With: "You can't remember things either? Tell me a story about something you forgot recently."

Introduction examples:

"Good Morning, I'm _____. Give a brief introduction (I have been working in dialysis for..., I have been working here since...). Today I'll be meeting with you for your "Take 5 to Tune In" time. I'll set the timer for 5 minutes and we can get started. What would you like to talk about today?

or

"Good morning, Ms./Mrs./Mr. _____.

Today I'll be meeting with you for your "Take 5 to Tune In" time. I'll set the timer for 5 minutes and we can get started. Is there something you would like to talk about?

Trainer

states out loud:

What did you notice about the interaction?

Acknowledge answers provided. Answer any questions raised.

Please divide up into pairs. I'd like you and your partner to practice a Take 5 session. We'll take five minutes then switch roles. During the conversation, as the patient, bring up something that may be too personal so the other person can practice redirecting. Go ahead and start.

Call time in five minutes.

OK. Let's come back together in our group. Let's hear what you thought of the interaction.

Wrap-Up and Questions

Trainer

states out loud:

You all did a great job with this discussion. Now, let's talk about what this how we will be doing this in our clinic.

Here are some suggestions for this part of the discussion.

Who will participate?

- All patients will be given an opportunity to participate
- Staff volunteers – you all have the opportunity to participate

Our “Take 5 to Tune In” lead is: _____.

Steps we'll be taking:

1. Encouraging patient participation.
 - a. Give each patient an invitation to participate.
“We're trying something new at the clinic to help improve communication and get to know each other better. It's very easy and should be fun. Different staff would meet with you monthly for at least 5 minutes just to talk about whatever you want to talk about. Having this as a project helps make sure you get special time just for you... where staff isn't distracted but focused on you. I'd like to know if you'd like to join us.”
2. When patient agrees- ask that they fill out the questionnaire and give them an envelope to put it in for privacy. Do not include their name on the questionnaire.
 - a. *“Before we start having the sessions, Heartland Kidney Network has asked us to have everyone answer a few questions. Your answers are anonymous and confidential. Please fold it and staff will bring an envelope around for you to put it in. The envelope will be mailed directly to Heartland Kidney Network.”*
3. Monthly all staff volunteers will pick from patients names that have agreed to participate.
4. Each staff will do their 5 minutes with the patient(s) chosen that month. Staff will work together to make sure that all patients are being monitored and cared for when someone is doing their Take 5 session.
5. Initial the Take 5 sheet next to the patient's name for the month.

Trainer

states out loud:

Do any of you have any questions or concerns before we finish? Thank you all for your participation today, please sign up if you want to take part in the project before you leave.



TOP 5 Ways “Take 5 to Tune In”- Talking Control Sessions are Different

1. **Distraction Free Time**- other patients are being monitored by teammates
2. **Patient Directed**- the patient chooses what they want to talk about
3. **Staff is not in “teacher” mode**- listening but not judging or reacting to “teachable moments”
4. **Sharing rather than advising**- staff have no agenda
5. **Time limited**- helps staff stay focused and patient can expect full attention

Example:

Mrs. J has been on dialysis for 4 years. She has trouble with fluid gains and diet. Her blood pressure is unstable. She came in 5 kg over her dry weight. How would you respond when she says:

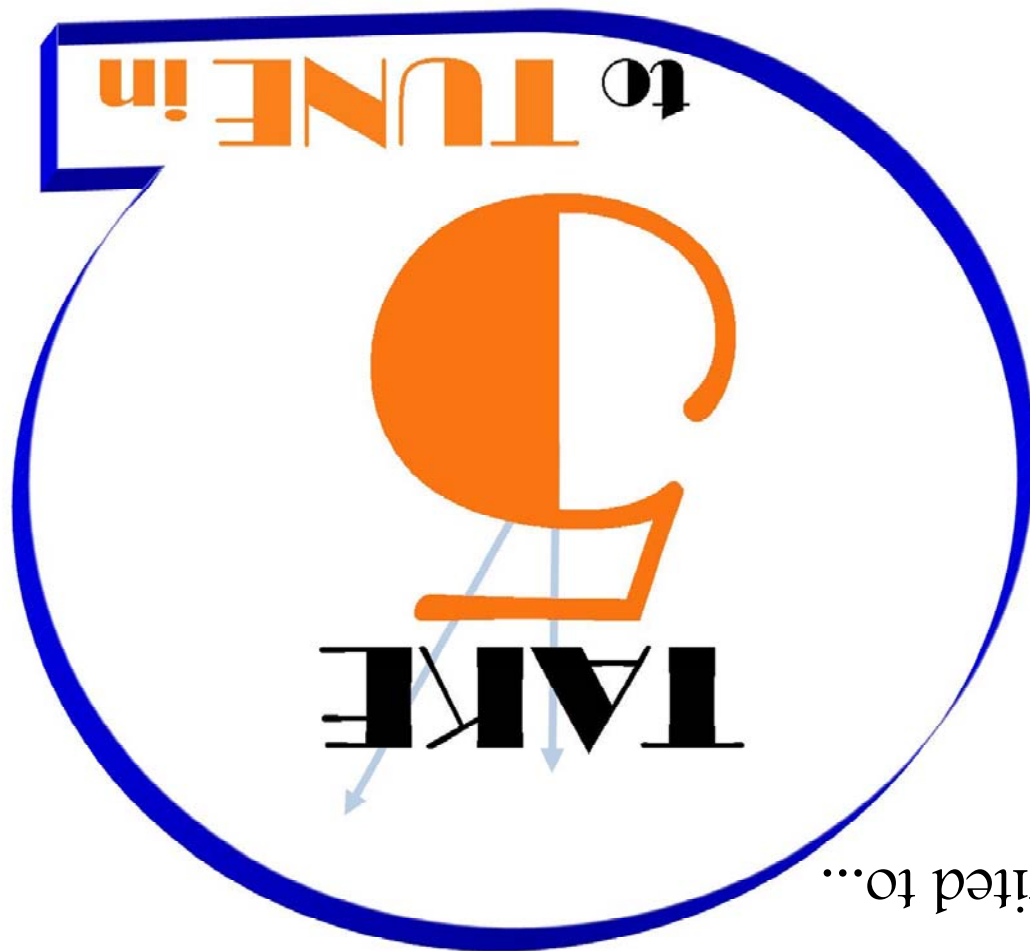
“I went to a wedding this weekend.”

Replace: *“That’s why you were so heavy today, you must of overdid it.”*

with Take 5- Talking Control Response:
“This weekend was beautiful for a wedding, was someone in your family or a friend that got married?”



[illegible]



For more information or to file a grievance please contact the Heartland Kidney Network at:
920 Main, Suite 801, Kansas City, MO 64105
Toll-free Patient Line (800)444-9965 • net12@nw12.esrd.net • heartlandkidney.org

WHO: YOU and one of the clinic staff (different each month)

WHAT: 5 minute chat

WHERE: At your dialysis chair

WHEN: During dialysis, just 1 time a month from June through October

WHY?

- ⇒ It's a great way to get to know each other better.
- ⇒ It's your 5 minutes with a staff member's total attention to listen to you and talk about whatever **you** want to chat about.
- ⇒ You can get to know staff better and meet new people.
- ⇒ It's FUN!

