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ORIGINAL ARTICLE

The Socratic Method in Cognitive Behavioural Therapy: A Narrative Review

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Abstract The Socratic Method has been described as an important component of CBT interventions yet an empirical case for its use has not been made. The objective of this paper is to review the role of the Socratic Method in CBT in four stages. First, a review of the literature describes how the Socratic Method is applied and defined within CBT, with assumptions regarding its proposed benefits identified. Second, a review of empirical literature demonstrates that multiple challenges to the evaluation of the Socratic Method exist and that no direct evidence supports the premise that it is beneficial in CBT. Evidence is examined which may suggest why the Socratic Method could be beneficial in therapy. Finally, the hypothesised function of the Socratic Method within therapy is discussed in reference to the Interacting Cognitive Subsystems framework. A number of avenues for future research are proposed in order to determine whether this potentially valuable therapeutic component contributes to the efficacy of CBT.

Keywords Cognitive therapy/CBT · Socratic dialogue · Socratic Method · Socratic questioning · Guided discovery

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Introduction

The Socratic Method is considered to be an important component of Cognitive Behavioural Therapy (CBT) interventions (e.g. Ehlers et al. 2005). The approach has been described as a "cornerstone" (Padesky 1993) of CBT and as an essential core competency of CBT therapists (Roth and Pilling 2007). Yet despite the purported significance of the Socratic Method, it has been subject to relatively little description or empirical investigation (Overholser 2011). The Socratic Method has been defined as "a method of guided discovery in which the therapist asks a series of carefully sequenced questions to help define problems, assist in the identification of thoughts and beliefs, examine the meaning of events, or assess the ramifications of particular thoughts or behaviours" (Beck and Dozois 2011, p. 401).

Through employing the Socratic Method, CBT therapists aim to help patients become aware of and modify processes involved in the maintenance of their difficulties; experience a shift in perspective and/or affect; and learn a method of re-evaluating thoughts and information (Padesky and Beck 2003). The fundamental rationale for employing this technique within CBT is predicated on the assumption that engaging in reflective questioning will be more helpful to patients than an approach where the therapist adopts a didactic approach (Padesky 1993). However, it is currently unclear what, if any, impact the Socratic Method has on improvement in symptoms as a result of treatment.

The Role of the Socratic Method in CBT Treatment Efficacy

Diagnosis-specific CBT interventions have proven to be efficacious treatments for a wide variety of psychological

disorders (e.g., Hofmann and Smits 2008) and the Socratic Method is involved in the delivery of many of these treatment protocols (e.g. Robichaud and Dugas 2006). CBT is the treatment of choice for a number of psychological disorders (e.g. NICE 2013; American Psychiatric Association 2009). The efficacy of CBT has been demonstrated within randomised controlled trials (RCT's) which assess whether a CBT treatment package results in significant symptomatic change. Consequently, it is not possible to know to what extent the efficacy of these treatments reflects the effect of therapist competences (e.g. therapeutic alliance or therapist questioning style; Roth and Pilling 2007), the behavioural and cognitive techniques designed to address disorder-specific maintenance processes (Clark 2004) or a complex interaction amongst these variables. Therefore the therapeutic benefit of utilising the Socratic Method cannot be derived from this outcome research.

The utility of certain CBT treatment components have been evaluated within dismantling studies, wherein the effects of a specific intervention component are isolated and assessed (e.g., Schmidt et al. 2000). However, this has not been the case for the Socratic Method and the empirical evaluation of Socratic approaches in CBT have been described as "non-existent" (p. 201, Hoffart et al. 2002). Consequently, reviewing the role of the Socratic Method in CBT is imperative, as it is not clear whether this approach, which is assumed to be of therapeutic value, is in fact a necessary component of CBT.

Challenges to the Use of the Socratic Method in CBT

Some researchers have questioned whether the Socratic Method is in fact an essential component of CBT. Fairburn (2008) suggests that the goals of the Socratic Method in treatment can be met by "simpler and more efficient means" (p. 28). However, many other CBT therapists would see the Socratic Method as being a cornerstone to the effective delivery of CBT. Clearly, further research is required to evaluate this. The application of the Socratic Method is inherently more time-consuming than a non-Socratic approach that primarily employs a didactic style. Therefore, the Socratic Method should provide therapeutic benefit in order to justify its utilisation within CBT. Similarly, significant time is given to developing therapist skills in the Socratic Method and it is considered to be a clinical skill that is technically hard to master (DeRubeis et al. 2009). Achieving competency in the use of Socratic questioning is considered a fundamental goal of cognitive therapy training (e.g. Liness and Muston 2011).

The importance of establishing whether an intervention which incorporates the Socratic Method is preferable to one that does not is further highlighted when considering existing evidence-based interventions. Publications describing the conduct and evaluation of a number of efficacious CBT interventions make no explicit mention of utilizing the Socratic Method within these treatments (e.g., Clark et al. 1994, 2003) making the role and importance of the Socratic Method in such interventions unclear. Whilst the Socratic Method has been noted in the delivery of efficacious treatments, the model of evaluation of CBT interventions means that it is not possible to determine whether the Socratic Method contributes to the overall effectiveness of treatment. This is an issue relevant to a number of CBT treatment components (Longmore and Worrell 2007). However, when faced with the time-limited nature of therapy and the organisational pressures of clinical reality, a pragmatic clinician may choose to limit the use of a time-consuming and technically difficult technique unless there is a clear rationale for its utility.

Further questions are raised regarding the role of the Socratic Method when considering guided-self-help and technology-assisted CBT which have efficacy in the treatment of anxiety and depression (Andrews et al. 2010). These interventions may be argued to reflect a number of aspects of the Socratic Method such as encouraging patients to synthesise information and generate conclusions. However, it is not clear to what extent these interventions mirror the processes targeted through use of the Socratic Method in individual therapy (Cavanagh and Millings 2013) or whether the idiosyncratic and context-dependent nature of the Socratic Method in face-to-face therapy can be captured in such media (Mason 2011).

Establishing the benefits of utilising the Socratic Method is essential in determining the most efficient way to deliver CBT and the relative importance of therapists developing proficiency in using this approach. If the Socratic Method is not clearly demonstrated to be an essential component of CBT then there is a risk that future CBT therapists may consider it as unnecessary. This could therefore lead therapists to neglect an approach which could contribute significantly to the efficacy of treatment. In addition, the Socratic Method has, to date, been poorly defined within the psychological therapy literature (Carey and Mullan 2004) and relatively little description of the procedural or structural framework for the delivery of the Socratic Method has taken place (Overholser 1993a).

No systematic review of the literature has been published which has described the role, definition and empirical investigation of the Socratic Method in CBT. The benefits of such a review would include delineating what evidence exists to support the assertion that employing the Socratic Method in CBT may be beneficial.

Aim of Review

The role of the Socratic Method in CBT will be reviewed in four stages. First, the role of the Socratic Method in CBT

will be described in addition to how it is applied and defined within cognitive therapy. Second, a review on the use of the Socratic Method in CBT will consider what evidence exists to support the premise that Socratic Method is beneficial. The review will then present a description of experimental literature which may contribute to an understanding of the benefits of the Socratic Method. Finally, the hypothesised function of the Socratic Method within therapy will be discussed in reference to the Interacting Cognitive Subsystems framework (Barnard and Teasdale 1991).

