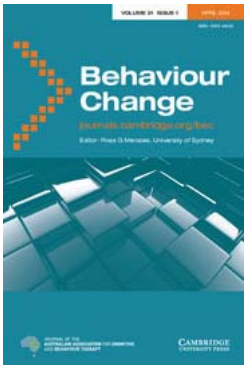

Unresolved Issues Regarding the Research and Practice of Cognitive Behavior Therapy: The Case of Guided Discovery Using Socratic Questioning

Nikolaos Kazantzis, Christopher G. Fairburn, Christine A. Padesky, Mark Reinecke and Maree Teesson

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Unresolved Issues Regarding the Research and Practice of Cognitive Behavior Therapy: The Case of Guided Discovery Using Socratic Questioning

Nikolaos Kazantzis,[1] Christopher G. Fairburn,[2] Christine A. Padesky,[3] Mark Reinecke,[4] and Maree Teesson[5]

[1] *Cognitive Behavior Therapy Research Unit, La Trobe University, Victoria, Australia*
[2] *Centre for Research on Eating Disorders at Oxford, University of Oxford, England, UK*
[3] *Center for Cognitive Therapy, Huntington Beach, California, USA*
[4] *Northwestern University, Chicago, Illinois, USA*
[5] *National Drug and Alcohol Research Centre, University of New South Wales, New South Wales, Australia*

This article presents a panel discussion on the integration of collaborative empiricism, specifically Socratic Questioning, into cognitive behaviour therapy. The panel comprised experts in research and practice who had been invited as keynote presenters for the 34th National Conference for the Australian Association of Cognitive and Behaviour Therapy, held in Sydney, Australia. Experts responded to questions regarding (a) the definition of Socratic dialogue, and (b) whether the purpose of Guided Discovery using Socratic Questioning is to impart information, correct, or dispute patient cognitions. The session was well attended by mental health professionals from around the globe and the panel enjoyed the opportunity to discuss questions and comments from those in attendance. This article presents this exchange so that the broader AACBT membership may benefit from the ideas and comments generated.

■ *Keywords:* Socratic dialogue, cognitive behaviour therapy, therapeutic process, questioning

> *What is the first business of him who philosophizes? To throw away self-conceit. For it is impossible for a man to begin to learn that which he thinks that he knows. (Epictetus, Discourses, Book 2, Chapter 17)*

Socrates considered that learning arises from questioning assumptions, and as a consequence of this, employed questioning as a central feature of the learning process to enlist engagement in the discovery of new ideas and perspectives. Dr Aaron T. Beck and colleagues included Socratic questioning as a defining attribute of the therapeutic relationship when first conveying how to practise cognitive therapy (CT; A.T. Beck, Rush, Shaw, & Emery, 1979) as a treatment for depression (see also DeRubeis, Tang, & Beck, 2001). Facilitating distance from thoughts, the experience of emotions and tolerance of their fluctuations and physiological counterparts through an empirical questioning of learned cognitions has remained central to the evolution of cognitive

Address for correspondence: Nikolaos Kazantzis, Cognitive Behaviour Therapy Research Unit, School of Psychological Science, La Trobe University VIC 3086, Australia. Email: N.Kazantzis@latrobe.edu.au

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behaviour therapy (CBT; e.g., A.T. Beck, Emery, & Greenberg, 1985; J.S. Beck, 1995, 2005, 2011; Blackburn, Twaddle, & Associates, 1996; Datillio, 2000; Freeman, 2005; French & Morrison, 2004; Ludgate, Wright, Bowers, & Camp, 1993; Renton, 2002; Overholser, 1992, 1993; Padesky, 1993; Rutter & Friedberg, 1999) and its utility for a range of clinical disorders, including those characterised by anxiety (Clark & Beck, 2010), eating disorders (Fairburn, 2008), interpersonal problems (A.T. Beck, Freeman, Davis, & Associates, 2004), psychosis (A.T. Beck, Rector, Stolar, & Grant, 2009; Kingdon & Turkington, 2005), and substance abuse (A.T. Beck, Wright, Newman, & Liese, 1993).

Self-questioning, and in particular, questioning thoughts, assumptions, rules, and beliefs was theorised to be important in gaining distance from thoughts, and in developing flexibility in assumptions central to the maintenance of emotional distress and reduced functioning (DiGiuseppe, 1991; Friedberg & McClure, 2002; Overholser, 1993). The role of the individual patient in arriving at their own understanding assists them in harnessing ownership over the therapeutic process (Dattilio & Padesky, 1990; Walen, DiGiuseppe, & Dryden, 1992; Williams et al., 2006), and is thereby intrinsically motivating (see Tee & Kazantzis, 2011, for a discussion of self-determination theory in CBT). Given its role in facilitating change in the thinking content and process, Socratic questioning has been suggested to enhance sustained benefit from CBT (Horvath & Greenberg, 1994). Thus, Socratic dialogue is inherently 'empirical' in that it is based within the patient's personal experience (Kazantzis, Beck, Dattilio, Dobson, & Rapee, 2013; Kazantzis, Freeman, Fruzzetti, Persons, & Smucker, 2013).