To sign up please fill out this card and give it to _____.

I _____ agree to participate in the "Take 5 to Tune In" project at our clinic from June through October 2016. I can decide not to take part at any time by just letting the clinic staff know.

Signature: _____ Date: _____

Thank you for agreeing to participate in this great new project!





Session in Progress

Session in Progress





Sorry we
missed you!



Sorry we
missed you!



Sorry we
missed you!



Sorry we
missed you!



As part of a “Take 5 to Tune In” the Heartland Kidney Network would like to ask you a few questions about your experiences at your clinic. Your answers are anonymous and confidential. The results will be shared with your clinic as a group average to make improvements.

1. How often does the clinic staff listen to you carefully?

☐ Never ☐ Almost Never ☐ Sometimes ☐ Almost Always ☐ Always

2. How often does the clinic staff spend enough time with you?

☐ Never ☐ Almost Never ☐ Sometimes ☐ Almost Always ☐ Always

3. How often do you feel the dialysis center staff really care about you as a person?

☐ Never ☐ Almost Never ☐ Sometimes ☐ Almost Always ☐ Always

Thank you for your time and participation!

Please fold and place completed form in the “Take 5 to Tune In” envelope.



As part of a “Take 5 to Tune In” the Heartland Kidney Network would like to ask you a few questions about your experiences at your clinic. Your answers are anonymous and confidential. The results will be shared with your clinic as a group average to make improvements.

1. How often does the clinic staff listen to you carefully?

☐ Never ☐ Almost Never ☐ Sometimes ☐ Almost Always ☐ Always

2. How often does the clinic staff spend enough time with you?

☐ Never ☐ Almost Never ☐ Sometimes ☐ Almost Always ☐ Always

3. How often do you feel the dialysis center staff really care about you as a person?

☐ Never ☐ Almost Never ☐ Sometimes ☐ Almost Always ☐ Always

Thank you for your time and participation!

Please fold and place completed form in the “Take 5 to Tune In” envelope.



Thank you for participating in "Take 5 to Tune In". Heartland Kidney Network would like to ask you a few questions about your experiences at your clinic and about the project. Your answers are anonymous and confidential. The results will be shared with your clinic as a group average to make improvements.

1. How often does the clinic staff listen to you carefully?

☐ Never ☐ Almost Never ☐ Sometimes ☐ Almost Always ☐ Always

2. How often does the clinic staff spend enough time with you?

☐ Never ☐ Almost Never ☐ Sometimes ☐ Almost Always ☐ Always

3. How often do you feel the dialysis center staff really care about you as a person?

☐ Never ☐ Almost Never ☐ Sometimes ☐ Almost Always ☐ Always

Please take a few minutes to tell us what you thought about your "Take 5 to Tune In" experience.

4. What I enjoyed most was....

5. I was surprised that....

6. Additional Comments or Suggestions:

Thank you for your time and participation!

Please fold and place completed form in the "Take 5 to Tune In" envelope.

For more information or to file a grievance please contact the Heartland Kidney Network at: **920 Main Street, Suite 801, Kansas City, MO 64105 Toll-free Patient Line (800) 444-9965**



A talking control for use in evaluating the effectiveness of cognitive-behavioral therapy

Marc Serfaty^{a,b,*}, Emese Csipke^a, Deborah Haworth^a, Shahed Murad^a, Michael King^a

^a Research Department of Mental Health Sciences, University College London Medical School, 2nd Floor, Charles Bell House, 67-73 Riding House Street, London W1W 7EJ, UK

^b Priory Hospital North London, The Bourne, Southgate, London N14 6RA, UK

ARTICLE INFO

Article history:

Received 16 July 2010

Received in revised form

10 May 2011

Accepted 11 May 2011

Keywords:

CBT

RCT

Placebo

Psychotherapy research

Non-specific effects

Common factor control

ABSTRACT

Objective: Common factors predict outcome in psychotherapy, but there is a dearth of research defining and standardising control conditions. A description and evaluation of a talking control (TC) used in a randomized controlled trial (RCT) of cognitive-behavioral therapy (CBT) for older people with depression in primary care is presented.

Methods: Two hundred and four older people participated in a RCT of CBT for people with a Geriatric Mental State diagnosis of Depression (Serfaty et al., 2009). One in 10 session of CBT or TC were evaluated using the Cognitive Therapy Scale (CTS) to examine common and specific factors in therapy.

Results: 1005 therapy sessions were delivered; 508 for TC and 497 CBT. There were higher total CTS scores ($P < 0.001$) for CBT (median 55.0; QR 52.0–55.0) than TC (median 23.0; QR 21.0–24.0). CBT scored better than TC for specific techniques (median 23.7; IQR 21.0–24.0 versus median 0.70.0; IQR 0.0–0.0, $P < 0.001$). Both interventions scored highly for interpersonal effectiveness, but no difference was observed. The TC was easily delivered, deemed acceptable by patients and was not associated with harm.

Conclusions: Development, standardization and measurement of a TC intervention is possible and provides a useful comparator in evaluations of effectiveness of CBT.

© 2011 Elsevier Ltd. All rights reserved.

Introduction

CBT is considered to be one of the best known and best tested psychological interventions (Enright, 1997). Three potential therapeutic ingredients are considered important; time effects, the specific effects of therapy and the placebo effect (Papakostas & Christodoulou, 2010). In drug trials, a comparison is made between two treatments so that the placebo effect can be subtracted from the active intervention in order to evaluate the specific treatment effects. In psychotherapy trials, we prefer to use Stevens et al.'s (2000) term “common factors control” to describe elements or dimensions of treatment not specific to any one technique, as terms “non-specific effects” and “placebo effects”, which are used interchangeably, are not synonymous (Safer & Hugo, 2006). Common factors are associated with outcome (Baskin, Tierney, Minimani, & Wampold, 2003; Frank, 1982; Luborsky et al., 1999; Stevens et al., 2000) and may reduce the apparent benefits of CBT

(Baskin et al., 2003; Grissom, 1996; Messer & Wampold, 2002). However, the relationship between common factors and outcome is complex. For example, common factors – e.g. therapist factors, client factors and their interaction (therapeutic alliance) Hovarth and Symonds (1991) – may have different effects with different therapeutic interventions (DeRubeis, Brotman, & Gibbons, 2005) and improvements in the therapeutic relationship may be a consequence of a positive therapeutic response rather than vice versa (Feely, DeRubeis, & Gelfand, 1999).

Up to 89 common factors in therapy have been identified (Greencavage & Norcross, 1990). The most important are: session structure (length and number of sessions), client's and therapist's expectancy, the act of assessment itself, instillation of hope or pessimism, the therapeutic alliance, therapist warmth, providing a setting which allows ventilation of feelings and how and by whom the intervention is delivered (Baskin et al., 2003; Bendall et al., 2006; Castonguay, 1993; Messer & Wampold, 2002; Roberts, 1999).

Although comparison control conditions have been recommended in trials of psychotherapy (Chambless & Hollon, 1998), it has long been argued that it is not possible to control for common factors in therapy (Basham, 1986; Borkovec & Nau, 1972; Borkovec & Sibrava, 2005; Brody, 1980; Horvath, 1988; Kirsch, 2005; Klein,

* Corresponding author. Research Department of Mental Health Sciences, University College London Medical School, 2nd Floor, Charles Bell House, 67-73 Riding House Street, London W1W 7EJ, UK.