Search Strategy

A series of literature searches were conducted of title and abstract published between 1964 and 2014 through searching online databases (*Medline*, *Embase and PsychInfo electronic databases*) and key CBT journals (e.g. *Behavioural and Cognitive Psychotherapy*) using a combination of the following terms: *Socratic*, *Socratic questioning*, *Socratic Method*, *Socratic dialogue*, *guided discovery*, *cognitive therapy*, *cognitive behaviour therapy*, *CBT*, *cognitive restructuring*, *thought re-evaluation* and *mechanism of change.*

The Socratic Method

Aaron Beck emphasized "it is important to try to elicit from the patient what he is thinking rather than telling the patient what the therapist believes he is thinking" (Beck et al. 1979, p. 69). The Socratic Method takes its name from Socrates, the Greek Athenian philosopher who avoided the use of direct teaching and instead used enquiry to encourage students to reach their own conclusions and to question the truth of popular opinion (Kennerley 2007). Debate exists as to whether the nature and form of Socrates' questioning approach is entirely analogous to that employed within present-day psychological interventions (DeRubeis et al. 2009). However, the premise that questioning which allows the subject to reach their own conclusions will be more beneficial than direct information-giving is central to the rationale for the Socratic Method.

Defining the "Socratic Method": (i) Terminology

A universally accepted definition of the Socratic Method in CBT does not exist. Throughout the CBT literature the terms Socratic questioning, Socratic Method, Socratic dialogue and guided discovery have been used synonymously (e.g. Calvert and Palmer 2003; Westbrook et al. 2011) but distinctions have been suggested. Carey and Mullan (2004) suggest that a number of authors write as if the Socratic Method and Socratic questioning reflect different entities. However, many descriptions of "Socratic questioning" (e.g. Padesky 1993) are similar to descriptions of Socratic Method or dialogue. Although intimately linked with questioning, the Socratic Method in CBT incorporates more than direct enquiry and describes those verbal strategies which help patients to consider relevant information which may be outside their current awareness (Beck et al. 1979) and reach new perspectives (Kennerley 2007). James et al. (2010) have described Socratic questions as "an umbrella term for a method in which questions are used to clarify meaning, elicit emotion and consequences, as well as to gradually create insight or explore alternative actions" (p. 85). This broad description is consistent with many descriptions of the Socratic Method within CBT (e.g. Beck et al. 1979; Overholser 2011; Padesky 1993; Wells 1997; Westbrook et al. 2011).

It must be noted that throughout the wider psychotherapeutic literature a wide variety of additional terms have been applied to Socratic approaches such as Socratic disputation (Bishop and Fish 1999) and Socratic rhetoric (Frusha 2002). Whilst these terms may share conceptual overlap with the Socratic Method in CBT they suggest a confrontational approach to challenging unhelpful ideas, whereas the Socratic Method in CBT emphasises a non-confrontational approach (Beck et al. 1979). The Socratic Method in CBT has been suggested to adhere to the philosophy of *guided discovery* where clients are guided, in an open and curious manner, towards particular insights or discoveries (thereby *guided discovery*) which may or may not incorporate the Socratic Method (Kazantzis et al. 2014).

Based on a synthesis of the literature describing the Socratic Method in CBT (e.g. Beck et al. 1979; Overholser 2011; Padesky 1993; Wells 1997; Westbrook et al. 2011) the term "the Socratic Method" is defined within this review as; *verbal exploration* (*incorporating questioning*, *summaries and reflections on part of both patient and therapist*) *that helps patients become aware of*, *reflect upon and achieve insight regarding*, *a particular subject of discussion and which prompts patients to generate their own conclusions.* Where qualitative differences exist in any research describing the conduct of the Socratic Method, these shall be noted, though the lack of specificity regarding what constitutes the Socratic Method in CBT remains an inherent problem when evaluating the literature.

Defining the "Socratic Method": (ii) The Delivery of the Socratic Method in CBT

Description of the Socratic Method and its application in CBT has been relatively limited as compared to the wealth

of literature on specific CBT change techniques and theoretical cognitive behavioural models. Its use has been purported to be helpful throughout all stages of CBT (e.g., Westbrook et al. 2011), in exploring the content and meaning of patients' experience (Wells 1997), in the delivery of both cognitive and behavioural strategies (Veale 2008), and across individual and group treatment settings (Siemonsma et al. 2013).

Padesky (1993) has provided one of the few comprehensive descriptions of the Socratic Method. She outlined the importance of the Socratic Method as part of the process of *guided discovery* in CBT, in which the therapeutic dialogue should aim to help the patient consider all relevant information and explore alternative explanations rather than the therapist trying to argue for or convince patients of a specific conclusion. The subject of discussion is explored in an open, curious and empathic manner where, *informational questions*, *empathic listening* and *summaries* are used to help broaden the patient's perspective on a given issue before *analysing/synthesising* questions ask them to consider how this information informs their initial perspective (Padesky 1993).

This approach has been argued to promote the acquisition of abstract conceptual skills that help patients create distance from, and an ability to evaluate, distressing appraisals (Padesky 1993; Padesky and Beck 2003). Guided discovery has been purported to facilitate engagement, whereas pushing patients toward a conclusion where the therapist *knows the answer* may result in disengagement (Overholser 1987, 1993a). Despite being based largely on clinical observation rather than empirical evidence, Padesky's (1993) conceptualisation of the Socratic Method has become widely reported and espoused throughout the CBT literature (e.g. Westbrook et al. 2011). Indeed, this account has become integral in the description of therapist competence in the delivery of CBT (Roth and Pilling 2007).

One of the only other comprehensive accounts of the Socratic Method in CBT has been described by Overholser (1993a, b, 2011). Overholser proposed a description that is consistent with Padesky (1993), where the Socratic Method facilitates *inductive reasoning* (Overholser 1993b), the subject of discussion is explored through *systematic questioning* (Overholser 1993a, b) to form new, more adaptive generalisations through the exploration and systematic review of relevant information (Overholser 1993b, 2011). The exploration of *universal definitions* is used to broaden the client's view of salient terms and definitions (Overholser 1994) with the aim of arriving at a more informed and helpful perspective. Overholser also highlights that this process facilitates patients to develop a position of scrutiny where they view information as comprised of tentative beliefs and personal opinions rather than objective facts. As with Padesky's (1993) account, this structure was derived from Overholser's clinical observation rather than empirical investigation.

Whilst the definitions offered by Padesky and Overholser emphasise the process by which a particular cognition or concept is explored, the Socratic Method has a wider application. Kennerley (2007) suggests that the Socratic Method may refer to any question which the client has the ability to answer and which provokes an alternative perspective. It is important to acknowledge that the definition of the Socratic Method in CBT offered does not incorporate descriptions of the approach in other psychological therapies, in teaching or philosophical texts. Descriptions of the Socratic Method in CBT manuals and training syllabi in the last 20 years have been, in the vast majority, largely consistent with, or derived from, the approach described by Padesky (1993). Therefore the central reference point for the conduct of the Socratic Method in CBT does not reflect an empirically derived framework but instead was shaped by clinician opinion.

