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

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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.

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,

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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 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 no 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.

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

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