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Editorial

Befriending: active placebo or effective psychotherapy?

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Summary
Befriending allows for control of the non-specific factors of the therapist–patient interaction in psychosocial research. Manualised befriending is at the very least an active placebo and potentially an effective intervention. Befriending now merits increased research attention to determine indications for use and to elucidate mechanisms of action.

Declaration of interest
D.T., H.S., L.L. and R.D. have all received payment for delivering lectures and workshops on the subject of cognitive–behavioural therapy for the treatment of schizophrenia and other psychoses.

Douglas Turkington (pictured) is an honorary professor of psychosocial psychiatry. He has led on numerous randomised controlled trials of cognitive–behavioural therapy (CBT) as compared with befriending, cognitive remediation and treatment as usual in schizophrenia. Helen Spencer is a doctoral researcher examining how psychosis may be better understood through the process of case formulation in CBT. Latoyah Lebert is a researcher in the field of CBT for psychosis working in the National Health Service. She delivers carer workshops in CBT-informed caring techniques. Robert Dudley is a consultant psychologist working in early intervention and the professional lead for the Northumberland, Tyne and Wear NHS Foundation Trust psychosis pathway.

What is befriending?

Befriending is different from supportive counselling, which is based on Rogerian principles, and has been shown to be as effective as cognitive–behavioural therapy (CBT) in the treatment of the psychopathology of schizophrenia at the end of therapy.[1] Befriending schemes offering social support were first developed within the voluntary sector as a psychosocial intervention for those with depression, anxiety and loneliness. Such schemes were described as being a highly cost-effective form of community care[2] when combined with the full range of necessary pharmacological and psychosocial components needed in individualised care packages. The key ingredients of professional social support have been described and include showing interest, active listening, patience, being outgoing/communicative, sympathetic, trustworthy and the sharing of feelings.[3] The three domains of social support were listed as emotional support, informational guidance and practical assistance.

Befriending was first tested out in chronic depression.[4] The professional befriending (by psychiatric nurses) designed by Kingdon and Turkington for use with schizophrenia, built upon this previous work and manualised the components.[5] We very much viewed this as purely a placebo intervention that was predicted to have minimal effects on the total symptom burden and distress of patients with chronic schizophrenia. The non-specifics of the comparator CBT intervention were to be controlled for, with the therapist remaining empathic and non-directive. Psychotic and affective symptoms were not dealt with in a focused or problem-solving manner. Instead, the time was spent focusing on comparatively neutral topics such as the weather, local events, previous holiday destinations, hobbies and general interests. For example, if the person with schizophrenia was highly delusional, the befriender would not dismiss what the person had said, but would acknowledge without colluding and move the conversation on to related, neutral or positive shared experiences. The befriender used personal disclosure of their feelings, interests and activities to maintain a dialogue. The key components of befriending for schizophrenia have recently been described as acceptance, non-collusion, non-confrontation, focus on interesting and enjoyable events from the present/past, personal disclosure, active listening, reflection and summary, humour and generating hope.[6] Befriending may therefore be a highly viable catalyst to improve therapeutic alliance that consistently predicts positive outcomes across different therapy modalities and different disorders.[7]

Studies comparing psychosocial treatments for schizophrenia with befriending

The original Sensky *et al*[5] study showed that there was a moderately strong effect for both CBT and befriending on all primary and secondary outcomes in a randomised controlled trial for patients with antipsychotic-resistant chronic schizophrenia. There was no significant difference at the end of therapy on overall symptom burden, positive symptoms, negative symptoms and depression. Interestingly the befriending effect was not durable and the individual was left 'grieving' the loss of their befriender at the end of the intervention, so the benefit was substantially lost by short-term follow-up. Milne *et al*[8] confirmed that both interventions were unique and there were no elements of CBT in the befriending limb. They argued that this professional social support intervention was 'no mere placebo'. However, Turner *et al*[9] reported in a meta-analysis that CBT was significantly more effective than befriending for reducing overall symptoms of psychosis ($g = 0.42$).