Experimental research has demonstrated that learning (Legrenzi, 1971; Zachry, 1985), critical thinking skills (Yang, Newby, & Bill, 2005), and problem-solving (McDaniel & Schlager, 1990) are enhanced when an individual reaches a discovery under their own volition (see also Claiborn & Dixon, 1982). However, it should be noted that while therapist interpersonal style has been shown to influence client reactions to the therapist and treatment outcomes (Miller, Benefield, & Tonigan, 1993; Patterson & Forgatch, 1985), there remains a need for empirical research to better understand the short- and longer-term benefits of Socratic questioning in CBT.

The ability to usefully employ Socratic questioning is considered a base level relational competency for CBT. The original Cognitive Therapy Rating Scale (Young & A.T. Beck, 1980) included Socratic questioning as part of the assessment for the patient-therapist interaction, and accordingly, had the implicit expectation that it would be present in every therapy session (see also Barber, Liese, & Abrams, 2003; Blackburn et al., 2001). Socratic questioning can be employed to establish goals for the session or the broader therapy, can be included in collaboratively setting a session agenda, in the review and selection of therapeutic homework, and can be useful in the identification of key cognitions and behaviours before applying techniques (Bishop & Fish, 1999; DeRubies et al., 2001; James, Morse, & Howarth, 2010). When employed for the generation of a new idea or perspective (i.e., a discovery, Calvert & Palmer, 2003; Wills & Sanders, 1997), questions are used alongside reflections, summaries, and suggestions (see Miller & Rollnick, 2002). Therefore, the term 'Socratic dialogue' is perhaps more reflective of the exchange possible in facilitating discoveries.

Despite the importance accorded to Socratic questioning in the practice of CBT, there exists little guidance for the clinician about how to ideally incorporate the process into sessions (Carey & Mullan, 2004). Central is a controversy about whether the questioning process is an effort to lead a patient to a specific point (Diaz-Guerrera, 1959; Freeman, 2005; Scraper, 2000), or whether it is designed to enable the

patient to truly discover a new idea or perspective (Overholser, 1992, 1993; Padesky, 1993).

In alphabetical order, keynote speakers to the 34th Annual Conference of the Australian Association for Cognitive and Behaviour Therapy (AACBT), Drs Christopher Fairburn, Christine Padesky, Mark Reinecke, and Maree Teesson were joined by Dr Nikolaos Kazantzis (Organiser and Chair) to respond to questions regarding (a) the definition of Socratic dialogue, and (b) whether the purpose of guided discovery using Socratic questioning is to impart information, correct or dispute patient cognitions. The session was well attended by mental health professionals from around the globe and the panel enjoyed the opportunity to discuss questions and comments from those in attendance. This article presents this exchange so that the broader AACBT membership may benefit from the ideas and comments generated.

Panel Discussion

Nikolaos Kazantzis. My name is Nikolaos Kazantzis and on behalf of the Australian Association of Cognitive Behaviour Therapy, I welcome you here this morning. It is my great privilege and a pleasure to introduce this expert panel to you. I am sure you all know Dr Chris Fairburn, Dr Christine Padesky, Dr Mark Reinecke and Dr Maree Teesson through their significant contributions to clinical psychology. They have contributed to our understanding of how to help clients presenting with anxiety disorders, eating disorders, depression, and suicide, as well as the comorbidity between mental disorders and drug and alcohol disorders. They have also contributed to our understanding about how we work with children, adolescents, families, couples and adults within the CBT model. Members of the panel have also contributed significantly, and are considered authorities, on central CBT processes such as collaborative case conceptualisation, and between them provide the training for tens of thousands of mental health professionals around the world. So, I think we are lucky to have the opportunity to have Chris, Christine, Mark and Maree with us here today to share with us their expertise and their guidance in a discussion on guided discovery using Socratic questioning. Please join with me in welcoming out expert panel here this morning.

The aim of this panel is to have a constructive conversation; a discussion. We are going to have a base assumption that Socratic questioning and guided discovery are important for therapy, and currently, most of our research in CBT has been focused on evaluating its outcomes for different clinical groups. And so, at the moment, there is an absence on research on important processes such as these. Therefore, I will offer some initial comments and some other questions for the panel to consider, but the aim here is to enable the panel to have a free-flowing conversation. The central goal is to offer you some guidance — some tips for clinical practice.

How can Socratic dialogue be defined? How does discovery happen in therapy? What is the role of the therapist in influencing the guided discovery process and how does Socratic dialogue and guided discovery lead to — and possibly contribute to — meaningful, cognisant change? And I encourage the panel to integrate case examples where they feel appropriate.