Assumptions Governing the Use of the Socratic Method

The primary rationale for employing the Socratic Method in CBT is predicated on one (often implicit) central assumption: the Socratic Method will lead to better therapeutic outcomes as compared to an approach which does not employ the Socratic Method within therapy (i.e. solely using non-Socratic approaches such as didactic information giving). It is therefore utilised under the premise that it is of greater value to patients to achieve insight and reach conclusions regarding a particular subject (e.g. the perception of a particular behaviour as being helpful) themselves as opposed to being directed to a specific conclusion by the therapist. A review of the literature identified five assumptions regarding the benefits of the Socratic Method, which include: (a) Reducing distress associated with unhelpful cognitions (e.g. Beck 2011); (b) Allowing patients to internalise the Socratic Method and develop skills in critical thinking in order to evaluate unhelpful cognitions (Padesky and Beck 2003); (c) Resulting in more "memorable and convincing" insights and conclusions (Westbrook et al. 2011, p. 139); (d) Increasing engagement and autonomy in therapy (Overholser 1987, 1993a); and through facilitating these processes, (e) Improving the outcome of CBT and reducing the likelihood of relapse. These assumptions were derived by listing all the stated benefits ascribed to utilising the Socratic Method which were identified within our review of the literature. These were then organized by grouping suggested outcomes which were adequately accounted for within other listed benefits [e.g. the Socratic Method facilitating patients'

insight was considered implicit within the assumptions (a) and (c) above]. These may not represent an exhaustive list of the benefits of the Socratic Method and were not empirically derived. Rather they represent our interpretation of the key benefits noted across descriptions of the Socratic Method. The evidence that exists for these assumptions will be considered below.

The Role and Function of the Socratic Method in CBT

The theoretical model which underlies CBT suggests that an individual's appraisal of a given stimulus or scenario may generate negative affect and a behavioural, physiological and cognitive response consistent with this appraisal and mood state (Harvey et al. 2004). For individuals with persistent distress, appraisals may reflect a process of misinterpretation and this distress may be maintained or exacerbated by the strategy employed in response to such cognition and emotion. A key aim of CBT is to help patients develop skills which allow the re-appraisal and modification of distressing cognitions, leading to a reduction in distress. The Socratic Method is used to encourage patients to re-evaluate their thinking and aims to help patients to consider their upsetting cognitions in relation to information that they have "closed off from scrutiny" (p. 29, Beck et al. 1993) and reach their own conclusions regarding the validity of the upsetting thought (DeRubeis et al. 2009). Such exploration might also be utilised for examining the function and consequences of a given behaviour. In exploring the validity of cognitions the Socratic Method has been suggested to help patients gain a perspective on cognitions which allows them to perceive their cognitions as not necessarily reflecting the truth (e.g. Beck 2011). The Socratic Method may also facilitate the patient focussing on facts relevant to their appraisal rather than reaching conclusions based on their affect, thereby attenuating the impact of emotional reasoning (Harvey et al. 2004).

Whilst the potential benefits of the Socratic Method have been elucidated, a comprehensive theoretical account of the processes by which it operates has not. At a basic level, pertinent (and potentially corrective) information and logical conclusions generated internally are believed to have greater subjective validity (Kennerley 2007). Self-determination theory suggests that when a decision to alter behaviour is experienced as being personally taken rather than being imposed, then this behavioural change may be more likely to endure (Ryan and Deci 2000). Furthermore, the theory suggests that through reaching subjective conclusions themselves, patients may be more likely to develop higher levels of intrinsic motivation to engage in change, motivation which may be more likely to lead to behaviour change than extrinsic motivational factors (Ryan and Deci 2000). It would therefore be useful for future research to determine if use of the Socratic Method leads to patients experiencing higher levels of intrinsic motivation.

In regards to its role in promoting cognitive change the Socratic Method involves pertinent information being brought into patients' awareness which may be subject to inductive and deductive reasoning processes (Overholser 1993a, b). Through this process patients may recognise and resolve logical inconsistencies and discrepancies in reasoning. Indeed there is evidence to suggest that when logical inconsistencies amongst interrelated beliefs become salient that these beliefs are modified to become more internally consistent (Henninger and Wyer 1976; Kardes et al. 2001). Therefore exploration using the Socratic Method may lead to a reduction in the subjective belief in a given maladaptive cognition and the generation and/or increased endorsement of an alternative cognition.

Whilst the cognitive model has specified the causal relationships amongst its components, the process through which cognitive change may occur has not been clearly specified (Rachman 1997). Nevertheless, a central principle on which CBT operates is that changes in cognitive processes will mediate symptom improvement (Haubert and Dobson 2007). Therefore the purported effects of promoting belief change in negative cognitions and an altered relationship with cognitive content through use of the Socratic Method is potentially of significant value within treatment. In support of this proposed mechanism of action, the monitoring and evaluation of distressing cognitions has been demonstrated to result in reductions in subjective distress and changes in the frequency and strength of belief in dysfunctional thoughts (e.g. Arnkoff 1986). There is also evidence that CBT results in substantial and enduring changes in cognition and depressive symptoms (e.g. Jarrett et al. 2007). These studies have not evaluated the role of the Socratic Method in facilitating this change. It could therefore be argued that the cognitive and symptomatic changes described could be achieved through more didactic means and are not something inherently linked to a Socratic approach.

As noted above, the Socratic Method is a verbal-based procedure and therefore may be most closely associated with cognitive work in CBT and, specifically, with the process of thought re-evaluation. The role and importance of cognitive strategies in CBT in general has been held up to scrutiny with some authors questioning their value (Longmore and Worrell 2007). However, the Socratic Method may be involved in the delivery of multiple elements of assessment and treatment, including in the planning, rationale and evaluation of behavioural techniques (Kennerley 2007). The optimal delivery of behavioural activation has been suggested to need to incorporate the

Socratic Method where "the patient is expected to be active and to try to generate solutions" (Veale 2008, p. 32). Therefore, whilst the Socratic Method has been widely discussed in reference to its value in promoting cognitive change, the potential value of the Socratic Method must also be considered over and above its use within cognitive restructuring. Notably, across both behavioural and cognitive strategies, the process through which the Socratic Method may operate has yet to be delineated or specified.

Challenges to the Evaluation of the Socratic Method in CBT

In order to evaluate the current evidence-base regarding the use of the Socratic Method a number of challenges to its application and assessment have to be considered.

The Differential Use of the Socratic Method Within Therapy

Whilst the Socratic Method has been suggested to be helpful throughout all the stages of treatment (Kennerley 2007), a purely Socratic approach is not advocated in CBT and effective questioning may involve switching between Socratic and non-Socratic dialogue (Overholser 1993a). Multiple question types may be used in CBT (James et al. 2010) and there is a place for directive and didactic style even in interventions employing the Socratic Method (Westbrook et al. 2011). Given the suggested importance of the Socratic Method it is perhaps surprising that across descriptions of CBT there is virtually no description of how and when a Socratic approach should be used. Consequently, it is unclear whether the Socratic Method is applied uniformly across CBT interventions. Indeed the term "CBT" in a singular form is a somewhat misleading label and the form and nature of cognitive therapy may have the potential to differ across diagnosis-specific protocols (Kazantzis et al. 2014).

The relative lack of any delineation of the components of the Socratic Method (Overholser 1993a) means that there is an impediment to clinicians learning to apply the Socratic Method. The adoption of Socratic or non-Socratic questioning styles is therefore dependent on clinician judgement, where experienced therapists are expected to operate according to "tacit procedural knowledge in asking what they perceive to be good questions" (Neenan 2009, p. 253). Such intuitive procedural knowledge and use of clinician judgement may be considered to be derived from individual clinical and training experiences as opposed to an empirically derived and replicable framework.