E-mail address: m.serfaty@ucl.ac.uk (M. Serfaty).

1997; Lambert & Ogles, 2004; O'Leary & Borkovec, 1978; Papakostas & Christodoulou, 2010; Parloff, 1986; Shepherd, 1993; Wampold, 1997, 2001a, 2001b; Wampold, Minami, Tierney, Baskin, & Bhati, 2005). Though this may be true for explanatory trials, in pragmatic trials common factors in therapy warrant further research and although attempts have been made to control for these, few trials have measured or standardised control interventions. Of the common factors control used for CBT in older people (Wilson, Mottram, & Vassilas, 2008), no intervention groups (e.g. wait list control), no additional active intervention (treatment as usual) or placebo interventions (relaxation, befriending, or supportive counselling) have been used. Wait lists do not control for the credibility of the treatment, nor for therapist's attention. A treatment as usual group does not address the issue of expectancy. Of the placebo control conditions, relaxation does not control for ventilation of feeling which may be common factor eliciting change in all talking therapies. Befriending does not control for therapist's factors e.g. warmth and empathy. Befriending, including a manualised version (Bendall, Killackey, Jackson, & Gleeson, 2003), may be unconstrained by time or professional responsibility (Cox, 1993; Van der Eyken, 1990) and/or may involve a volunteer delivering a service (Cowen, 1982; Heller, Swindle, & Dusenbury, 1986) or offering advice (Bendall et al., 2006; Drury, Birchwood, Cochrane, & MacMillan, 1996; Harris, Brown, & Robinson, 1999a, 1999b, 1999c; Sensky et al., 2000; Turkington & Kingdon, 2000). Both befriending and supportive counselling may elicit cognitive and behavioral change, even though this is not the intent.

Safer and Hugo (2006) recommend identifying common and specific factors in the active intervention (CBT), that specific elements known in existing treatments should not be used in a control condition and the control should be credible. Although it may be impossible to control for these factors completely in different settings, we attempted this as well as possible by using the same therapist to deliver both interventions. Finally, Safer and Hugo (2006) recommend that common factors should be measured as specifically as possible. We used this model to inform a "talking control" (TC) intervention supporting the notion that the beneficial effects of CBT are more than just common factors in therapy (Baskin et al., 2003; Critelli & Neumann, 1984).

The aims of the study were to:

1. Describe the development and application of a talking control (TC) used in determining a trial the clinical effectiveness of individual cognitive-behavioral therapy for depressed older people in primary care.
2. Confirm that specific factors of therapy were absent in the TC but not the CBT intervention.

Development of talking control in pilot study

The TC was developed in a pilot study in which 33 older people were equally randomized to one of three groups; TAU, TAU plus a TC or TAU plus CBT (Csipke, Serfaty, & Buszewicz, 2006). In accordance with Safer and Hugo's model, common factors of therapy (instillation of hope, empathy, interpersonal effectiveness, professionalism, ventilation of feelings) were matched by offering an intervention, TC or CBT, delivered by the same therapist. TC was compared with conventional Beckian CBT. The Cognitive Therapy Scale (CTS; Young & Beck, 1980) was used to measure ensure that common factors were present in both TC and CBT, but that specific elements were present in the CBT only. Offering sessions of equal length, number of sessions helped match for time spent with the therapist.

Typically the therapist would start with "Today I am here to listen to what you have to say and leave you to talk about whatever you would like". The TC proceeded easily and covered a range of topics; recent television programmes, health, religion, history etc. In cases where the conversation might have dried up, the therapist used was more active in talking and occasional used self-disclosure. Unlike befriending, there was no discussion of emotional issues, no advice given and no attempts at solving problems were made. The therapist's concerns about not being able to use specific techniques soon settled and the clients liked to talk. The following methods were helpful where clients were caught in depressive thought patterns: 1. Showing warmth and empathy; 2. Listening carefully but saying very little, e.g. "I hear what you say" and 3. Drawing the client's attention to other topics.

The therapist undertook three hours of role plays to master the TC techniques, prior to contact with participants. The therapist was then supervised weekly for one hour by MS using audio-taped material from therapy sessions, TC and CBT, to facilitate this process. Any potential problems were identified and used prior to the definitive trial (Serfaty et al., 2009). In the pilot study a total of 17 sessions, median 4 (QR 3–8.5) were delivered to 9 individuals (2 were unable to engage with the study due to physical health problems).

Table 1 below provides a summary of the recommendations of the TC and also specifies why this is not CBT.

Examples of the TC intervention, taken from audiotape recordings of therapy sessions, obtained from the randomized controlled trial by Serfaty et al. (2009).

Transcripts of tapes confirmed that dysfunctional thinking styles were not challenged. For example when a client commented: "I am sure my children think I'm a burden and dread visiting me", cognitive interventions such as: "How do you know your children don't like visiting you?" were not used. The response "You have children? How many and how old are they?" was given. This focuses on factual information and whilst warmth and interest is expressed the intervention does not focus on underlying beliefs or emotional problems. Furthermore, alternative activities and coping strategies

Table 1
Recommended guidelines for talking control.

<i>Techniques to be utilised within talking control sessions</i>
<input checked="" type="checkbox"/> Sessions are client-led
<input checked="" type="checkbox"/> The therapist shows enthusiasm and interest towards the client
<input checked="" type="checkbox"/> The therapist is sympathetic towards the client, allowing him/her to ventilate their feelings
<input checked="" type="checkbox"/> The therapist is non-judgemental
<input checked="" type="checkbox"/> The therapist uses self-disclosure in moderation
<input checked="" type="checkbox"/> The therapist uses neutral tone, words and body language
<input checked="" type="checkbox"/> The therapist encourages the client to talk about their history/youth, encouraging them to reminisce
<input checked="" type="checkbox"/> The therapist encourages the client to talk about their family and friends
<input checked="" type="checkbox"/> The therapist tries to stay with neutral topics such as hobbies, news, holidays, etc
<i>Things to avoid contaminating talking control with therapeutic techniques</i>
<input checked="" type="checkbox"/> Setting an agenda for the session
<input checked="" type="checkbox"/> Trying to conceptualise the case
<input checked="" type="checkbox"/> Focusing on key problem areas
<input checked="" type="checkbox"/> Applying specific cognitive or using other known psychotherapeutic techniques.
<input checked="" type="checkbox"/> Applying specific behavioral techniques.
<input checked="" type="checkbox"/> Asking for feedback about clients' view/understanding of the session
<input checked="" type="checkbox"/> Trying to collaborate with clients to solve problems
<input checked="" type="checkbox"/> Trying to lead the client in a guided discovery to form new perspectives on problems
<input checked="" type="checkbox"/> Exploring underlying belief systems
<input checked="" type="checkbox"/> Setting assignments for out of therapy time
<input checked="" type="checkbox"/> Encourage the client to engage in activities

Table 2

Sample transcript of dialogue from talking control session.

The patient describes the impact of his stroke on him:

P: I was a very good man, now I am sick, I am very depressed- I don't have a life at all, 24 hours at home watching TV, I have too many friends, but now they don't want to bother to see me, I don't know why.

