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SPECIAL SERIES

Collaborative Empiricism in Cognitive Behavior Therapy

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Introduction

Using Techniques via the Therapeutic Relationship

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In this work, we have the opportunity to hear people's most private concerns, worries, distress, and share in their hopes, aspirations, and dreams for the future. The work involved in the practice of cognitive behavior therapy; our knowledge, theories, techniques, and strategies are practically useless if we are unable to relate to our clients. Relational attributes were incorporated as part of the defining features essential to therapeutic change in the seminal guide for cognitive therapy (A. T. Beck, Rush, Shaw, & Emery, 1979). Conceptualizations of "collaboration" and "empiricism" have since been misconstrued with the construct of the working alliance in the past, although both have unique distinctions and implications for practice. This article presents an introduction to a special series in Cognitive and Behavioral Practice, which illustrates the vital role of collaborative empiricism within culturally responsive CBT, through the structure of the therapy session, cognitive case conceptualization, self-monitoring, interventions focused on cognitive change, and exposure to emotions and situations. We invite you to join with us in considering the extent to which the ideas shared herein are relevant for your work with clients. It is also our hope that you will consider evaluating and incorporating the utility of these ideas in your therapy.

During the course of our treatment, we have the opportunity to hear our clients' most private concerns, worries, and distress: We share in their hopes, aspirations, and dreams for the future. For the hours spent in-session, we have the opportunity to connect to a person's life. It is, thus, privileged, honorable, and meaningful work that we do. How many times do we catch ourselves explaining to a client a concept, an idea, and realize that it is an understanding that we have realized for ourselves? How many times are we expressing ideas that we have also expressed to our loved ones? The work involved in the practice of cognitive behavior therapy (CBT; A. T. Beck, Rush, Shaw, & Emery, 1979) is clearly relational. Our knowledge, theories, techniques, and strategies are essentially useless if we are unable to relate to our clients.

Keywords: collaboration; empiricism; cognitive behavior therapy; cognitive therapy

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CBT is a critically important psychotherapeutic approach for all of the professions involved in the service of mental health delivery. Whether a colleague elects to practice purely based on A. T. Beck's (1976) model of psychopathology, or integrate its theory and associated techniques with other modalities (see discussion in Petrik, Kazantzis, & Hofmann, in press), few colleagues would report that their psychotherapy practice has not been influenced by CBT (Orlinsky, Norcross, Rønnestad, & Wiseman, 2005). Despite the broad influence of the approach, many colleagues are surprised to learn that the seminal guide for practice considered relational attributes as defining features essential to the facilitation of cognitive change (A. T. Beck et al., 1979; and see also J. Beck, 1995, 2005, 2011). For example, helping clients to question their thoughts and associated features of distress, using the same questions asked by the therapist and developing new questions of their own, was considered the cardinal purpose of Socratic dialogue (Kazantzis, Fairburn, Padesky, Reinecke, & Teeson, in press). Similarly, joining with the client to understand and apply the scientific method to their cognitive, affective, physiological, behavioral/interpersonal experience to

evaluate the utility of new strategies and techniques was considered the basis of collaboration and empiricism, commonly referred to as "collaborative empiricism" (Tee & Kazantzis, 2011). Therefore, along with the specific interventions of CBT, the relational attributes and relational processes serve as important change agents in CBT because they help clients to develop new cognitive processes and content (DeRubeis et al., 1990; Garratt, Ingram, Rand, & Sawalani, 2007; Whisman, 1993).

"Collaboration," or shared work, presents the client with an opportunity to develop skills and ultimately take the lead for the application, refinement, and design of new therapeutic techniques (Dattilio, Freeman, & Blue, 1998; Dattilio & Hanna, 2012). Implicit in this conception of collaboration is the notion that the balance of contributions is even. While therapists hold greater responsibility for the work early in the therapeutic process, clients hold greater responsibility later during the course of treatment. Although this operationalization may sound familiar upon first reading, the feature of "shared work" has been omitted from the broader efforts to study collaboration in psychotherapy, as well as in studies of the therapeutic relationship in CBT. A central problem has been that "working alliance" has been equated with "collaboration."