Similarly, it is unclear to what extent the philosophy of guided discovery is adhered to within CBT. Padesky (1993) suggests that therapists should employ the Socratic Method in a manner where they do not guide the patient to a pre-determined conclusion and the therapist does not know the conclusion that they wish the patient to reach. In contrast, Beck (2011) suggests that when an unhelpful belief is identified, therapists will formulate more adaptive beliefs that may be more appropriate before addressing the unhelpful belief. Consequently any Socratic evaluation of beliefs, in this manner, arguably does not completely fit with Padesky's notion of the therapist not knowing the conclusion that they wish the patient to reach. It has been suggested that a CBT therapist balances a desire to be curious and collaborative against actively guiding a patient to a particular conclusion (DeRubeis et al. 2009). The lack of a replicable framework means that the manner in which clinicians are trained to deliver the Socratic Method has the potential to vary significantly across research evaluating CBT interventions, training centres and individual clinicians. Furthermore, the degree to which therapists in published clinical trials of CBT have utilised the Socratic Method in therapy is unclear. Additionally, any study seeking to evaluate the Socratic Method in isolation may be limited in its generalizability due to the fact that there may be significant differences in how the Socratic Method is understood and applied across contexts. These pose significant barriers to the assessment of the role of the Socratic Method in CBT.

The Differential Use of the Socratic Method Across Patients

A consideration of who the Socratic Method will be helpful for is also problematic. CBT is effective for a wide range of psychiatric disorders, across which patients are likely to demonstrate a large diversity in their engagement with the questioning process due to differences in attention, motivation, executive functioning and memory (James et al. 2010). Qualitative differences will also exist in the nature of the appraisals which are problematic across specific disorders (Kazantzis et al. 2014). It has been suggested that when working with patients from different cultural backgrounds that a Socratic approach may be less helpful as it may be more likely to be interpreted as a criticism of their thinking (e.g., Naeem et al. 2010). There is no data to guide when and with whom to use Socratic Method. Consequently the Socratic Method cannot be considered a uniform construct applied in a unilateral fashion across patients and therapeutic tasks. This also presents a significant challenge to researching the approach.

The Assessment of the Socratic Method in CBT

A further challenge to the evaluation of the role of the Socratic Method is the lack of an adequate tool to assess the

use of the Socratic Method. The most widely used measures of assessing therapist competence in CBT training are the Cognitive Therapy Rating Scale (CTS; Young and Beck 1980) and the Cognitive Therapy Rating Scale-Revised (CTS-R; Blackburn et al. 2001). At present these are the only standardised measures which incorporate assessment of the use of the Socratic Method in as much as versions of each of the scales include an item on Guided Discovery. Despite establishing reliability across raters (e.g. Blackburn et al. 2001), these scales fail to assess the different components of the Socratic Method or how it is differentially applied across individuals, cognitions, or the different stages of the session. For example, the CTS-R asks the assessor to rate a therapist on *Guided Discovery* on a sliding scale from 0—"No attempt at guided discovery (e.g. hectoring and lecturing)" to 6—"Excellent guided discovery leading to a deep patient understanding…" (Blackburn et al. 2000, p. 11). As a measure of the competent delivery of the Socratic Method the CTS-R can be seen as lacking sensitivity, where the perceived appropriateness of its use has the potential to vary greatly across assessors.

The lack of a measure which offers a fine-grained evaluation of the use of the Socratic Method is inextricably linked to the poor delineation of the structural and procedural components of the approach. Consequently, research into the use of the Socratic Method in CBT takes place within a context where an adequate tool to evaluate its application across therapeutic scenarios does not exist. It is therefore important to develop a measure of the Socratic Method and to try to determine how and when it is beneficial to apply.

Empirical Investigation of the Socratic Method in CBT

Results of Literature Review

There was no research identified which evaluated the impact of the Socratic Method on belief change, subjective distress, retention of information, acquisition of skills or patient engagement as part of a CBT intervention or through direct manipulation of Socratic/Non-Socratic conditions. The only pertinent research identified relates to the impact of therapist competence on therapeutic outcome, an analysis of the structure of the Socratic Method in cognitive restructuring and an investigation of patient engagement and observer perception of a Socratic approach.

The Socratic Method and Therapeutic Outcome

Whilst there have been a number of studies investigating therapist competence and treatment outcome in CBT (for review see Rakovshik and McManus 2010), there is little research examining whether the Socratic Method has an impact on treatment outcome. The studies that have examined therapist competence and treatment outcome have typically used the CTS without looking at the specific component of Guided Discovery. Trepka et al. (2004) carried out an investigation of Therapist Competence (as measured by the CTS) Therapeutic Alliance and outcome of cognitive therapy for depression. The study found that therapist competence was related to outcome and that items coding for "Specific CBT Techniques" (Guided Discovery, Conceptualization, Cognitive Focus, Cognitive Techniques, Behavioural Techniques, Homework) were significantly correlated with final patient score on self-report measures of depression—i.e., patients achieved better outcomes after working with therapists who scored higher on the CTS items looking at specific CBT techniques (which included Guided Discovery). In contrast, Shaw and colleagues (Shaw et al. 1999) found that the structural components of the CTS (Feedback, Understanding, Interpersonal effectiveness, and Collaboration comprising the *Structure* subscale) were related to whether patients demonstrated clinically significant improvement on depression measures, but did not find a similar relationship with outcome for the CBT Skill subscale. Whether guided discovery played any role in treatment outcome cannot be determined from this research. Strunk et al. (2010) examined therapist CTS competence ratings in the treatment of sixty patients with cognitive therapy for depression. They found that overall competence predicted session-to-session symptom change in therapy. Specific items were found to significantly predict symptom change (e.g. Agenda, Focusing on Key Cognitions or Behaviours) but, notably, the "Guided Discovery" item was not found to be a significant predictor of symptom change.

Only one study was identified which explicitly evaluated the role of guided discovery on therapeutic outcome. Hoffart et al. (2002) conducted a process-outcome study which evaluated the treatment of 35 patients with Panic Disorder and/or Agoraphobia and DSM-IV (APA 1994) Cluster C personality traits. Treatment involved an 11-week inpatient program which incorporated Clark et al.'s (1994) treatment of Panic Disorder and Young's (1990) schema-focused approach. Measures included emotional distress, schema belief, patient self-understanding, experience of therapist empathy, and expert observer ratings of patient understanding and therapist use of guided discovery (using the CTS). The authors reported that they found no indications that therapist use of guided discovery had an impact on the assessed outcome measures. The failure to detect any impact of guided discovery is noteworthy given the scarcity of reported investigation of the construct. However, a number of factors limit the

generalizability of these results. First, the small sample size may have limited the ability to detect significant interactions. Second, as acknowledged by the authors, overall treatment outcome was somewhat attenuated as compared to outcome of reported effect sizes for the treatment of Panic Disorder or Personality Disorder, meaning that the modest outcomes may have limited the opportunity for the detection of effects of guided discovery on outcome. Third, observer ratings of the conduct of therapy were consistently rated as being delivered with moderate-to-high competence—which suggests that regardless of the extent to which therapists were engaging clients in the Socratic Method, they were consistently doing this at a '*good enough*' level. Therefore any therapeutic benefits of the Socratic Method may have been present across all patients.

As part of the review of the literature, RCT's which evaluated the efficacy of CBT in the treatment of psychological disorders were reviewed. We were unable to identify any which reported evaluating the impact of the Socratic Method on treatment outcome. The failure to measure the use of the Socratic Method across RCT's means that it is not possible to establish whether this "core" component of CBT interventions (Harvey et al. 2004) plays any role in mediating treatment outcome, or if it impacts upon other factors which may influence outcome.