(The patient is describing many factors maintaining the depression, but the therapist does not comment on these, but asks a clarifying question)

T: That happened since you had the stroke? –

Yes. They are afraid to come to see me, as though they will catch it – it is not true

T: Of course not. It is very difficult. (the therapist is sympathetic, empathetic)

P: I wake in the middle of the night, I sleep only two or three hours. I wake up, I sit up, I don't know what I'm doing. I'm not crazy, my mind is working.

T: Do you live on your own? Do you have any family here?

P: I have brothers in France, they bring me a lot of things.

The therapist asks for factual information, but does not use guided discovery to allow patient to challenge his beliefs. The conversation then moves on to practical issues about arranging sessions, a discussion about where the patients' family lives. The therapist asks clarifying questions, but gives no information about depression or how it is maintained. She is sympathetic, but not informative, and makes no attempt to follow through what the patient says. She lets the patient lead if talking about neutral subjects, but steers the conversation away from more emotive topics.

were not discussed. For example, when a client said: *"I get so bored sitting in my flat all day"* (to which a cognitive-behavioral intervention may be: *"Let's consider what hobbies might you take up and the advantages and disadvantages of doing these"*) the TC intervention was *"I guess that time can drag."* This is consistent with the empathic approach recommended by Burns (2000) for those with consistent unproductive complaints, "complainers"; it shows empathy but does encourage ruminations. Homework is not assigned. For example, if asked *"What should I do between this session and next week?"* the therapist replied *"There is no need to do any work between sessions, but we will be talking next week"*. Table 2 below, provides an example of a dialogue between therapist and client in a TC session.

Therapists' and participants' experience of TC

Although in initial role plays the therapists reported that initially the TC might seem very non-specific, superficial and possibly harsh, and that focusing on neutral topics would not generate a sense of understanding, in practice clients liked to talk and did not feel distressed by this. Indeed clients often expressed the view that it was "good to talk". As TC sessions were unstructured clients could talk about what they wanted without interruption. There was even some suggestion that talking may be therapeutic: *"When I spoke to you last week about my problems I felt very depressed. Today I feel much better because we spoke about other things"*.

At the very start of the project in the role plays the therapists experienced having to "sit on their hands" and be non-interventionist in the TC condition. However this approach was manageable. For example, an elderly lady who had recently lost her grandson and who was experiencing problems dealing with behavioral symptoms of depression, asked the therapist *"What do I need to do?...Tell me what to do?"* However, having previously been briefed in the TC role plays on how to deal with such questions, the therapist gave the response *"I am really here to listen rather than offer advice"* and this was accepted by the participant and the session moved on.

Quantitative methods to evaluate talking control

Target population

The quantitative data presented arises from the definitive single-blind, randomized, controlled trial, similar in design to the

pilot study. It compares treatment as usual, or treatment as usual plus CBT or treatment as usual plus the TC (For convenience we will refer to TAU plus CBT or TAU plus TC as CBT and TC respectively) for people of 65 years or more with Geriatric Mental State depression and a DSM-IV diagnosis of depressive disorder were selected. CBT was compared with the TC to determine whether improvement was associated with specific effects in therapy. TAU and TC controlled for spontaneous improvement with time. The study took place between April 2004 and September 2007 (Serfaty et al., 2009). It was conducted with the approval of Camden and Islington's Community Health Service Research Ethics Committee. The randomization process was described verbally and in writing to potential participants, indicating that we did not know which intervention was the most effective. They were told that they could receive usual care or one of two talking interventions, one would examine the way they thought and behaved and in the other they would simply be encouraged to talk.

The interventions

The TC has already been described. Manualized cognitive-behavioral techniques for older people (Thompson, Gallagher-Thompson, Laidlaw, & Dick, 2000) were used. This employed a conventional CBT approach of challenging thoughts and behaviors (Beck, Rush, Shaw, & Emery, 1979). Treatment as usual consisted of allowing whatever medication, routine support, or referral to other services was felt appropriate by the GP. The only constraint was to refrain from referring them for CBT or other brief talking therapies unless absolutely necessary. Antidepressant medication, as a routine part of TAU was not constrained.

Summary information from definitive trial

Two hundred and four people were randomly allocated to one of three groups; treatment as usual, TC or CBT. Sixty seven received TC, 70 CBT and 67 TAU. There were no baseline differences between all three groups; the mean age was 74.1 (sd 7.0) years. Of the 204 participants 192 (94.1%) were Caucasian, 75 (36.8%) were widowed, 159 (77.0%) had a previous history of depression and 54 (26.5%) were being prescribed antidepressants at baseline.

Follow-up was high; 87% were followed up post intervention (four months post baseline). Data for completers found that the baseline BDI-II score for CBT was 27.3 (sd 8.7), $n = 70$, for TC was 26.4 (sd 6.9), $n = 67$ and for treatment as usual (TAU) was 27.7 (sd 7.7), $n = 67$. At four months post baseline, scores for CBT were 18.4 (sd 10.8), $n = 64$; for TC 20.2 (sd 9.0), $n = 58$ and for TAU 20.3 (sd 11.3), $n = 55$. Adjusting for dropouts using intention-to-treat analysis, improvements of -3.65 (95% confidence interval, -6.18 to -1.12) in BDI-II scores in favour of CBT versus TC were observed. More detailed data are available in Serfaty et al. (2009).

Evaluation of the intervention

A random sample of 1 in 10 recordings of therapy sessions (TC or CBT) was selected and rated by SS who was blind to the study design. The rater (SS) had attended two university training courses on the use of the Cognitive Therapy Scale (CTS; Young & Beck, 1980) and gained extensive clinical practice in using the scale 3 times weekly for over 3 years prior to the study.

Timing of collection

Data concerning the evaluation of TC and CBT were collected by a researcher through self report and through objective ratings of

Table 3

Median scores, 95% confidence intervals of the median and comparisons for talking control (TC) and CBT interventions for the three subscales of the Cognitive Therapy Scale and total CTS scores.

	Intervention actually given	N	Median	95% Confidence interval of median	Kolmogorov–Smirnov Z	P value
General interview procedures	TC	43	9.0	7.0–9.0	4.85	P < 0.001
	CBT	50	16.0	16.0–16.0		
Interpersonal effectiveness	TC	43	15.0	14.5–15.0	0.91	NS
	CBT	50	15.0	15.0–15.00		
Specific CBT techniques	TC	43	0.0	0.0–0.0	4.81	P < 0.001
	CBT	50	24.0	24.0–24.0		
Total CTS score	TC	43	23.0	22.0–24.0	4.70	P < 0.001
	CBT	50	55.0	54.0–55.0		

therapy from a random sample of one in ten audiotapes. Data collection was at baseline and at the end of the intervention period.