Let's begin by talking about a definition. For over 100 years in psychology and psychiatry and a broader range of mental health professions, we have debated the issue of genetic versus environment, and in hindsight the answer, like many other things in life, is not *A* or *B* but *C* — *all of the above*. How often can we say that things are just one

way or another, and how often does it happen that when we look at dichotomies we appreciate their connectedness? Perhaps the same is true in psychotherapy. We have debated the issue of therapeutic technique versus relationship, and some empirical reviews have been interested in determining the proportion of variance in outcome due to technique or due to the relationship. But, the recent taskforce of the American Psychological Association (APA), which has been put together to understand what are empirically supported therapy relationships, concluded it is actually very difficult to separate the relationship from the technique. They concluded that, in fact, they are inextricably linked, dependent processes. The therapeutic technique very rarely sits in a room by itself — it needs a therapist to work. And the technique also depends upon the therapist's relationship with the client in order to work.

Our professional community has witnessed a marked evolution in defining therapies and a marked development in defining what is behavioural therapy and what is cognitive therapy. Some of our colleagues say that cognitive behavioural therapies share more similarities than differences; others say that most of the differences exist in the therapist's mind, in how the therapist self-labels or self-identifies their practice. Yet, the majority of practitioners in the field who have responded to surveys express a reluctance to identify with a specific therapeutic model and rather, the observation is that they integrate more than one system of psychotherapy in their practice. And the same finding has been found across different countries, among professionals working in different clinical contexts. So, I wonder whether these observations reflect that we, as therapists, have an important role in defining the therapy? And perhaps it is the way we adapt the therapy for the clients sitting in our office? For their unique preferences, their expectations, their cultural context. And I also wonder whether our way of defining our practice incorporates the idea that maybe we are a little bit more than the brand of therapy that we practise. It is our way of relating. It is who we are as people that shapes and moulds our therapeutic work. Therefore, regarding the definition of Socratic dialogue I'd like to ask the panel two questions:

1. How can we define Socratic dialogue in Beck's cognitive behaviour therapy?
2. Would Socratic dialogue be a method, a style, an intervention or all of the above? Or, something else?

Christine Padesky. I am going to start then. First of all, as we begin talking, I want to make a distinction between Socratic dialogue and other guided discovery methods, which I think pervade all the CBT approaches. Therapy, from my way of thinking, is a learning enterprise, so whenever we are choosing a therapy method we have to think, *What's the best way to foster client learning*? Now, permeating all the CBT techniques is a process called guided discovery and there are many ways to do guided discovery. We can do it through behavioural experiments, through teaching people who are depressed to use thought records ... there are lots of ways to guide clients to discovery. The Socratic dialogue is often used across and integrated with all these methods. I see Socratic dialogue as a verbal method in which we are using questions to broaden the client's perspective and to draw their attention to information that is relevant to the beliefs that we are testing out and the behaviours we are evaluating. So, we are asking questions to draw their attention to relevant information.

As you know, I like to call it 'Socratic dialogue' because I think that it is equally important that we listen to what the client says and responds to our questions, and that we agree to follow where the client's answers lead us and that we are not just trying to

ask questions that change the client's mind. And then I think that an important part of the Socratic dialogue process is actually in making summaries of the information that we retrieve from the client and get the client to recognise and pay attention to. And then the key part of Socratic dialogue, once we have made a written summary with the client of the information, is to ask them: *What do you make of this? How do you put this together with your belief?* I think a defining question of the Socratic process is for us not to tell them the conclusion but instead to ask them: *What do you make of this? How do you put this? How do you put these ideas together?* Taking together these four steps of Socratic dialogue — asking informational questions, empathic listening, making written summaries and asking the analytic synthesising question — I think it is the analytic synthesising question following the summary process that really defines the Socratic method (Padesky, 1993; Padesky & Greenberger, 1995, p. 11).

Mark Reinecke. Yeah, I would agree, all that . . . the best way of thinking about it is as being a learning experience. My little addendum to this, I have two things. One is to note that the essence of all learning experiments in changing beliefs, changing the patient's expectations, the attributions they are making, what they think about their experiences in the world (and different patients hold beliefs with different strengths, different intensities), and what I took the liberty of writing, because I wanted to get the quote correct, is from Benjamin Franklin, who I like a lot. And he says: 'Being disputatious is a very bad habit. Confronting people produces disgusts and perhaps enmities. People of good sense I have learned seldom forget this, except lawyers, university men and men of all sorts who are bred in Edinburgh!'

Now, what am I getting at here is if you go directly after a belief and challenge it, you are going to get — for lack of a better term — a reaction. I don't use the term *resistance* because of all the conceptual baggage that comes with it. But there will be a reaction to it. And so what you are to do is, don't be disputatious. It's a gentle enquiry. And I like the notion that it is a dialogue rather than an enquiry, because there is no presumption that the therapist, at least from my perspective, has a particular ownership of truth. There was a philosopher who recently passed away, Richard Rorty, who said that 'truth is a label we give to ideas that we like', so I don't presume that I have any access to truth. All I presume is that the way that the client is thinking about things isn't quite working for them. So it's a very gentle enquiry — I am just wondering if there is another way of thinking about it. But the essence of it then is the targeting of a specific maladaptive core belief and a gentle encouragement to sort of — I put my hand up like this — to turn the prism in the light and see if there's another angle from which it can be understood.