Elements from psychodynamic psychotherapy (Freud, 1910/1957; Greenson, 1965), client-centered therapy (Rogers, 1957), and social-influence theory (LaCrosse, 1980; Strong, 1968) were synthesized in the definition of the working alliance (Bordin, 1980) and its assessment (Horvath & Greenberg, 1986). Specifically, the concept of alliance has been defined as a collaborative agreement between client and therapist on session and broader goals for therapy (Bordin, 1994; Horvath & Luborsky, 1993; Horvath & Symonds, 1991), and agreement on what tasks will enable those goals to be achieved (Bordin, 1980). Expressions of mutual liking, trust, respect, empathy, positive regard, and appreciation between client and therapist comprise the final element, referred to as bond (Horvath & Greenberg, 1989). Other assessments of the working alliance concentrate on the assessment of productive client and therapist work towards goals (Alexander & Luborsky, 1986) or psychodynamic interactional processes (Hartley & Strupp, 1983). While these conceptions of working alliance refer to important aspects of the relationship between a client and therapist, neither the definition nor assessment within these measures captures the notion of "shared work" central to the definition of collaboration in CBT.

Integral to CBT is the therapeutic use of the client's inner and environmental experiences as the context for the work. If therapy was solely based on logic or principle, it would appear distantly related to the client's life, and unlikely to motivate engagement in therapy (Tee & Kazantzis, 2011). The client's experience guides both the focus of interventions and the development of criteria for evaluating the benefit of interventions. It is this tailoring of therapeutic work for each individual client that operationalizes "empiricism" in CBT. However, there are misconceptions about the notion of empiricism for the practice of CBT.

A Clarification for Empiricism in CBT

The field of psychotherapy research has helped us to utilize the scientific method as a context for defining and evaluating our practices. To operate as a competent, ethical, and professional practitioner is to evaluate the effectiveness of clinical work, and adjust it based on those data (Levant & Hasan, 2008; Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). Thus, the first "level" of empiricism concerns the evidence for our therapeutic work and the data we gather to support those therapies in the settings in which we work (see Figure 1).

The field of psychotherapy research has also sought to examine, and directly contrast, the benefits of specific interventions for specific clinical populations. Excellent examples of this evidence include studies supporting the subset of interventions labeled behavioral activation (Gortner, Gollan, Dobson, & Jacobson, 1998; Martell, Addis, & Jacobson, 2001), rational reevaluation (Tang, DeRubeis, Beberman, & Pham, 2005), exposure (Feske & Chambless, 1995), prolonged exposure (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2000), exposure and response-prevention (Wilhelm & Steketee, 2006), self-monitoring (Shapiro & Shapiro, 1982), and cognitive restructuring (Matthews & Litwack, 1995). Thus, the second "level" of empiricism concerns the evidence for our therapeutic interventions incorporated into our therapies (see Figure 1). (A common misconception of CBT is that in order to practice "pure" Beckian CBT is to be restricted in the selection of interventions, when in fact, the definition of pure vs. integrative practice centers on how those interventions are theorized to help;

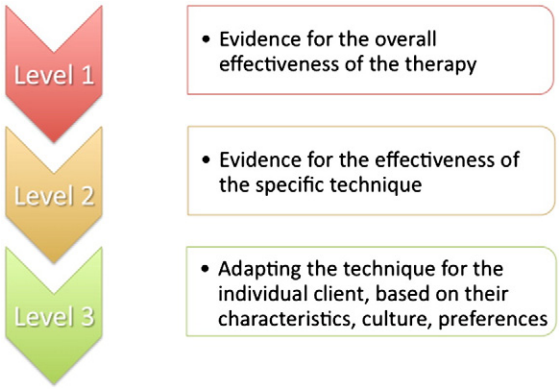

Figure 1. Levels of empiricism in CBT.