Measures

The following measures were collected: a) Baseline information. b) Objective measure of therapy psychometric properties of the CTS have been well established (Vallis, Shaw, & Dobson, 1986). Specific and non-specific factors in therapy were calculated from 13 questions contained in the 3 sections of the CTS [general interview procedures (4 items), interpersonal effectiveness (3 items) and specific cognitive-behavior techniques (6 items)]; each question being rated from 0 to 6. A rating of 39 or more is generally taken as a threshold to define adequate CBT treatment in people of all ages (Dobson, Shaw, & Vallis, 1985). c) Engagement with treatment: The number of therapy sessions was recorded as a measure of engagement. Attendance is also related to treatment preference (Kwan, Dimidjian, & Rizvi, 2010) and client satisfaction (Donovan, Kadden, DiClemente, & Carroll, 2010) and this was also recorded. Client satisfaction was assessed using the counselling questionnaire (Corney, 1992, 1999). Participants were asked to rate, on a three point scale (yes, no, unsure), whether they found CBT or the TC sessions useful and their therapist easy to talk to. d) Measures of bias: expectancy and demand components are recognised determinants of outcome (Borkovec & Sibrava, 2005). Measures included the participant treatment preference; prior to therapy, they were asked to choose whether they had a preference for TAU, TAU plus CBT, TAU plus TC on a four point Likert scale (0–3) or no preference. Secondly, a measure of the credibility of treatment, adapted from Borkovec and Nau (1972), was made at the start and end of therapy. Therapists were asked how much they thought patients would improve, using a visual analogue scale marked –3 (very much worse), –2 (much worse), –1 (worse –1), 0 (no difference), +1 (better), +2 (much better), +3 (very much better). Participants were asked to rate response, using a similar range, to express whether they thought therapy would be –3 (much more harmful) to +3 (much more helpful). Once therapists had met their clients they were asked to predict the degree of improvement for each person they saw. Thirdly, although the rater was not aware of the purpose of the study, he did comment that participants appeared to be in receipt of two different treatments and was asked to retrospectively to rate the group allocation.

Analysis

The 3 subscales of the CTS were analysed to see whether TC and CBT differed with respect to general interview procedures and CBT techniques, but not interpersonal factors (many components of which are regarded as non-specific factors in therapy – empathic skills, interpersonal effectiveness and professionalism). As data were not normally distributed, median scores with 95% confidence

intervals are presented and the Kolmogorov–Smirnov test was used. All analyses used Stata release 9 SE (StataCorp, College Station, Texas).

Results

Over one thousand therapy sessions were delivered; 508 TC and 497 CBT. Of the 100 tapes selected at random 53 were CBT and 47 TC and over 90% of tapes rated (93 tapes; 50 CBT 43 TC; a small number of tapes were not sufficiently audible). Seventy six people accounted for the 93 tapes analysed; some individuals had more than one tape rated. The demographic characteristics of those in whom tapes were rated was similar to all 204 participants and showed no between group (TC or CBT) difference. The mean age, in years, of participants for TC group was 75.0 (sd 7.1) and CBT group was 74.4 (sd 7.6); 17 were male and 50 female in the TC group and 11 male and 59 female in the CBT group. Over 90% of participants were Caucasian (28 in TC and 32 in the CBT group).

Table 3 shows median scores and 95% confidence intervals for the total CTS scores and its subsections; general interview procedures, interpersonal effectiveness and cognitive-behavioral techniques for CBT and TC interventions respectively. All of those allocated to CBT received a score of over 39 and none of those allocated to TC achieved this, with the highest score on one tape being 24.

Satisfaction with TC and CBT: Of 137 people allocated to one of the two intervention groups, 97 people completed the counselling questionnaire (Corney, 1992) (Table 4). The remaining forty did not complete it for the following reasons: Six were physically or mentally too ill, five refused, two were unhappy with the allocation, one was unhappy with the therapist, one had died, one had developed cognitive problems, 23 gave no reason but the researcher noted that a number of individuals appeared to be experiencing fatigue at final interview and it was felt unethical to insist on more information. One questionnaire was incorrectly completed and excluded from the analysis.

The counselling questionnaire (Table 4) suggests that both interventions were equally useful (question 1) with no differences between the TC and CBT with respect to the more passive components of therapy (questions 2–4, 6). However, the more active components of therapy (questions 5, 7, 8, 9 11) were more helpful in the CBT group who also felt that no more help or advice was necessary (questions 15, 16). The length of the sessions was about right (questions 17–20). There was no significant difference between the mean number of sessions taken up for CBT (mean 7.1, sd 4.4) or TC (mean 7.6, sd 4.6). None of the client expressed fear or anxiety about ending contact in the TC group.

Treatment preference, expectations of treatment by participants and therapists and blindness by rater of tapes

There was no significant difference in expressed preference for CBT and allocation was balanced between the groups (Table 5).

Table 4

Clients' satisfaction with treatment questionnaire.

Client's satisfaction with treatment		Intervention given		Where significant χ^2 , df, P value provided
		TC (n)	CBT (n)	
1. The visits useful?	No	9	10	NS
	Yes	29	37	
	Unsure	8	4	
2. Was the therapist easy to talk to?	No	4	4	NS
	Yes	42	44	
	Unsure	0	3	
3. Enough time to explain your problems	No	9	12	NS
	Yes	28	33	
	Unsure	9	6	
4. Understand your problems and feelings	No	7	6	NS
	Yes	34	39	
	Unsure	5	6	
5. Helped you work out how to solve your problems	No	19	11	13.4, 2, $P < 0.01$
	Yes	11	31	
	Unsure	16	9	
6. Relief at being able to talk about problems	No	10	12	NS
	Yes	27	34	
	Unsure	9	5	
7. Helped cope with feelings	No	15	11	7.83, 2, $P < 0.02$
	Yes	17	33	
	Unsure	14	7	
8. Helped to change within yourself	No	24	18	6.81, 2, $P = 0.03$
	Yes	10	24	
	Unsure	12	9	
9. Helped you understand yourself Better	No	15	17	7.66, 2, $P < 0.02$
	Yes	10	25	
	Unsure	10	9	
10. Helped change with partner or family members	No	31	24	9.49, 2, $P < 0.02$
	Yes	1	11	
	Unsure	11	11	
11. Improve communication between yourself and your partner	No	27	14	15.9, 2, $P < 0.001$
	Yes	1	14	
	Unsure	6	9	
12. Help sort out any sexual difficulties	No	21	15	NS
	Yes	1	1	
	Unsure	0	1	
	N/A	24	34	
13. Give you a clearer picture of yourself	No	29	19	11.0, 2, $P < 0.04$
	Yes	6	22	
	Unsure	11	10	
14. Clearer picture of the future	No	28	20	6.4, 2, $P = 0.04$
	Yes	5	15	
	Unsure	13	16	
15. Would you prefer more practical help	No	27	43	10.5, 2, $P < 0.005$
	Yes	14	3	
	Unsure	5	5	
16. Would you prefer more advice on what to do	No	27	43	12.8, 2, $P < 0.002$
	Yes	16	3	
	Unsure	3	5	
17. More sessions	No	11	19	NS
	Yes	11	9	
	Unsure	1	1	
18. Longer sessions?	No	21	25	NS
	Yes	1	5	
	Unsure	1	0	
19. Shorter sessions	No	23	28	NS
	Yes	0	1	
	Unsure	0	0	
20. Fewer sessions	No	23	26	NS
	Yes	0	2	
	Unsure	0	1	

Prior to any contact, all therapists predicted that people would be “much better” (+2) with CBT and “better” (+1) with the TC intervention. However, their expectations of improvement were less optimistic once they had had contact with clients. The mean expectation of improvement was 0.84 (sd 0.70), $n = 64$ for CBT and 0.63 (sd 0.61), $n = 60$ for TC. This difference was not significant. Participants anticipated that therapy would be “more helpful” with CBT ($n = 176$, mean 1.7 (sd 0.97)) and helpful with TC ($n = 176$, mean = 1.3 (sd 0.92)). Fourteen percent (28/204) did not know whether there would be a change with CBT or TC. This difference in belief between treatments was significant ($t = 4.91$, $df = 174$, $P < 0.001$). Participants and therapists were inevitably aware of which psychotherapeutic intervention was delivered and it was not possible for either to remain blind to the treatment allocation. The person rating the tapes of therapy sessions guessed correctly that there were two groups in all cases. None of the participants reported receiving another psychological treatment during the course of the trial.