Maree Teesson. Well, I come to this probably thinking about the issue as a researcher working with my clinical colleagues, trying to think about working in substance abuse disorders. Substance abuse disorder treatment is a treatment by stealth. It is very difficult to get people with substance abuse disorders even to the point of thinking about entering into therapy. So it has really been for me CBT by stealth. Picking up on what Mark's saying, is that different disorders and problems have different contexts and it's very hard to ignore that. If I ask young graduates who I am teaching, 'When would you think about looking at a drug and alcohol problem in a person?' their answer often is, *When they're having problems with their liver. When I send them to the GP and they come back with a negative result on the test.* That's when we start to ask them about

their drug and alcohol problems. I don't think it's just an Australian problem, we need to task sooner.

Chris Fairburn. Well, now, I'm very pleased to be on this panel. I thought I was going to be out of tune with everyone else but I'm in tune! I thought I'd make a couple of remarks. One is that if you come from Oxford you tend to meet experts in other topics, and recently I had dinner with an international expert on Socrates. From what he told me, Socrates certainly did not engage in what we refer to as Socratic questioning. He would not identify with what we talk about. He was apparently famously ruthless with his questioning and would pin people to the ground almost with his questioning. He liked to baffle people by asking mysterious questions that were slightly off topic, but he had a target and he would pursue people in his questioning until he could find some flaw in their position or argument. He was famous for being aggressive in his questioning, whereas I think all of us are taking the opposite stance of wanting to be gentle rather than confrontative. So, the term is probably a misnomer but it exists. But what is more relevant is that I think that there isn't such a thing as Beck's cognitive therapy — singular.

Beck, between the 1960s and 1970s, devised this marvellous way of thinking about mental health problems and working with people with mental health problems, which is formulated in the 1979 book pretty well. It was very influenced by working with people with depression. That was 30 years ago and a lot has happened in the interim. Cognitive therapy of depression has evolved but it has also differentiated into different applications and the different applications use Beck's approach differently. I have spent the past two years going to workshops by different people to find out how they do cognitive therapy, and it is clear that cognitive therapy differs markedly according to the client group that you work with. So, it's difficult to say there is a single right way of doing cognitive therapy. But I think none of us are saying that. Rather, the cognitive therapies involve a style and strategy for trying to help people discover and reflect on unthought-of assumptions and the implications of new ways of behaving. It is questioning to discover that is probably common across most CBT approaches.

Mark Reinecke. I don't know that it has got to be this way. There has got to be an alternative. And it looked like a wheel spinning in the sand or spinning in the snow. So the second tip then is that we should look for the viable alternative. What is the other way of looking at this that really makes sense? Now, I've got clinical examples — I'm sure you've all got clinical examples — but when a patient gets that, *Ah, I can look at this differently, there's another way of understanding it*, that's when the shift occurs; that's when the emotional shift occurs.

Chris Fairburn. I find it very helpful to blend questioning with quite strategic planned changes in the way people behave.

Mark Reinecke. I think the key word in that is 'strategic'. In all of this there's a sense that we sort of know where we're going — what the essence of the problem is and what we are going to try and change. I'll give you a simple example.

I had a patient come in many years ago. We have all had this experience where a patient says something along the lines of — you should know ... poor patient, just didn't have money for his medication and things like that — and he goes, 'You know Mark, nobody really cares about me any more. Even ... come on ... if it wasn't for

the payments you wouldn't be seeing me.' And I'm looking at him and I'm like, you know … he's just like you've just walked into him. And I opened up my chart note and in the corner of my progress notes, set up in the corner, I said, 'Would you read this up here?' and it said 'NC', and I said, 'Do you know what that means?' and he said, 'No', and I said, 'It means no charge.' I flipped it through one page after the next with no charge written. He said, 'Dammit!' and he takes a chair and hurls it across the room, 'You can't do that. You fucking can't do that. You can't do that.' Because what he had was a behavioural experience that was entirely inconsistent with his way of looking at his life since he was a little child. Now is that Socratic questioning? Is that a behavioural experiment? I'm not quite sure, but basically when he said … as soon as the words came out of his mouth, 'You don't care for me, it's only about the money', I knew where we had to go. But that's where these things all blend in together. Where the sort of questioning and looking for the strategic point, you know what I mean?

Christine Padesky. When I'm advising people about how to get better at using Socratic dialogue and guided discovery in therapy, one of the things that I emphasise the most is having a genuine curiosity, because I think curiosity — genuine curiosity on the part of the therapist — is often the best predictor of how good a therapist is going to be at using Socratic processes. I would disagree with one aspect of what you said Mark, because you said 'We know where we're going'. And I think that sometimes we do have a sense of where we are going but I think that it's a dangerous trap if, as therapists, if we have too much in our minds, in the sense that we know where we're going.

