Available online at www.sciencedirect.com

ScienceDirect

Cognitive and Behavioral Practice 20 (2013) 429–444

Cognitive and Behavioral Practice

www.elsevier.com/locate/cabp

Collaborative Empiricism in Cognitive Therapy for Psychosis: A Practice Guide

Paul Hutton and Anthony P. Morrison, *Greater Manchester West Mental Health NHS Foundation Trust and University of Manchester*

We outline our understanding of collaborative empiricism (CE) as used in cognitive therapy (CT) for psychosis. We discuss how CE can be thought of as a technique for facilitating cognitive change in the service of a client's goals, but also as an expression of respect for client autonomy, recognizing the ethical imperative to empower clients by involving them in decisions about their care. Taking a CE approach is therefore consistent with user-led conceptualizations of recovery, and the related movements of "shared decision-making" and "evidence-based patient choice." We discuss how CE can aid with engagement, assessment, formulation, and intervention in CT, illustrating this with case material. We focus on how CE can help with distressing intrusive experiences and beliefs, and also consider its role in helping clients achieve wider life goals. Adaptations to CE for working with people with problems with learning, attention, and memory are discussed, as are considerations for working with high conviction and conceptual disorganization.

Collaborative empiricism (CE) has been a defining feature of cognitive therapy (CT) ever since the latter was invented (Beck, 1967). It forms a particularly important part of CT for people with psychosis, where CE is the general approach taken when helping clients evaluate the validity, reliability, and usefulness of their appraisals, behavior, and wider belief systems (Chadwick, Birchwood, & Trower, 1996; Fowler, Garety, & Kuipers, 1995; Gumley & Schwannauer, 2006; Kingdon & Turkington, 2005; Morrison, Renton, Dunn, Williams, & Bentall, 2004). According to Beck and Dozois, "Collaborative empiricism means that the patient and the therapist become co-investigators both in ascertaining the goals for treatment and investigating the patient's thoughts. Methods of guided discovery are used to help patients to test their own thinking through personal observations and experiments rather than via cajoling or persuasion" (Beck & Dozois, 2011).

CE is particularly important for case conceptualization in CT. According to Kuyken and colleagues, collaboration between therapist and client here involves "bringing their respective expertise together in the joint endeavour of describing, explaining and helping resolve the client's presenting issues," while empiricism involves a synthesis of theory, research, and observation, and a hypothesis-testing approach to clinical decision-making (Kuyken, Padesky, & Dudley, 2008).

However, Tee and Kazantzis have drawn attention to some uncertainty over the definition, noting that the term "collaborative empiricism" now means different things to different theorists (Tee & Kazantzis, 2011). These authors offer a fresh perspective on how CE leads to belief change, using the framework of self-determination theory. They note the lack of scrutiny of CE, and make a call for empirical work to examine, among other things, the components of CE, the relationship of CE to other constructs and variables, and the effectiveness of CE in CT.

CE may be therapeutically valuable in two important and complementary ways. First, it may be an aid to achieving the overall goal of helping a client reduce their suffering and emotional distress. Clients with psychosis have reported finding it inherently engaging to be treated as an equal partner (Kilbride et al., 2012), and they may be more likely to consider the full range of evidence before them when they have taken at least an equal role in discovering it (Tee & Kazantzis, 2011). Second, helping clients form views or make decisions based on evidence (and reason) may help them make more reliable and informed decisions, now and in the future (Stacey et al., 2011). Thus, CE might be viewed as a process that helps to build and protect decision-making capacity which, in turn, may promote autonomy (Owen, Freyenhagen, Richardson, & Hotopf, 2009).

Our aim in this paper is to discuss the use of CE in CT with people who have received a diagnosis of a psychotic illness. We first discuss why CE is a particularly important

Keywords: collaborative empiricism; schizophrenia; psychosis; cognitive therapy; cognitive behavioral therapy

1077-7229/12/429–444$1.00/0

feature of CT with this group, focusing on how CE can help clients achieve cognitive change. We then outline examples of CE in CT, illustrated using anonymized case material.

CE in CT for Psychosis

CE may be a particularly important aspect of CT for psychosis, for several related reasons. First, adopting a collaborative stance can aid engagement with clients who are more likely than others to be experiencing high levels of suspiciousness. A willingness to collaborate might communicate a willingness to cede control and power, thus reducing the extent to which the clinician is viewed as a threat. Collaboration from the outset may help to ensure the goals of therapy are clearly defined and shared, reducing the likelihood of disagreement and misunderstanding.