Discussion

This is the first study to describe and measure a talking control condition for CBT for older people with depression. This study suggests that it is possible to define, implement and evaluate a TC intervention. Participant ratings of therapy suggest that they felt it was an acceptable intervention. Independent audiotape ratings of therapy demonstrated that CBT and other problem solving techniques were not used in TC, but that it was high on empathy and warmth. Findings suggested that non-specific effects may have been a positive experience to participants, as both therapists and participants felt it was helpful to talk about problems and ventilate feelings. Treatment preference is associated with engagement (Kwan et al., 2010). More people requested CBT and although this was non significant a type 2 error cannot be excluded. Nevertheless it is striking that the number of sessions attended was very similar in CBT and TC, which suggests that treatment preference is only one factor associated with engagement.

CTS scores found no between group differences for non-specific characteristics (interpersonal effectiveness) were observed between the treatment group, but were higher in the CBT group for the other components of therapy. A score of thirty nine or more is generally taken as adequacy of CBT treatment in people of all ages (Dobson et al., 1985). Although the CTS may behave differently in this population, adequacy of treatment was achieved with CBT, but not TC. This is the largest study providing data of the use of CTS in older people and supports the premise that it is possible to deliver a TC, which is not CBT.

The therapists' and clients' belief about the efficacy of treatment may be an important factor predicting outcome. The therapist's belief is usually based on personal experience and their knowledge of the effectiveness of therapy. In the case of trying out a novel intervention, the therapists should try to be neutral and keep an open mind. The therapists ensured that any focus on problems

Table 5

Measures of treatment preference by group allocated. Shown in brackets (percent): the expressed treatment preference and what they actually received.

Measures of biases		Allocated treatment group			Total
		CBT	TC	TAU	
Treatment preference	CBT	37 (35%)	36 (35%)	31 (30%)	104 (100%)
	TC	10 (24%)	11 (27%)	20 (49%)	41 (100%)
	TAU	1 (100%)	0 (0%)	0 (0%)	1 (100%)
	No preference	22 (34%)	20 (38%)	16 (28%)	58 (100%)
	Total	70 (34%)	67 (33%)	67 (33%)	204 (100%)

were kept to a minimum, however they did demonstrate a number of Rogerian characteristics, such as warmth, empathy and regard for the client and allowed for the ventilation of feelings. We observed that a reduction in belief in the improvement with CBT fell 1.16 points (c.f. 0.37 for the control group) post therapy. Whilst this was not statistically significant, it is a type 2 error cannot be excluded and this observation highlights the difficulty of assessing changes in the credibility of the treatment which may occur during the course of therapy. Differential changes in the credibility of the treatment may complicate outcome. Evaluating beliefs about the efficacy of treatment was only undertaken prior to and after therapy. Tracking these beliefs during the course of the interventions to determine the effects of differential changes in the credibility of treatment may be revealing. The study nevertheless demonstrates the practicality of using the TC intervention. The therapists found that engaging in client-led “free-floating” conversations required less effort than providing CBT. A major difficulty for the therapists during TC sessions was avoiding specific aspects of therapy. After years of working as a psychologist the therapists quickly adjusted to not setting any therapeutic aims and the need to avoid a focus on problems during treatment which may be particularly difficult with more depressed participants preoccupied with negative thinking. This issue was supported in regular supervision.

We would suggest that a TC is ethical as it does not appear to do harm; satisfaction with TC was high and it avoidance of negative emotion temporarily alleviates distress. Furthermore TC, delivered in addition to TAU, allows for the additional monitoring of mental state by therapists for dangers such as intense suicidal ideas.

All participants received the same brief written neutral description of the treatment conditions with an opportunity to ask specific questions. Although less popular than CBT (which is a widely publicized treatment), it is striking that a fifth (41/204) of participants would have chosen the TC intervention as a first choice. Some of these participants expressed reluctance at the possibility of being required to complete homework and suggested they would or did not like the structured nature of CBT.

Borkovec and Nau (1972) suggested that treatment credibility is important in constructing placebos.

The indication that participants may have accepted that the TC was bona fide is suggested by (i) pre-treatment measures: participant choice and how much participants predict therapy will be helpful and (ii) post treatment measures; the number of sessions attended and satisfaction with treatment. We did not find a difference between TC and CBT with respect to treatment preference, credibility, satisfaction with treatment and number of sessions taken up. Whilst it seems unlikely that people would chose and attend a therapy in which they do not have faith the relationship between treatment preference, engagement and outcome is complex. For example older people may choose a treatment which does not involve homework and/or be more compliant despite being less satisfied with the treatment received.

We acknowledge that determining outcome may be complicated by changes in both participants' and therapists' belief in treatment as the intervention proceeds. Nevertheless, our data suggest that over 70% of people felt positively about the TC as a treatment. Unconditional positive regard, warmth and genuineness (Rogers, 1957) appear to be beneficial non-specific factors in therapy. Writing down feelings is therapeutic (Pennebaker, 2003) and enabling the expression of emotion may have a therapeutic effect in itself. It is also possible that some people may prefer the TC approach for the distraction and comfort it offers. A central premise of any treatment is that it should have some benefit and certainly not be of harm. It may be suggested that gently guiding clients away from talking about their problems might heighten distress as it

does not provide people with the opportunity to ventilate their feelings. However, no one commented that this was distressing. Only 20% (9 out of 46) stated that they did not find the visit useful.

TC provided company for participants, but is not “befriending” in the strictest sense. TC specifies the number of treatments offered and the duration of each session. The take up of therapy sessions was strikingly similar and suggests that they were equally engaged. Although participants indicated that they would have preferred more sessions, they felt the number received was sufficient sessions and the length of these was appropriate.

Criticisms and recommendations

Although the narrow confidence intervals on the CTS are explained by the significant skewing of data, so the confidence interval coincides with the point estimate, the validity of the CTS should be questioned. The CTS may not be sufficiently sensitive to measure what it purports to measure and also may have the disadvantage of focusing largely on aspects of treatment that are common to most forms of CBT Fairburn and Cooper's (2011).