The Structure of the Socratic Method

There has been little clear procedural description of the Socratic Method within CBT beyond that already described. Similarly, there has been little research which has attempted to systematically evaluate the structure or use of the Socratic Method in CBT. Froján-Parga et al. (2011) studied the verbal behaviour of six clinicians utilising the Socratic Method within cognitive restructuring when treating eight patients. They coded therapists' verbal behaviour based upon seven hypothetical functions related to behavioural operations and terms (Froján-Parga et al. 2009). The authors suggested that therapist verbalisations during the Socratic Method could be categorised as a series of functions: Discriminative, Elicitation, Reinforcement, Punishment, Instructional, Motivational and Informative verbalisations. Their analysis of the 18 segments of treatment sessions suggested that Socratic Method followed three stages: Start—The therapist decides to apply restructuring in response to a non-adaptive verbalisation and aims to challenge this through verbalizations. Course—The therapist provides alternatives and checks whether the client expresses the proposed alternatives. End—When the client emits the "target verbalisation" the therapist expresses approval assigns homework and/or summarizes previous information. Calero-Elvira et al. (2013) conducted an in-depth analysis of therapist and patient verbalisation during the Socratic Method and coded the verbal effectiveness of the dialogue. Their conclusions suggested that the analysis of the dialogue of a single therapist across seven clients was consistent with a process of "verbal shaping" whereby the therapist modifies the patient's "non-adaptive" verbal behaviour.

The extent to which this process can be generalised to the conduct of the Socratic Method in CBT across settings is unclear. First, the analysis refers only to cognitive restructuring and therefore segments of therapy where the therapist is actively promoting cognitive change and not client insight through the Socratic Method generally. Second, the coding framework used in the analysis presupposes the validity of a framework derived from behavioural operations principles to the function of the therapist's verbal behaviour within the Socratic Method. The coding framework is therefore unable to account for the extent to which the dialogue engages the patient's higher level reflective cognitive processes, and therefore the extent to which the patients' verbalisation reflect the generation of subjectively valid conclusions, or simply been shaped through verbal prompts. The latter would seem to deviate from the general principles of guided discovery. Clearly the opportunity to build upon this research to evaluate cognitive change in relation to therapist verbalisations and the therapeutic dialogue generally would be of significant value.

Patient Engagement and Perception of Questioning Style

No research was identified which explicitly aimed to examine patient engagement or perception of the Socratic Method in CBT. The only study of perception of questioning style in therapy identified was that of Bishop and Fish (1999). The study compared psychology trainee and undergraduate non-therapists' perception of psychotherapy analogues comparing three questioning styles: *Socratic Disputation* as part of Rational Emotive Behavioural Therapy; *Solution-Focused Questioning* and *Diagnostic Interviewing*. They found that all subjects rated solution focused questioning as more helpful than other approaches. Whilst this study did evaluate a form of Socratic methodology, the applicability of such findings to CBT is limited. This is because "Socratic disputation" incorporated "direct challenge of irrational beliefs" (Bishop and Fish 1999, p. 117). In contrast, the solution-focused questioning style involved the therapist and client attempting to "jointly create a perceptual and/or behavioural alternative to the problem" (Bishop and Fish 1999, p. 119). The latter description is more closely aligned with the Socratic Method and the principles of guided discovery and

collaborative empiricism outlined by Padesky and Beck respectively. Therefore any inferences for CBT that can be taken from this study are limited. A number of qualitative research studies have been carried out which have aimed to investigate patient experience of psychological interventions and CBT specifically (Hodgetts and Wright 2007). Perhaps surprisingly, within this research there is little to suggest whether patients find the Socratic Method to be a helpful or unhelpful aspect of therapy. This is despite the fact that patients have identified certain CBT techniques, which would be expected to incorporate use of the Socratic Method, as particularly helpful. These include "thought challenging" using a thought record in the treatment of depression (Clarke et al. 2004) or "learning to interpret experiences differentially through experiential learning practiced in therapy in the treatment of Social Phobia" (McManus et al. 2010). No direct qualitative evaluation of the Socratic Method was identified.

Evaluating the Purported Benefits of the Socratic Method and Areas for Future Research

The results of the literature review suggest that, at present, there is little direct empirical evidence to suggest whether the Socratic Method has any beneficial effect in CBT. However, the absence of this evidence does not show that it is not an essential component of CBT, rather it highlights the urgent need for research to address the importance of the Socratic Method in CBT. The review did not identify any direct evidence which supported the five assumptions regarding the benefits of the Socratic Method in CBT. The five assumptions will therefore be considered in terms of the broader research literature in terms of evidence that supports and/or undermines each assumption. Possible avenues for future research will be considered.

Assumption (a) Reducing Distress Associated with Unhelpful Cognitions

Although the Socratic Method in CBT has a scope beyond facilitating thought re-evaluation, the many descriptions of the approach focus upon its utility in the modification of maladaptive appraisals. A significant body of research has demonstrated that CBT results in cognitive change along with changes in depressive symptomology (e.g., Jarrett et al. 2007). However it remains to be determined whether the Socratic Method contributes to facilitating this change.

"*Cognitive reappraisal*" refers to the process of "reframing a negative emotional event such that the new understanding renders the event less aversive" (p. 269, Lieberman 2007). Reappraisal is a process central to the aims of the majority of CBT interventions and therefore one which the Socratic Method seeks to facilitate. Despite the centrality of reappraisal in CBT and evidence that it is an effective method of regulating negative affect (Goldin et al. 2012), there has been relatively little investigation of the impact of re-evaluating distressing cognitions within therapy. McManus et al. (2012) evaluated the impact of reappraising cognitions in a non-clinical sample with fears around physical contamination. They demonstrated that the re-evaluation of anxiety-provoking cognitions through completing a thought record (Greenberger and Padesky 1995), within a single 30-min intervention resulted in significant reductions in dysfunctional beliefs, anxiety and fear-related behaviour, as compared to a control condition. Christine Padesky has suggested that the use of seven-column thought records to explore the validity of cognitions may allow clients to internalize the Socratic Method (Kazantzis et al. 2014). Expanding on this point, Padesky suggested that the potential benefits of the Socratic Method, in generating belief change, can be seen in evidence that individual use of thought records as homework leads to improved outcomes in the treatment of depression (Kazantzis et al. 2014; Neimeyer et al. 2008). In summary the process of re-evaluation of cognitions can result in belief change and reduce distress, which will also affect future behaviour. The Socratic Method may therefore be hypothesised to facilitate belief change through encouraging the use of cognitive reappraisal. Whether the Socratic Method facilitates belief change is an important area for future research to explore.

Assumption (b) Allowing Patients to Internalise the Socratic Method and Develop Skills in Critical Thinking in Order to Evaluate Unhelpful Cognitions

The Socratic Method is argued to facilitate patients' ability to evaluate their cognitions in an objective manner (Beck and Dozois 2011). This critical standpoint may arguably be conceptualised as being reflected within individuals' use of cognitive reappraisal. There is provisional evidence to suggest that patients who undergo CBT for Social Anxiety Disorder achieve significant increases in their perceived ability to use cognitive reappraisal to regulate their emotion and this mediates symptom change (Goldin et al. 2012). Given that a goal of the Socratic Method is to facilitate the development of skills in re-evaluating distressing cognitions, this may be an important avenue through which the Socratic Method could be beneficial. A direction for future research is to evaluate whether using Socratic Method facilitates use of cognitive reappraisal and whether this leads to increases in patient well-being.

Critical thinking is a construct that has been variously described as involving the recognition of assumptions and values, the ability to reason and evaluate information in

order to draw conclusions and employ effective decision making (McMillan 1987). These are cognitive skills that CBT aims to facilitate through the Socratic Method. Evidence from educational settings suggests that critical thinking skills are better facilitated by the Socratic Method than didactic presentation of information (e.g. Yang et al. 2005). Future research should therefore evaluate whether the Socratic Method contributes to the development of critical thinking skills and if this is clinically beneficial.