Mark Reinecke. I think you're right. I mean, I don't mean to overplay it. I was talking about this once at another conference or something and somebody said, *How did you know to do that?* And I was like, *I'm not sure where that insight came from that in that moment this was the place to intervene.* And that's why I think I view it as a somewhat sense of where you're going. It's not random floating around.

Christine Padesky. See, the way I would think about it — and I want to pick up on Chris' comment earlier about how these methods look different in application to different clinical issues — is that I think there's a combination of genuine curiosity combined with our knowledge of the evidence base and empirical findings about different disorders, and when we put those two things together it does often give us some directional pursuit. But, we have to also be clear-headed and true scientists, which means that when we ask a question and we are informed by the empirical literature, we have an expectation that a certain answer is going to come back; but we have to be very open and happy and even excited when a very unexpected answer comes back that maybe does not fit with our models. We have to be willing to equally be happy to pursue that. I don't believe that every belief that clients have that causes them distress are false beliefs or unsupported beliefs. So we have to have an openness to really explore with our clients their belief systems and what they think is working or not.

I think, Chris, the reason that Socratic methods look so different in their different applications has to do a lot with the different disorders. If you take someone who is depressed, they have got a pervasive negative thinking system, so using Socratic methods to test out ideas, looking for evidence that supports and doesn't support in a broad-based way makes a lot of sense. But if you get someone with panic disorder, where we have so much evidence that it is catastrophic misinterpretation of particular

sensations then you can, in a very targeted way, go at testing those particular sensations and beliefs and you don't have to do a broad-based Socratic method. In fact, you would be wasting time if you did so — you'd be much better off just going for testing the central misinterpretations. In eating disorders I have had very limited experience, but I think of one client I worked with. When I started working with her she was a 14-year-old girl who was just out of emergency care. She was about 48 pounds and she was a very low body weight. With someone who is so low in body weight and has organic problems related to low body weight, to try and engage with Socratic dialogue with someone at that point of therapy would seem fruitless. I mean, she would not have been capable of it. Later in her treatment, as her body weight got up based on more behavioural eating changes and that sort of thing, we could engage her in it. So, I think our knowledge of what we are dealing with, combined with genuine human curiosity about this person's experience, combined with the knowledge of which strategies, whether targeted or more broad-based, are likely to help with this particular problem — all of those things are going on in the back of our minds as therapists when we are doing this.

Chris Fairburn. I completely agree with that but with the addition of something. I think that the use of Socratic dialogue or questioning is definitely influenced by the problem you are addressing, but also very much by the personality of the person who has got the problem. In my area of eating disorders, many people are perfectionists with low self-esteem. I think the way the therapy has evolved to help these people has been influenced by these personality characteristics as well as the psychopathology. It is the personality of the people you work with and interventions that suit them that influence the therapy that you deliver. This is why prescribing a single right way of doing cognitive therapy is a mistake.

Christine Padesky. Yes. We learn to work differently with different client populations. My early work was with depression — since it was the 1970s and that's all that we used cognitive therapy for in the 1970s, was depression! And one of the things I learned as a new therapist — new to cognitive therapy — when I would ask questions and get evidence that did not support depressive negative thinking, I would get really excited and I had a tendency to say, 'Oh so you have these experiences that show that you're not a completely worthless human being', and I would be all excited about that. When I did that, the clients would supervise me. They would say, 'Well, yes, I have those things but I don't usually do those most of the time', or 'I'm doing that less now'. By attending to that client feedback I learned, with depression in particular, it is really important when you get evidence that contradicts the negative beliefs that you as a therapist downplay the positive meaning of that evidence. So, if someone says to me, 'Well I'm … you know I'm a good bricklayer, that's something that I do well', then I might say, 'So on occasion you're able to do a pretty good job as a bricklayer.' I actually repeat back summaries that are less of a strong statement than they have made because I know when people are depressed they are constantly correcting what you say and I want them to be correcting me in the positive direction rather than the negative direction. If I say things positively they are going to correct in the negative direction. So I downplay it and have them correct me, 'Well actually I'm a pretty good bricklayer.' I then can accept their positive correction, 'Oh are you? Well, okay.' So I think we do learn and by listening to client feedback we can also learn,

as you say, whether it is an individual client issue or an across-the-board diagnostic issue. We learn ways to modify our approach to the client population we are working with.

Maree Teesson. Listening to our conversation where probably the ultimate aim for us, in particular in my area [addiction], is around non-judgmental approaches and about not looking uncomfortable when a person is talking to you. And I just worry . . . it is very difficult sometimes when you are talking to people about this, particularly people coming into the field to start to work in the area, that is a hugely difficult thing to do in the context of the environment that we are working in and our society and the issues around stigma. So, I feel like you have to be really aware about having that. So, holding that non-judgmental approach and not being uncomfortable when someone is explaining a trauma or explaining their drug use is very, very difficult.