Although examples of the TC intervention have been provided, it needs to be acknowledged that the material presented may be subject to selection bias. By virtue of the different characteristics of the TC and CBT, it would be impossible for a person rating therapy to remain blind to the intervention. However, differences in CTS scores were accounted for by the subscales of relating to the structure of therapy and specific CBT techniques. If differences were explained by therapists' allegiance, differences in all subscales of the CTS may be expected. Transcription of audiotapes and analysis of therapy sessions using more formalized qualitative methods (Patton, 1989) may be helpful in confirming that the TC was consistent with our model. The description of the TC should provide sufficient material to allow replication of our methods. Truax and Carkhuff (2008) suggest that it is not possible to be warm and empathic without encouraging change, which may occur indirectly. It needs to be acknowledged that it is not possible to identify, control and measure all factors which may predict outcome. Nevertheless, this study is one of the first pragmatic trials which attempts to control and measure common factors. Although we stipulated that therapists should not deliver specific components of CBT to the TC group, no adherence scale for the TC was created. In retrospect it may have been useful to measure adherence to the TC intervention so that confirmation that this did not occur in CBT was possible; for example, quantifying when a therapist specifically detracted from focusing on a problem area. Our sample population consisted of older people who may be more secluded and welcome any form of talking. Although the proportion of people reported living alone and feeling lonely was similar in both the TC and CBT groups, caution is advisable when considering the generalisability of our findings to other populations.

Conclusions

The nature of control interventions in psychotherapy research has been ill defined and poorly operationalized. The randomization process aims to control for known or unknown factors in therapy (Jadad, 1998). In pragmatic trials standardization and measurement of control interventions is may strengthen the design. This study demonstrates it is possible to deliver and measure a TC intervention which is acceptable and ethical. Although highly trained therapists may find it difficult to withhold usual therapy skills at first, the TC techniques can be rapidly learned and measured. Possibly by using standardised role plays (Fairburn & Cooper, 2011) for difficult situations, the therapists' sense of ease with the TC may be facilitated so that the therapists do not feel the need to employ specific

therapeutic interventions. We recommend our TC approach as a standard comparator for trials in which specific methods and elements of therapy are being evaluated.

Acknowledgements

We wish to thank Prof A T Beck for reviewing this manuscript and the Health Foundation and NoCTeN supporting this study by grants 2219 and 2697 from the Health Foundation; and the North Central Thames Research Network respectively.

Additional contributions

We wish to thank S. Comegys, MSc, Marla J. Stromberg, BA, MSc, BABCP(Accred), Saskia Ohlin, MA, BABCP(Accred), Fozia Shah, MSc, BABCP(Accred), Judith Argent, RMN, Dip CBT, BABCP(Accred), Rosa Hernando, MSc, BABCP(Accred), and Nathalie Salaun, MSc, CPsychol, BABCP(Accred), for delivering the interventions and Satwant Singh, RMN, MSc, Dip CT, BABCP(Accred), for providing independent ratings of the therapy tapes. We are grateful to Ken Laidlaw, MPhil, PhD, University of Edinburgh, for his help and provision of the cognitive-behavioral therapy treatment manual.

Financial disclosure

None reported.