Assumption (c) Resulting in More "Memorable and Convincing" Insights and Conclusions

Asking patients to engage in reflection and summarising of information may be hypothesised to lead to better recall of information. More in-depth processing at the time of encoding has been linked with increased recall (Craik 1983). Similarly, a large body of experimental literature has demonstrated that verbal information in the form of words or sentences are better recalled when items are self-generated than items which are presented to them (Lengenfelder et al. 2007; Slamecka and Graf 1978). Therefore, a therapeutic approach which emphasises patient summaries and their verbalisations of conclusions may be hypothesised to be more likely to harness this enhanced recall than a didactic approach.

Evidence from educational settings suggests that key components of the Socratic Method increase learning. For example, Socratic questioning in teaching leads to greater learning than didactic lectures (e.g. Rosé et al. 2001); reflection on the content of training leads to greater learning and utilisation of information than when reflection is absent (Bennett-Levy and Padesky 2014); and the understanding and acquisition of procedural skills is significantly improved by eliciting self-explanations as compared to individuals receiving explanations (e.g.; Chi et al. 1994). An area for future research is to evaluate whether asking clients to summarise information as part of the Socratic Method leads to better recollection of information discussed as compared to therapeutic dialogue where this is absent.

Assumption (d) Increasing Engagement and Autonomy in Therapy

A number of therapist and therapy variables have been implicated in being associated with client progress and therapeutic outcome in CBT. These include expectancy, specific therapy techniques, therapist communication style and the therapeutic alliance (Lambert and Barley 2001). Therapeutic alliance has been conceptualised as being dependent on patient and therapist agreement on therapeutic goals, the tasks to achieve those goals and on quality of the bond that develops between them (Keijsers et al. 2000) and has been demonstrated to be strongly associated with treatment outcome in CBT (e.g. Raue et al. 1993). The philosophy underlying the delivery of the Socratic Method would clearly potentiate the opportunity for patient and therapist to collaboratively develop therapeutic goals and for the rationale for any therapeutic tasks to be generated through discussion (and therefore shared). It might therefore be hypothesised that use of the Socratic Method could enhance the therapeutic alliance.

One area of research that may be particularly relevant to the Socratic Method is the investigation of therapist use of directive statements and perception of therapist as being directive. The Socratic Method involves collaboratively generating conclusions and developing a joint rationale for given tasks. Therefore interventions employing the Socratic Method would be expected to employ fewer directive statements. Motivational interviewing (MI; Miller and Rollnick 2009) is a collaborative, person-centered intervention which shares some of the features of the Socratic Method in CBT, including the collaborative exploration of the subject of discussion and an emphasis on patients reaching their own conclusions regarding this subject. A small body of evidence suggests that MI increases patient engagement (Longshore et al. 1999) and helps reduce resistance (Miller et al. 1993) in the treatment of substance abuse, suggesting that this therapeutic approach may be beneficial. Research within behavioural interventions has found both positive associations (Williams and Chambless 1990) and negative associations (Keijsers et al. 1995) between directive statements and treatment outcomes. Keijsers et al. (1995, 2000) suggest that a possible explanation for such inconsistent findings is due to timing of measurement, suggesting that directive statements and explanations may be more helpful (or unhelpful) to treatment outcome depending on the stage of therapy. Whilst inferences for the Socratic Method are extremely tentative, this again points to the notion that the Socratic Method (i.e. an approach which would attempt to effect change with minimal use of directive statements) may ideally be applied differentially across the course of therapy.

It has been suggested that in encouraging individuals to reach and state their own conclusions through the Socratic Method that they will be more engaged with the therapist and their progress within therapy (e.g. Overholser 1987, 1993a). Self-determination theory (e.g. Ryan and Deci 2000) has been used to highlight the value of the Socratic Method in promoting engagement within teaching (Yengin and Karahoca 2012). The rationale for this being that the Socratic Method satisfies individual need for autonomy and perceived competence, the conditions which self-determination theory posits will lead to promoting goal-directed intrinsic motivation. The potential value of this within

therapy is that through a Socratic approach, patients will be more motivated to engage in therapeutic tasks and undertake behavioural change.

A priority for evaluating the impact of the Socratic Method within treatment would therefore be to measure the impact of the approach on patient engagement within therapy. A first step may be to obtain detailed qualitative data on patients' subjective experience of the Socratic Method. It would seem reasonable to assume that the utility of the Socratic Method may vary across individuals and presenting problem and similarly it might seem reasonable to hypothesise that the impact of the Socratic Method on patient engagement and resistance may vary significantly across individual differences (e.g. personality characteristics, patient attitude towards therapy).

Assumption (e) Improving the Outcome of CBT and Reducing the Likelihood of Relapse

The factors which impact upon the long-term impact of CBT are not clearly understood. The suggested benefits of the preceding assumptions, if correct, would be expected to have the cumulative effect that the Socratic Method will lead to a better therapeutic outcome for clients than when this is not employed (i.e. through reduction in distress, high recall of key learning points from therapy and increased engagement). It may be hypothesised that the "internalisation" of the Socratic Method may help prevent relapse through the increased use of cognitive reappraisal and therefore this may be seen as a logical extension of assumption (b). As mentioned above, individual use of seven-column thought records as homework (argued to teach clients the Socratic Method; Kazantzis et al. 2014) results in improved post-treatment outcomes for clients with depression (Neimeyer et al. 2008). Additionally, it is hypothesised that the Socratic Method encourages collaboration within therapy and may enhance patients' sense that they are responsible for positive therapeutic changes—something suggested to enhance self-efficacy and reduce likelihood of relapse (Horvath and Greenberg 1994). However, until there is an efficient method of evaluating the nature of the Socratic Method within treatment and assessing the impact of this upon therapeutic outcome, this assumption is difficult to evaluate.

Proposed Model of the Impact of the Socratic Method in CBT

There are a number of processes that may be relevant to facilitating the proposed benefits of the Socratic Method in CBT but these have not been operationalised or evaluated. Based on the existing literature and theorised benefits of the Socratic Method, we propose a hypothesised model for the processes and outcomes which could be facilitated by the use of the Socratic Method in Fig. 1. The model reflects a synthesis of the literature described and is being used to highlight the potential areas in which the Socratic Method may be beneficial and therefore provide an outline for avenues for future research. In order to evaluate the various components described within the model experimental designs comparing Socratic versus non-Socratic conditions could be utilised to test the hypothesised impact of the Socratic Method on each of the outcomes outlined. More specifically, it would also be of significant interest to determine whether any particular component of the Socratic Method (e.g. use of analysing/synthesising questions, patients verbally summarising the information discussed) may be necessary to achieve any of the hypothesised effects. Similarly, conducting a detailed measurement of use of the Socratic Method over the course of therapy and evaluation of the impact of this upon therapeutic outcome (e.g. symptomatic change) is a priority.

A tentative inference drawn from the research reviewed might be that encouraging patients to have an active voice, to reach their own conclusions and to report their beliefs and understanding may be more likely to lead a number of benefits (e.g. the acquisition of cognitive affect-regulation skills, increased recall of therapy). A significant body of focused empirical research is needed in order to determine whether this is actually the case.