Christine Padesky. What are some of the ways that you help the people that you are training? What are some of the ways that you help them hold that, because you have to hold that not just in your mind but you have to hold that non-verbally because clients are so sensitive to our — more sensitive — to our non-verbal behaviour . . .

Maree Teesson. So it's often attitude.

Christine Padesky. So how do you practise that? Do you role-play it?

Maree Teesson. We do, and we can do it. We have gotten fantastic results when we are analysing our controlled trials (e.g., Mills et al., 2012). People with multiple, difficult traumas, extensive drug use, they come through the other end of the trial and they do really well. Our biggest agenda is probably getting people to deliver the therapy because they thought that if they dealt with the person's trauma it would lead to increased drug use; for example, how do we do that outside of our context? I don't know. It's a real challenge. When we are asked what advice we would offer colleagues, I think about the context in which they work in, and the support that they have, and the support is not always there — and I don't know how eating disorders clinicians cope with that. Is that different?

Chris Fairburn. No, it's exactly the same. I have got a tangential question, which I don't know if it's the right time or place.

Nikolaos Kazantzis. It is.

Chris Fairburn. I am also very interested in self-help, guided self-help and internet-based treatments based on cognitive therapy. In these treatments, there is a therapeutic relationship created somehow — in a book, through its writing style, pace and use of words. I wonder whether the more successful books or programs somehow create a Socratic dialogue within the user. Have any of you got thoughts about that?

Mark Reinecke. We have been doing some research with teenagers. It's an internet-based CBT for depression for adolescents. Now, I can't speak to the Socratic dialogue question. I just don't know, but I did come across when we were preparing, a very cool finding where it turns out — at least in adults — that they develop a therapeutic alliance with their software program. They like it, *it understands me*. They know that they are talking to a computer, but in fact — I thought this was a very interesting

finding — the strength of the therapeutic alliance with the computer is linked, is correlated — I won't say caused — but it is correlated with treatment response, with clinical improvement. Now, what that means, I'm not sure. As I was mentioning, I think that it's that we are sort of attuned as individuals to align with individuals who are helpful to us, and now we have brought software into it as well.

Christine Padesky. Of course, we don't know. Research shows that therapy alliance is predictive of good therapy outcome (Raue & Goldfried, 1994), but other research shows that when you start to improve in therapy, your alliance all of a sudden becomes positive (DeRubeis, Brotman, & Gibbons, 2005), perhaps because we feel good about a therapist and relationship that helps us.

Mark Reinecke. I think we really have to rethink what we mean by a therapeutic rapport/alliance and its relationship to outcome. It's not this simple linear model that we have all been taught about in school. It's more complex than that.

Christine Padesky. I do think though your question is intriguing, Chris. When Dennis and I wrote *Mind Over Mood* we were helped by the fact that we were teaching therapists how to use thought records (c.f. Greenberger & Padesky, 1995; Padesky & Greenberger, 1995). I really think that the thought record is a method of teaching Socratic dialogue to clients — particularly this seven-column thought record as I developed it. We provided a series of questions in the book to help fill out each column so that people could identify key situations, what their emotional responses are, what automatic thoughts and images they had, figure out the hot thought . . . and then questions to help them search for evidence that supports and does not support their thought. So, in fact, we were teaching the Socratic process to clients. And what we found clinically is that when people go through that written process enough times they actually then incorporate and learn a thinking process. It's like their brain learns a new wiring. After people have done a number of written thought records — for some people it might be 15 times, other people it might be 20 times or 30 times — after people have done enough written thought records they do find themselves automatically thinking the questions. When they have a negative thought they find themselves automatically saying, *Well hang on, what's the evidence?* And once people have that automatic questioning response they may no longer need to actually write it out because they actually are leaning a new way of thinking about things. And I do think that that's part and parcel to what can be helpful for reducing relapse and remission.

There was one study done — and it's the only study I know of — where they did look at people in a group depression treatment program. It was done by Dr Guillem Feixas many years ago, I think in the early 80s, and they found that depressed clients who could fill out a thought record without a therapist's help and have a mood shift, those were the clients who were least likely to relapse. So, that's one of the only bits of evidence I know where actually learning those question skills for oneself in a depression has some value in terms of keeping one well over time (c.f. Neimeyer & Feixas, 1990; Neimeyer, Kazantzis, Kassler, Baker, & Fletcher, 2008).

Nikolaos Kazantzis. It has been a really interesting discussion to listen to, and one of the threads that has been present is the role of the therapist, and I am wondering if we could unpack that a little more now.

CBT involves many useful behavioural and cognitively focused interventions, but it is the empirical way in which we collaborate with our clients that ultimately determines their utility. And when we talk about collaborating in an empirical way we are talking about using the client's unique experience to gauge the effectiveness of our interventions. So this is how we tailor our therapy. I think what the panel is talking about is this same process of tailoring and ensuring that the processes are guided by the client's experience — that's certainly relevant for Socratic dialogue and guided discovery. If we are hoping that our patients, as we have been speaking about here, find themselves spontaneously, independently working through a thought record or a questioning process, I wonder how their role in that process might change over time? And if we are asking the question as therapists, doesn't that mean we are taking an active role? So, if our goal is to depend less on our involvement/our influence, I am wondering what it looks like in the course of therapy when clients eventually take the lead in the questioning process of a session?