References

- Basham, R. B. (1986). Scientific and practical advantages of comparative design in psychotherapy outcome research. *Journal of Consulting and Clinical Psychology*, 54, 88–94.
- Baskin, T. W., Tierney, S. C., Minimani, T., & Wampold, B. E. (2003). Establishing specificity in psychotherapy: a meta-analysis of structural equivalence of placebo controls. *Journal of Consulting and Clinical Psychology*, 71, 973–979.
- Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *The cognitive therapy of depression*. New York, NY: Guilford Press.
- Bendall, S., Jackson, H. J., Killackey, E., Allott, K., Johnson, T., Harrigan, S., et al. (2006). The credibility and acceptability of befriending as a control therapy in a randomized controlled trial of cognitive behaviour therapy for acute first episode psychosis. *Behavioural and Cognitive Psychotherapy*, 34, 277–291.
- Bendall, S., Killackey, E., Jackson, H. J., & Gleeson, J. (2003). *Befriending manual*. Orygen Research Centre, University of Melbourne.
- Borkovec, T. D., & Nau, S. D. (1972). Credibility of analogue therapy rationales. *Journal of Behavior Therapy and Experimental Psychiatry*, 3, 257–260.
- Borkovec, T., & Sibrava, N. (2005). Problems with the use of placebo conditions with psychotherapy research, suggested alternatives, and some strategies for the pursuit of the placebo phenomenon. *Journal of Clinical Psychology*, 61, 805–818.
- Brody, N. (1980). *Placebos and the philosophy of medicine: Clinical, conceptual, and ethical issues*. Chicago: The University of Chicago Press.
- Burns, D. (2000). *The feeling good handbook* (2nd ed.). New York, NY: Plume.
- Castonguay, L. G. (1993). "Common factors" and "nonspecific variables": clarification of the two concepts and recommendations for research. *Journal of Psychotherapy Integration*, 3, 267–286.
- Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 66, 7–18.
- Corney, R. (1992). Studies of the effectiveness of counselling in general practice. In R. Corney, & R. Jenkins (Eds.), *Counselling in general practice*. London: Routledge.
- Corney, R. (1999). Evaluating clinical counselling in primary care and the future. In J. Lees (Ed.), *Clinical counselling in primary care*. London: Routledge.
- Cowen, E. L. (1982). Help is where you find it: four informal helping groups. *American Psychologist*, 37(4), 385–395.
- Cox, A. D. (1993). Befriending young mothers. *British Journal of Psychiatry*, 163, 6–18.
- Critelli, J. W., & Neumann, K. F. (1984). The placebo. Conceptual analysis of a construct in transition. *American Psychology*, 39, 32–39.
- Csipke, E., Serfaty, M., & Buszewicz, M. (2006). Optimising recruitment from primary care: methods of recruiting older people with depression. *Primary Health Care Research & Development*, 7, 1–8.
- DeRubeis, R. J., Brotman, M. A., & Gibbons, C. J. (2005). A conceptual and methodological analysis of the nonspecifics argument. *Clinical Psychology: Science and Practice*, 12, 174–183.
- Dobson, K. S., Shaw, B. F., & Vallis, T. M. (1985). Reliability of a measure of cognitive therapy. *British Journal of Clinical Psychology*, 24(4), 295–300.
- Donovan, D. M., Kadden, R. M., DiClemente, C. C., & Carroll, K. M. (2010). Client satisfaction with three therapies in the treatment of alcohol dependence: results from project MATCH. *American Journal on Addictions*, 11, 291–309.
- Drury, V., Birchwood, M., Cochrane, R., & MacMillan, F. (1996). Cognitive therapy and recovery from acute psychosis: a controlled trial – 1. Impact on psychotic symptoms. *British Journal of Psychiatry*, 169, 593–601.
- Enright, S. J. (1997). Cognitive behavior therapy – clinical applications. *BMJ*, 314, 1811–1816.
- Fairburn, C. G., & Cooper, Z. (2011). Therapist competence, therapy quality and therapist training. *Behaviour Research and Therapy*, 49, 373–378.
- Feely, M., DeRubeis, R. J., & Gelfand, L. A. (1999). The temporal relations of adherence and alliance to symptom change in cognitive therapy for depression. *Journal of Consulting and Clinical Psychology*, 67, 578–582.
- Frank, J. D. (1982). Therapeutic components shared by all psychotherapies. In J. H. Harvey, & M. M. Parks (Eds.), *Psychotherapy research and behavior change* (pp. 5–37). Washington, D.C.: American Psychiatric Association.
- Greencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities amongst the therapeutic common factor? *Professional Psychology: Research and Practice*, 21, 372–378.
- Grissom, R. J. (1996). The magic number. 7+/-2: meta-meta-analysis of the probability of superior outcome in comparisons involving, therapy, placebo and control. *Journal of Consulting and Clinical Psychology*, 64, 973–983.
- Harris, T., Brown, G. W., & Robinson, R. (1999a). Befriending as an intervention for chronic depression among women in an inner city. I: randomised controlled trial. *British Journal of Psychiatry*, 174, 219–224.
- Harris, T., Brown, G. W., & Robinson, R. (1999b). Befriending as an intervention for chronic depression among women in an inner city. II: role of fresh-start experiences and baseline psychosocial factors in remission from depression. *British Journal of Psychiatry*, 174, 219–224.
- Harris, T., Brown, G. W., & Robinson, R. (1999c). Befriending can lead to remission in women with chronic depression. *Research Digest*, 171, 241.
- Heller, K., Swindle, R. W., & Dusenbury, L. (1986). Component social support processes: comments and integration. *Journal of Consulting and Clinical Psychology*, 54(4), 466–470.
- Horvath, P. (1988). Placebos and common factors in two decades of psychotherapy research. *Psychological Bulletin*, 104, 214–225.
- Hovarth, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: a meta-analysis. *Journal of Counselling Psychology*, 38, 139–149.
- Jadad, A. R. (1998). *Randomised controlled trials*. London: BMJ Books, ISBN 0727912089.
- Kirsch, I. (2005). Placebo psychotherapy: synonym or oxymoron? *Journal of Clinical Psychology*, 61, 791–803.
- Klein, D. (1997). Control groups in pharmacotherapy and psychotherapy evaluations. *Treatment*, 1(1). http://journals.apa.org/treatment/vol1/97_a91.html.
- Kwan, B. M., Dimidjian, S., & Rizvi, S. L. (2010). Treatment preference, engagement, and clinical improvement in pharmacotherapy versus psychotherapy for depression. *Behaviour Research and Therapy*, 48, 799–804.
- Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Handbook of psychotherapy and behavior change* (5th ed.). (pp. 139–193) New York: Wiley.
- Luborsky, L., Diguer, L., Seligman, D. A., Rosenthal, R., Krause, E. D., Johnson, S., et al. (1999). The researcher's own therapy allegiances: a "wild card" in comparisons of treatment efficacy. *Clinical Psychology: Science and Practice*, 6(1), 95–106.
- Messer, S. B., & Wampold, B. E. (2002). Let's face facts: common factors are more potent than specific ingredients. *Clinical Psychology: Science and Practice*, 9, 21–25.
- O'Leary, K. D., & Borkovec, T. D. (1978). Conceptual, methodological, and ethical problems of placebo groups in psychotherapy research. *American Psychologist*, 33(9), 821–830.
- Papakostas, Y. N., & Christodoulou, G. N. (2010). Cognitive psychotherapy and the placebo effect. *European Psychiatric Review*, 3(1), 13–15.
- Parloff, M. B. (1986). Placebo controls in psychotherapy research: a sine qua non or a placebo for research problems. *Journal of Consulting and Clinical Psychology*, 54, 79–87.
- Patton, M. Q. (1989). *Qualitative evaluation methods*. London: Sage.
- Pennebaker, J. W. (2003). Writing about emotional experiences as a therapeutic process. Key readings in social psychology. In A. J. Rothman, & P. Salovey (Eds.), *Social psychology of health* (pp. 362–368). New York, NY, US: Psychology Press, xii, 396 pp.
- Roberts, C. (1999). The implications of variation in outcome between health professionals for the design and analysis of randomized controlled trials. *Statistics in Medicine*, 18, 2605–2615.
- Rogers, C. R. (1957). The necessary and therapeutic conditions of personality change. *Journal of Consulting Psychology*, 21, 95–103.
- Safer, D. L., & Hugo, E. M. (2006). Designing a control for a behavioural group therapy. *Behavior Therapy*, 37, 120–130.
- Sensky, T., Turkington, D., Kingdon, D., Scott, J. L., Scott, J., Siddle, R., et al. (2000). A randomized controlled trial of cognitive-behavioral therapy for persistent symptoms in schizophrenia resistant to medication. *Archives of General Psychiatry*, 57, 165–172.
- Serfaty, M. A., Haworth, D., Blanchard, M., Buszewicz, M., Murad, S., & King, M. (2009). Clinical effectiveness of cognitive behaviour therapy, versus control treatment or treatment as usual for depressed older people in general practice. *Archives of General Psychiatry*, 66, 1332–1340.
- Shepherd, M. (1993). The placebo: from specificity to the non-specific and back. *Psychological Medicine*, 23, 569–578.

- Stevens, S. E., Hynan, M. T., & Allen, M. (2000). A meta-analysis of common factor and specific treatment effects across the outcome domains of the phase model of psychotherapy. *Clinical Psychology: Science and Practice*, 7, 273–290.
- Thompson, L. W., Gallagher-Thompson, D., Laidlaw, K., & Dick, L. P. (2000). *Cognitive-behavioral therapy for late life depression: A therapist manual*. UK version. Edinburgh: University of Edinburgh, Department of Psychiatry.
- Truax, C. B., & Carkhuff, R. (2008). *Towards effective counselling and psychotherapy: Training and practice*. 35 Berrue Circle, Piscataway, New Jersey 08854-8042, USA.: Aldine Transactions, Transaction Publishers, Rutgers- The State University, ISBN 978-0-202-30988-0.
- Turkington, D., & Kingdon, D. (2000). Cognitive-behavioural techniques for general psychiatrists in the management of patients with psychoses. *British Journal of Psychiatry*, 177, 101–106.
- Vallis, T. M., Shaw, B. F., & Dobson, K. D. (1986). The cognitive therapy scale: psychometric properties. *Journal of Consulting and Clinical Psychology*, 54, 381–385.
- Van Der Eyken, W. (1990). *Home-start: A four year evaluation*. Leicester: Home-Start Consultancy.
- Wampold, B. E. (1997). Methodological problems in identifying efficacious psychotherapies. *Psychotherapy Research*, 7, 21–43.
- Wampold, B. E. (2001a). Contextualizing psychotherapy as a healing practice: culture, history, and methods. *Applied and Preventive Psychology*, 10, 69–86.
- Wampold, B. E. (2001b). *The great psychotherapy debate: Model, methods, and findings*. Mahwah, NJ: Erlbaum.
- Wampold, B. E., Minami, T., Tierney, S. C., Baskin, T. W., & Bhati, K. S. (2005). The placebo is powerful: estimating placebo effects in medicine and psychotherapy for randomized clinical trials. *Journal of Clinical Psychology*, 61, 835–854.
- Wilson, K. C. M., Mottram, P. G., & Vassilas, C. A. (2008). Psychotherapeutic treatments for older depressed people. *Cochrane Database of Systematic Reviews*, 1(1), CD004853.
- Young, J., & Beck, A. T. (1980). *Cognitive therapy scale: Rating manual*. Philadelphia, USA: Center for Cognitive Therapy.