It must be noted that the model presented does not reflect a proposed mechanism-of-action for the operation of the Socratic Method, but rather an overview of what impact the Socratic Method may have within therapy. The process through which the Socratic Method operates in therapy remains to be clearly delineated and specifying a hypothesised mechanism-of-action must be considered an important area for development. The traditional Beckian cognitive model, whilst offering a compelling rationale for treatment, does not clearly specify processes through which the proposed effects of the Socratic Method can be clearly understood. It would therefore be useful to have a theory that could help to understand the role and effectiveness of the Socratic Method in CBT. A theoretical framework which may be used to provide some insight into the clinical utility of the Socratic Method is the Interacting Cognitive Subsystems (ICS) framework (Barnard and Teasdale 1991). The final part of this review will therefore consider how the ICS framework may help understand the benefits of the Socratic Method in CBT.

The Interacting Cognitive Subsystems Framework and the Socratic Method

The Interacting Cognitive Systems model can be used to understand cognition and the maintenance of distress (Barnard and Teasdale 1991). The model proposes nine

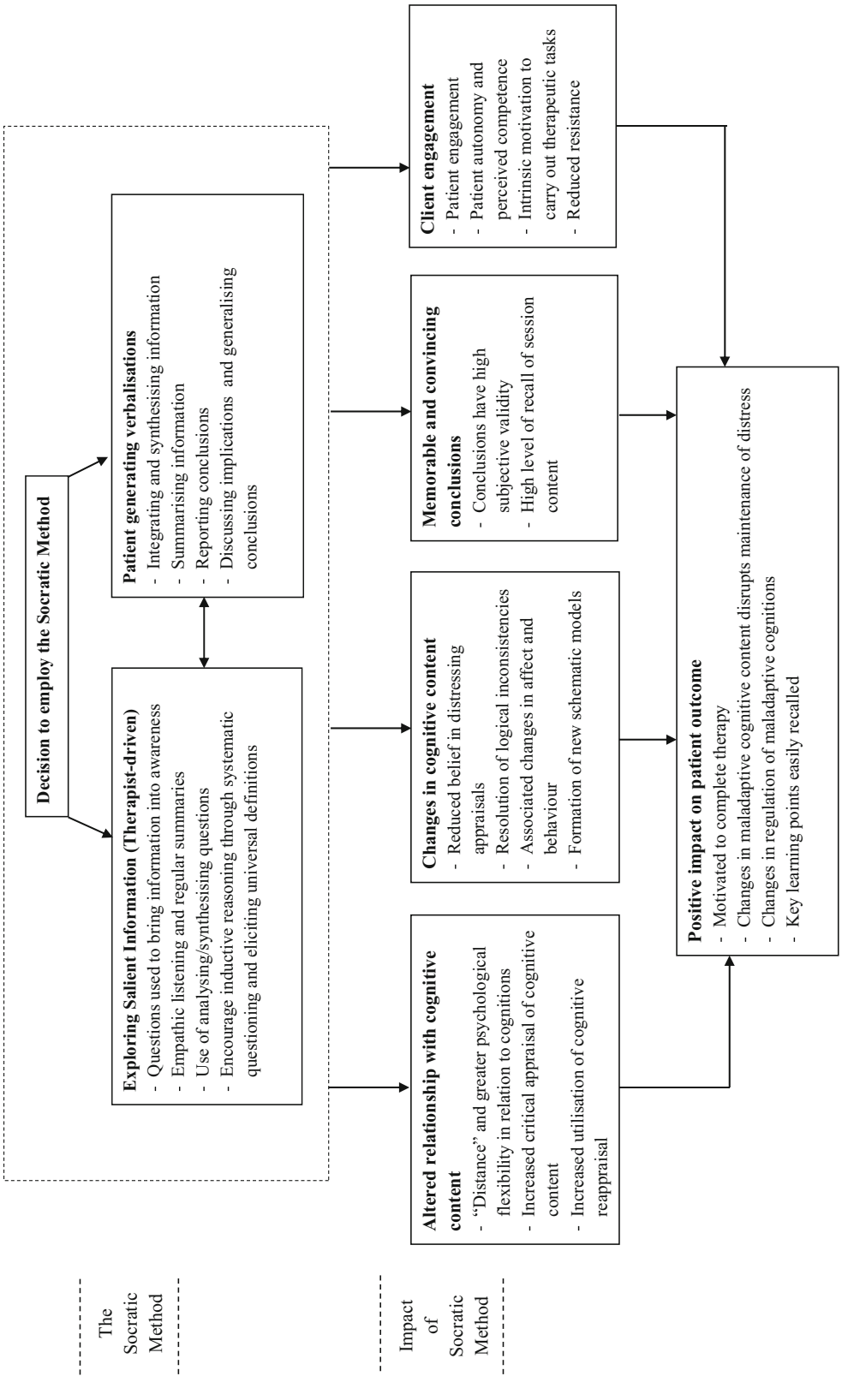

Fig. 1 A hypothesised model for the impact of the Socratic Method in CBT

subsystems which govern processes such as cognition, emotion, motor and sensory experience and has received some empirical support (e.g. Bennett-Levy 2003). Whilst the complexity of the model precludes an in-depth description, the way the ICS framework proposes that meaning is represented in human cognition is pertinent in understanding the Socratic Method in CBT.

The ICS model has similarities with the Beckian cognitive model in suggesting negative meaning may contribute to the maintenance of distress. However, in contrast to the Beckian model, the ICS framework specifies two distinct levels of meaning: *propositional* and *implicational* meaning. Fundamentally, this distinction separates "emotional" beliefs (implicational meaning) and "intellectual" beliefs (propositional meaning; Gumley et al. 1999), and therefore has significant implications for therapy. Propositional meaning refers to the verbal-based manner we mentally represent the relationships between concepts. Intellectual beliefs that involve propositional meaning, such as dysfunctional *if–then* assumptions (e.g. "if I don't perform *X* safety behaviour then there will be *Y* catastrophic outcome"), are a major focus in CBT. However, despite the emphasis on intellectual beliefs in CBT, the ICS model specifies that propositional meaning does not directly link with emotion or physiological responses. Instead, emotional and sensory processes are directly linked to holistic schematic models of cognitive-affective experience (Barnard 2009) which reflect *implicational* meaning. Such meaning is holistic as it does not code the relationship between specific concepts or objects (which would reflect propositional meaning) but maps a "felt sense" or implicit meaning such as ['somethings wrong'] or ['hopelessness'] (Bennett-Levy 2003). Implicational meaning cannot be easily considered in terms of being true or false (Gumley et al. 1999) and reflects the accumulation of sensory, affective and cognitive experiences and influences the way we behave and understand the world. The ICS model suggests that emotional distress is maintained at the level of implicational meaning (Teasdale 1993) and this is where change needs to occur to create any enduring emotional shift.

Teasdale (1996) noted that the distinction between propositional and implicational meaning highlights the importance of guided discovery. This is because the use of rational argument to invalidate specific upsetting thoughts (propositional meaning) will often fail to alter the emotional response, even where patients agree with this argument on an intellectual level, as specific verbal content does not affect the "felt sense" that is implicational meaning. Teasdale outlined that instead of challenging specific thoughts therapists need to help patients create "whole, coherent, alternative views at a schematic level" (i.e. in implicational meaning; Teasdale 1996, p. 44) to facilitate change.