The specific questions I would like to offer the panel to consider are:

1. What does it say about our role as therapists if we centre a process of discovery in logic or general principle?
2. What does it say about our role as therapists if we direct the client to consider just one perspective, or imply that there's one correct and one true answer?
3. What does it say about our role as therapists if we attempt to impart information, to correct, to dispute, or to change the client's mind?

Chris Fairburn. I'll pick this one up because I have zero problem with imparting information! I think it's one of our responsibilities rather than something that we should hide from. Certainly, in my area, most of my clients hold misconceptions that they have acquired through the media and through years of reading magazine articles etcetera. For them, reliable information is needed and of value. I see it as one of our responsibilities to inform people about some things. On the other hand, we then have to discuss, have a dialogue, to help them think through implications of this information. Not to provide this information would be an error. So for me, providing information at the right time and in the right way with a psychological context to it, is part of good therapy.

Christine Padesky. I would agree with you Chris and I think one of the misconceptions people have about my own work, because I have done so much teaching about Socratic methods, is that people then assume that I am using Socratic methods 100% of the time in the therapy session and that would just be unruly and unnecessary. As I said, psychotherapy is a learning situation and you are trying to figure out the best way to help your client learn. There is certainly lots of information and clients are just fascinated to get the information, so if there's information that can be just straight out given, then you want to straight out give the information in a helpful way and in doses and language that the client can understand. Where Socratic method comes in is when clients have beliefs that interfere with their willingness or ability to take up that information, or when they have beliefs that are quite contradictory to the information. When you're testing out closely held client beliefs then I think Socratic methods are often the best way to go to think about, *What is the information the client's not seeing? What questions or experiments can we do to bring that information out into the room? How can we then look at it together in a curious way, having built alliance with the*

client? Say, 'Well gee, what do we make of this? You strongly believe this and yet we've just done this experiment and this is what happened and yet you predicted this other thing would happen but it didn't happen. How are we to understand this?' So the Socratic method is brought to the fore when you have client beliefs that are barriers to progress and that, of course, happens all the time. I often say that 'no one comes to therapy for lack of good advice in their life', so it's not that people haven't been told, you know, *Eat a little bit more and you'll feel better* or *Get dressed and you'll feel better about yourself*. It's not that people haven't been told that. So there are certain things you can't just tell people with good effects. So the things you can tell people and educate them on that they can take on board, by all means, just tell them those things and have that benefit. But then there are those other things that, because they run contrary to tightly held client beliefs, the client can't take on board. That's when I think the Socratic method is most valuable.

Maree Teesson. Listening to you Christine, it struck me that I felt slightly overwhelmed about how much knowledge and information I would need to have and be confident in. I mean, it's sort of more a question than . . . do we have to specialise or can we be broad because the person coming to us is going to be quite complex, so how do we juggle that? How do we balance that?

Christine Padesky. Well, I really don't think there's a lot of information that we need to have, and because I do a lot of teaching to people who are new to CBT, it's one of the things that I am very sensitive to. What I usually recommend that people do is pick one area that they try to learn about first and try to learn the CBT skills and apply them to that one area. As you gradually read and learn, add to that knowledge. Luckily though, there are some fundamental things that permeate all the CBT applications and so, once you learn the processes of using guided discovery and Socratic method, once you begin to develop a library of information, it gradually comes together. For example, I do a lot of consultation with therapists and they present cases where I know nothing about that case or diagnosis, but luckily we know ways of gathering information. There are good books and articles that we can access . . . it is a process. It takes time. But I think if you follow the methods of being curious and collaborating and using guided discovery with your clients and keeping an open mind, you can actually get quite far with those generic skills. And then if you refine your knowledge base, it's more specific. If you find yourself working a lot with substance abuse or eating disorders or depression or certain anxiety disorders and you refine your knowledge in those areas you can then become better and better at it.

Concluding Comments

One of the useful conclusions that emerged from this expert panel discussion is that Socratic dialogue is just one means of facilitating new ideas and discovery. Although the phrase 'guided discovery' is usually paired with Socratic dialogue, all interventions in CBT are designed to facilitate change in thinking, and put differently, all techniques are discovery orientated. That is, all techniques can be understood as requiring an understanding of the client's concern, exploring information (new or existing) related to the concern, and then facilitating and evaluating the usefulness of the discovery (see Figure 1).