Second, people with psychosis tend to experience relatively greater coercion from mental health services to adhere to treatment, which all too often consists of antipsychotic drugs alone (Burns et al., 2011; Monahan et al., 2005). However, there is good evidence that people with psychosis wish to be involved in making decisions about their care and treatment (Byrne, Davies, & Morrison, 2010; Hamann, Cohen, Leucht, Busch, & Kissling, 2005), and that many retain the capacity to do so (Grisso, Appelbaum, & Hill-Fotouhi, 1997; Stroup et al., 2005; Vollmann, Bauer, Danker-Hopfe, & Helmchen, 2003). Nonetheless, exclusion from these and other important decisions is not uncommon (Hamann et al., 2008). Thus, clients may be very receptive to a clinician who takes a collaborative approach.

Third, adopting CE as an approach requires that clinicians pay close attention to the evidence informing their client's fears and concerns, and that they avoid making assumptions about their truth. This means a client's values, experiences, and perspective are taken seriously and not simply dismissed as delusions, meaningless symptoms, or epiphenomena. Experience suggests that clients are often quite preoccupied with not being believed and frequently feel frustrated and isolated as a result. CE can protect against that frustration being directed at the therapist, thus helping to ensure engagement.

Fourth, there is evidence that delusional conviction is associated with a general tendency to form conclusions quickly based on limited evidence (Fine, Gardner, Craigie, & Gold, 2007; Garety et al., 2005; Startup, Freeman, & Garety, 2008), as well as a greater inflexibility in considering alternative explanations (So et al., 2011). If developing *"the ability to question the way I look at things"* (Greenwood et al., 2010) is a shared goal of therapy, then adopting a CE approach, with its focus on considering evidence and generating explanations, may be well-placed to help. It might be argued that service-users are unlikely to ever adopt such a goal, particularly if they believe their existing way of looking at things with complete conviction. On the other hand, delusional conviction varies a great deal (Brett-Jones, Garety, & Hemsley, 1987), while experience suggests that the formulation process can help clients recognize the link between fluctuating conviction and intensity of emotional distress. There is some evidence that reasoning training and metacognitive training focused on addressing various biases can be particularly effective (Aghotor, Pfueller, Moritz, Weisbrod, & Roesch-Ely, 2010; Moritz, Kerstan, et al., 2011; Moritz, Veckenstedt, Randjbar, Vitzthum, & Woodward, 2011; Ross, Freeman, Dunn, & Garety, 2011), and there is no reason why aspects of these procedures cannot be incorporated into standard CT if the formulation suggests so.

Overall, CE has much in common with other constructs such as person-centered care, shared decision-making, evidence-based patient choice, and value-based practice (Fulford, 2011), all of which are appropriate responses to the growing "recognition of the ethical imperative to properly involve patients in decisions about their care" (Elwyn et al., 2010). Moreover, the emphasis on collaboration brought by CE makes it an approach that is consistent with the philosophy and ideals of the recovery movement, where "choice, self-determination, and empowerment are foundational values" (Deegan & Drake, 2006). In a recent qualitative study, Pitt and colleagues found recovery from psychosis involved three themes: rebuilding self, rebuilding life, and hope for a better future. If experiencing choice, self-determination, and empowerment are important prerequisites for achieving these broader goals, and if CE can promote these effectively, then CE may have a role to play in promoting recovery.

We will now offer some guidance as to how CE can best be implemented in CT for psychosis, specifically focusing on the assessment and treatment of cognitive factors involved in hallucinations and delusions, should these be identified by clients as obstacles to their recovery. However, symptomatic improvement is often not necessary or sufficient for a recovery which is meaningful to service users. Therefore, we also focus on how CE might help with wider life goals.

The Practice of CE in CT for Psychosis

Engagement

It is common to encounter clients who are locked in a frustrating battle of wills with their psychiatrist or case worker. We find this is particularly likely when a client has decided not to take antipsychotic medication, which is often the only treatment being offered. Indeed there is some evidence that shared decision-making (not dissimilar to CE in its ethos) matters more to clients who are dissatisfied with their treatment (Hamann, Mendel, Reiter, et al., 2011). Such clients may believe that their mental health professional is not taking their fears and values seriously; often, the mental health professional believes their client