In order to explore why the Socratic Method may be beneficial, we will consider the ICS conceptualisation of depression. According to the ICS model (e.g. Teasdale 1993), the maintenance of depression can be explained by the establishment of self-perpetuating processing where a "cognitive loop" occurs and cognitive subsystems become locked in processing a limited range of negative content (Teasdale 1996). Schematic models give rise to verbal-based thoughts within the propositional subsystem consistent with themes of implicational meaning and recurring patterns across propositional knowledge and sensory and emotional experience may either maintain this implicational meaning or give rise to the synthesis of new schema. For example, a schematic model may encode a theme of ["global-view-of-self-as-failure"], resulting in negative specific (propositional) meanings consistent with this content e.g. negative predictions about the self in the future, negative thoughts of self as a failure (Teasdale et al. 1995). This propositional meaning then feeds back into and maintains implicational meaning. Barnard (2009) also notes that when depressed, rumination persists and attention is directed towards propositional meanings resulting in distress being perpetuated as implicational meaning is not updated. The ICS model suggests that in order to achieve enduring emotional change the processes which maintain implicational meaning need to be updated, with the aim of forming more adaptive schematic models.

The ICS model suggests that fostering change in implicational meaning is best achieved by methods which will: (1) increase individual awareness of implicational meaning (Barnard 2009); (2) facilitate the recognition of patterns in propositional meaning which are not consistent with depressogenic schema (Gumley et al. 1999); (3) maximise experience (e.g. behavioural, attentional, interpersonal) inconsistent with depressogenic schema (Gumley et al. 1999) and (4) foster new mental models through instigating change in how patients relate to their thoughts, feelings and experience (Bennett-Levy 2003). The use of Socratic Method in CBT is hypothesised to facilitate each of these aims. For instance, when exploring a negative self-evaluative cognition such as "no one likes me" a clinician may choose to use reflective questioning to help the client explore the implications of this cognition, ask the patient to consider how this thought relates to similar cognitions and explore the underlying personal meaning (a generalised global statement about the self). This exploration facilitates insight into the client's general patterns of cognitions, global personal meaning and associated emotion, thereby increasing individual awareness of implicational meaning.

Similarly, the occurrence of a consistent pattern in propositional meaning has been suggested to increase access to implicational meaning more readily and maximise the opportunity to update this meaning (Gumley et al.

1999). When exploring the thought "no-one likes me", a clinician utilising the Socratic Method could help the client generate evidence that is both consistent and inconsistent with this appraisal before using synthesising questions to help the client generate new generalisations. Generalisations resulting from reflecting on patterns of propositional meaning may maximise the opportunity for these to be transformed and integrated into the implicational subsystem. The use of the Socratic Method to reappraise cognitions also allows patients to build repeated episodic representations where they are adopting an alternative relationship with thoughts and emotions e.g. ["thoughts-as-thoughts-and-not-facts"]. This repeated experience may create a meta-level change in how people conceptualise and respond to their cognitions and emotions and lead to the synthesis of new schema, which may be key to enduring emotional change (Bennett-Levy 2003). Didactic challenging of cognitions would seem less likely to achieve this (Teasdale 1993).

Furthermore, the use of the Socratic Method may effect implicational meaning indirectly in a manner that a non-Socratic approach may not. Specifically, the Socratic Method may engage patients in a dialogue which impacts on implicational meaning by providing experience inconsistent with depressogenic behaviour (i.e. how one behaves and responds in a manner consistent with implicational meaning). For example, a schematic model such as ["global-view-of-self-as-useless"] might give rise to a number of cognitive processes associated with negative self-evaluation, and interpersonal behaviour consistent with this felt-sense of being useless. This could manifest in withdrawal and passivity within interpersonal interactions, feelings of helplessness and negative cognitions (e.g. "What I think doesn't matter to anyone"). As noted above, schematic change is suggested to occur through repeated episodic representations of more adaptive patterns of experience (Gumley et al. 1999). Using the Socratic Method would encourage a high level of active participation within the dialogue (which would necessitate alternative interpersonal behaviours), implicitly communicate the fact that the client is part of a collaborative process in which they are responsible for addressing their difficulties (something inconsistent with a sense of helplessness or hopelessness), and provide experience inconsistent with their appraisal that their thoughts are not important. Therefore engaging this client in the Socratic Method may provide repeated experiences which are inconsistent with the schema ["global-view-of-self-as-useless"] and result in the synthesis of new implicational meaning (i.e. a non-depressogenic schema).

Collectively, these proposals suggest that the Socratic Method could help patients to adopt wider, alternative perspectives and may be more likely to bring about schematic change than a didactic information-giving approach. As schematic change is the route through which distress would be alleviated and more adaptive functioning harnessed, the ICS model suggests that the Socratic Method may have a number of benefits in CBT. In contrast, a direct challenging approach to addressing cognitions may only instigate change in specific propositional meaning or negative automatic thoughts (Teasdale 1996). However, it must be noted that the ICS account does not necessarily suggest that the Socratic Method is an essential treatment component. Indeed the model suggests that a non-Socratic approach which encouraged patients to engage in non-depressogenic behaviour or attentional processes would similarly be expected to impact upon implicational meaning.

Given the paucity of research on the Socratic Method using the ICS model to understand this method needs further research. The ICS, as with the Beckian cognitive model, may be subject criticism for insufficient empirical data to assert the validity of the constructs discussed or the implied causal relationships between these constructs (Longmore and Worrell 2007). Nevertheless, this does provide a provisional theoretical rationale as to why a Socratic approach may be helpful. This account would therefore benefit from being significantly expanded upon (e.g. to consider the role of reasoning processes), operationalised in greater depth and empirically tested.

Conclusion

The Socratic Method has, both explicitly and implicitly, been conceptualised as an important component of CBT interventions. Our review and the analysis of the Socratic Method using the ICS framework may suggest that there is a theoretical rationale for its use within therapy. Yet, to date, the value of this approach within therapy has received little investigation. Reasons for the neglect within research may be partially attributable to the challenges inherent in measuring the construct and the necessity for the differential application of the Socratic Method across individuals, presenting difficulties and therapeutic activity. Given the ubiquity of references to the Socratic Method in CBT texts and training materials, there is an inherent interest in the Socratic Method throughout the CBT community. This review, reflecting the current status of the literature, may therefore give rise to certain frustrations on the part of the reader. Such frustrations may occur due to (1) the vagueness of the definition of the Socratic Method and the potential differences that may exist in what the term connotes; (2) the lack of clarity regarding how the Socratic Method is applied across evidence-based CBT interventions; (3) the lack of a clearly operationalised mechanism through which a Socratic approach would operate; and (4)

the lack of empirical data to assert whether the proposed benefits of the Socratic Method are present/absent on manipulating the use of a Socratic approach. We would therefore wish for this review to reflect a "call-to-arms" for clinicians and researchers to work towards addressing these issues.

CBT stands at somewhat of a crossroads, where CBT interventions which arguably do not include substantial Socratic elements (such as low-intensity CBT and guided self-help), are being widely utilised and have demonstrated efficacy. Given the time-consuming nature of the Socratic Method in therapy, and in mastering its use during training, there is a clear imperative for researchers to assert its value within CBT. The literature reviewed indicates a general opinion that the Socratic Method is beneficial and, indeed, may be fundamental to CBT. However, in a climate where clinicians may feel pressured to deliver the most cost and time-efficient treatment and training methodologies, there is a risk that the Socratic Method may be neglected due to being considered a non-essential component. There is therefore a clear onus on researchers to determine what benefits the Socratic Method may provide within CBT and make an empirical case for its use.

Compliance with Ethical Standards

Conflict of Interest Gavin I. Clark and Sarah J. Egan declare that they have no conflict of interest.

Informed Consent All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (national and institutional).

Animal Rights No animals were used in the present study.

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