In a methodologically robust trial Shawyer *et al*[10] compared acceptance and commitment therapy (ACT) with befriending and both interventions had a moderately strong effect on the primary outcome at the end and at short-term follow-up. ACT was significantly more effective at follow-up on two secondary outcomes (positive symptoms and hallucinatory distress). ACT is a third-wave manualised form of brief CBT based on group training in mindfulness techniques and acceptance of psychotic symptoms (such as voices) in order to act mindfully in line with an individual's key values. ACT is viewed as one of the most potentially beneficial new treatment modalities for positive symptoms of schizophrenia.[11] Mindfulness is described as often being a highly effective coping strategy for voices.[12] One point to make in relation to the minimal significant differences between

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the interventions was that both did well and their effects were in addition to the benefits of antipsychotic medication. However, antipsychotic-resistant positive symptoms are often linked to underlying trauma[13] and neither of these approaches specifically targeted this particular feature. It is possible to argue that there are also elements of ACT present within professional befriending. Befriending may act as an effective distraction from voices and delusions, which often involves the discussion of interests and activities that will be linked to values, so it is unlikely that a sustained conversation can be held on a subject that is not valued by the patient. Perhaps then, the answer as to why befriending is seen to be as helpful as an active intervention, lies more in the fact that befriending is not merely a placebo or even an active placebo, but may in itself be an effective intervention for schizophrenia.

How might befriending produce benefit in schizophrenia?

If befriending is an active intervention it may act to reduce distress in a number of ways. It may work by reducing social isolation. A regular weekly visit for an hour is hugely appreciated by patients with schizophrenia who in many locations have little opportunity for social interaction. It is also possible that self-esteem and self-nurture can be improved by regular contact with another human being in which a relationship can begin to develop and where the patient feels the focus of genuine interest and care. Stigma and self-stigma can begin to dissipate within this developing relationship.

Samarasekara *et al*[14] showed that there was a differential effect within the Sensky *et al*[5] study with befriending producing better outcomes than CBT for persecutory delusions. It was also shown that the lower the level of insight and the higher the level of perceived persecution, the more beneficial the befriending. The befriending style helped by 'taking the heat out of the delusion' at a time when (owing to delusional preoccupation and anxiety) working on a problem list, worry reduction, reality testing or on behavioural homework experiments were simply unrealistic and unacceptable to the patient. In relation to negative symptoms, it was also clear that the non-expectation of homework or target-setting was greatly appreciated by patients who, within befriending, did start to do more activities at their own pace. It may be that a secondary analysis of Shawyer *et al*[10] demonstrates differential benefits for ACT and befriending within the target population, with befriending being more beneficial for those with linked paranoid delusions.

Finally, and perhaps the most astonishing phenomenon within the befriending sessions has been the emergence of unsolicited disclosure of previous traumatic episodes. These included childhood and adult sexual abuse and assault and physical abuse. The befriending platform may therefore have been used by patients as an opportunity to disclose and process painful memories that were often acting to exacerbate and maintain psychotic symptoms. This was handled as sensitively as possible by the befrienders who were adhering to the manual as closely as they could.[5]

Implications for research and clinical practice

Befriending is perhaps more than an active placebo and should be viewed as an intervention that is an essential ingredient of all good psychiatric practice. It would be useful to investigate further to discover whether activation of positive psychology processes and/or competitive memory principles are key mechanisms. Competitive memory training allows the enhancement of retrieval of beneficial information from memory to enhance self-esteem.[15] If it is an effective intervention, then testing CBT against treatment as usual should now be replaced in all studies by at least a befriending control condition. As access to CBT for psychosis and other expert interventions remains scarce, there has been a move towards implementing low-intensity interventions. Befriending (particularly if family members and other carers can be trained in the approach) could act as a stepping stone to other sources of help to increase social/physical activity and engagement in education and training. Perhaps befriending schemes should be more closely examined in terms of medium- to long-term outcomes. Befriending merits further investigation as an intervention in its own right and possibly implementation, under the umbrella of low-intensity psychosocial interventions for schizophrenia and other psychoses.

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