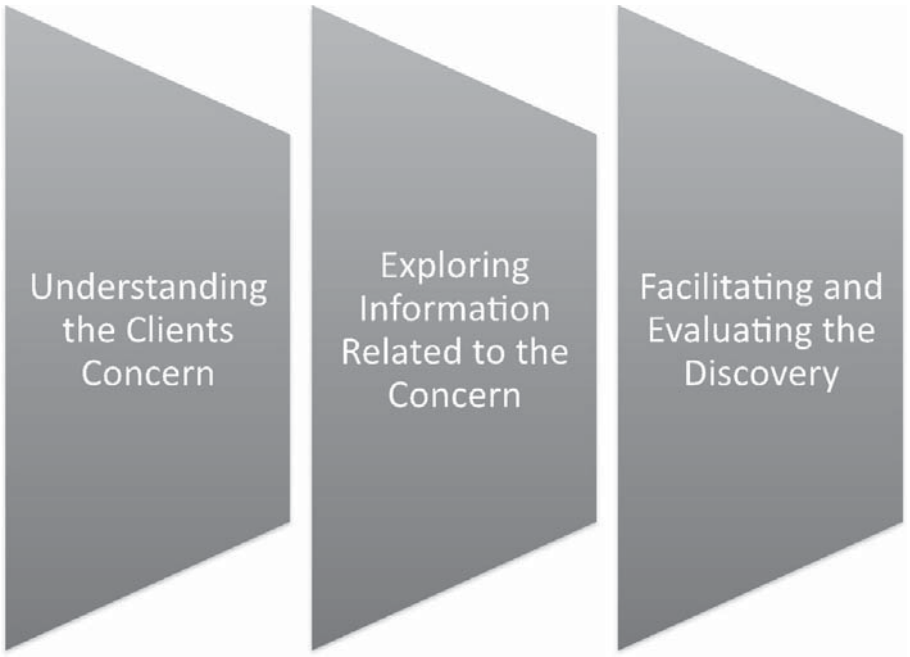

FIGURE 1

Major process elements of facilitating discovery in CBT.

A second useful conclusion has been that questioning is just one form of dialogue that can be useful when adopting a Socratic method in CBT. Holding in mind that questions are to be used alongside reflections, summaries, and suggestions is important as it reminds the clinician that the process can be one of genuine discovery from the client (i.e., rather than a process of leading the client to a predetermined point). Good discovery-orientated questions include: *What do you make of this? How do you put this together with your belief? What do you make of this? How do you put this? How do you put these ideas together?* and noticeably do not influence the potential for a particular conclusion.

A third useful conclusion is that being 'disputatious' as a therapist is contrary to the specific form of therapeutic relationship espoused within Beckian CBT. Along with facilitating client self-questioning, A.T. Beck and colleagues defined the therapeutic relationship as one strong in active client and therapist involvement (also known as collaboration) and in which the content of discussion is centred in the client's experience (also known as empiricism; see discussion in Kazantzis, Tee, Dattilio, & Dobson, 2013). A range of views was expressed on the panel about the extent to which the process was one that would ideally strategically lead a client to a particular point or facilitate an entirely unexpected discovery that the therapist did not necessarily have in mind. It remains an empirical question whether an obviously open approach on the therapist's behalf makes a measurable difference in terms of other process or outcomes in CBT. We also don't know when and how much a therapist can helpfully influence the discovery in some sessions with some clients. Experts noted the potential for

differences by clinical disorder, as well as client attributes, such as their suitability for short-term CBT (i.e., evidence of strong relationship building, personal responsibility for change, access to cognitions).

Development and evaluation of a comprehensive measure of therapist competence in the facilitation of discoveries using Socratic dialogue is currently being undertaken as part of the work at the Cognitive Behavior Therapy Research Unit at La Trobe University, Australia.[11] One goal of the research is to establish a more refined assessment of therapist competence in using Socratic dialogue to assist in the training and supervision of therapists in this core therapeutic process. Another primary goal is to enable prospective treatment outcome research to evaluate whether a more comprehensive assessment of therapist competence will more meaningfully and significantly predict therapy outcomes, even when overarching therapist competence in practicing CBT (i.e., as assessed by the Young and A.T. Beck, 1980, Cognitive Therapy Rating Scale) and other central relational processes such as working alliance have been taken into account.

As is always the case when gathering colleagues together for a discussion, it has been a wonderful experience to participate in the panel and to contribute to this article on the use of Socratic dialogue to facilitate discovery in CBT. As this article attests, the panel discussion was enjoyable and light hearted, and served as a good model for witnessing the power of good questions, and how new ideas and perspectives can arise from questions and discussion. The panelists demonstrated their considerable expertise as theoreticians, researchers, clinicians, and trainers in this discussion, and their ideas will likely provide many readers with a new perspective on their therapeutic relationships with clients. In reaching this point, the only thing left to do is extend a sincere thank you to Christopher, Christine, Mark, and Maree for giving so generously of their time and expertise on this important topic. It is valuable to have their ideas on Socratic dialogue and guided discovery represented here.

Endnote

[1] The lead author is conducting the Socratic dialogue project in collaboration with advanced doctoral trainee Matthew E. Stuckey from the La Trobe University Cognitive Behavior Therapy Research Unit. Matt is gratefully acknowledged for research assistance work contributing to the literature review represented in this article.

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