Socratic Dialogue
Rating Scale & Coding Manual

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Overview

This manual and its rating scale operationalize the model of Socratic Dialogue developed by Padesky (1993, 2019). It is designed to:

- Provide formative guidelines for therapists, supervisors, and consultants in order to improve use of Socratic Dialogue in psychotherapy
- Offer an assessment tool of Socratic Dialogue competence for psychotherapy trainers and researchers
- Create a measurement standard so researchers can evaluate if and how Socratic Dialogue competency is related to therapy processes and outcomes

Socratic Dialogue is described in Padesky (1993, 2019). This manual operationalizes in detail the four stages of Socratic Dialogue she describes:

1. Informational questions
2. Empathic listening
3. Summaries
4. Analytical/synthesizing questions

The defining processes and qualities of each of these stages is described so that raters can detect the presence / absence of these features and rate the extent to which competency in this area is demonstrated in a given therapy session. Our goal is to produce an assessment tool that can reliably and comprehensively rate CBT therapist skills in using Socratic Dialogue.

Socratic Dialogue

Socratic Dialogue (SD) is grounded in the best collaborative empiricism principles of CBT. Therapist interventions embedded in SD are designed to maximize client engagement and participation in active inquiries and investigations.

Collaboration is marked by a variety of therapist behaviors and attitudes including:

- Back and forth interactive conversations instead of therapist mini-lectures
- Questions asked with genuine curiosity
- Silence after questions are asked, with the therapist nonverbally signaling keen interest in the client's answers
- Therapist willingness to adopt client's language (vocabulary, metaphors, and/or imagery)
- Prompts after psychoeducation, e.g., "how would you say that in your own words?"
- Lively and engaged facial expressions and eye contact
- Openness to client ideas
- Willingness to make changes based on client feedback
- Interactive writing to capture observations and make summaries

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Empiricism is also embedded throughout each stage of SD. Features include:

- Active search for data during the inquiries about issues
- Follow where the data lead rather than aiming for a predetermined endpoint
- Equal degrees of curiosity for facts that both fit and don't fit a given model
- Comparison of evidence-based models with client observations and experiences
- Use of empirical methods such as real-time observations, behavioral experiments, thought records, and detailed examination of client experiences
- Modification of a conceptualization or treatment plan when unexpected data are discovered
- Written summaries of observations made followed by analysis and synthesis of findings

The goal of Socratic Dialogue is to promote client discovery (Padesky, 1993). While SD is largely a verbal process, it often follows and is used to unpack learning from more active investigations such as between session learning assignments, behavioral experiments, learning from written exercises (e.g., thought records, responsibility pies), role plays, and imagery exercises (Padesky, 2019).

The Four Stages of Socratic Dialogue

The four stages of Socratic Dialogue often occur in sequence although there can be some movement back and forth among them. For example, the first two stages, Informational Questions (Stage 1) and Empathic Listening (Stage 2) generally occur in tandem. Empathic listening (Stage 2) will hopefully be present throughout the process. Brief (minor) summaries can be made in writing or verbally at any time but it is expected that a major summary of ideas or observations (Stage 3) will be made before SD ends. Ideally this major summary will be written. Once a major summary is complete, the therapist asks the client Analytic/Synthesizing questions (Stage 4) in relation to this summary. Client answers to these questions can lead to additional analytical and synthesizing follow-up questions or to adding ideas to the summary or even to additional informational questions and empathic listening.

Socratic Dialogue does not occur constantly in therapy. Client discovery is not enhanced when a therapist overuses Socratic Dialogue, employing it constantly throughout therapy sessions with a result of little forward progress. Instead, it is practiced when the therapist wants to either (a) help the client investigate or evaluate a belief, behavior, plan of action, conceptual model or (b) debrief an experience that has potential learning value relevant to therapy progress and goals. Here is a brief description of each stage:

<u>Stage 1: Informational Questions</u>

Informational questions are those that ask clients to make active observations and reflections about their experiences. Therapists need to get details about client experiences in order to understand them. Ask questions such as "Who? What? When? Where? Why? How long?" These questions prompt clients to vividly recall experiences so they can evaluate them.

Further, therapists strive to ask questions suggested by evidence-based models for particular client issues. For example, therapists inquiring about thoughts linked to depression can be informed by Beck's negative cognitive triad (Beck, 1967) and ask questions such as "What did you think this situation said about you? About your life? About your future?" Therapists addressing panic disorder will ask specific informational questions about physical and mental sensations and thoughts/images linked to catastrophic misinterpretations of these (Clark, 1986).

Therapist curiosity is a key to successful informational questioning. It is not sufficient to ask basic questions. Therapists want to be curious and ask follow-up questions in order to get enough detail

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about client experiences that all the potentially relevant elements are captured. In addition to relying on evidence-based models to guide questioning, therapists can ask informed questions based on their own life experiences when these are relevant. For example, when parents say "I don't do anything right," therapists can draw on their knowledge of parenting to ask about common parental routines that the client might be discounting (e.g., "Do your children dress and feed themselves in the morning?" "What are your nighttime routines with the children?")

Finally, the best informational questioning strategies often approach an issue from several different angles or perspectives. For example, in the parenting example above it may be relevant to ask about the client's experiences with their children, how these same experiences might compare with those of other parents, the roles played by stress or fatigue or mood on the client's experiences, and how the client thinks they would view this situation if a friend were describing similar situations.

Stage 2: Empathic Listening

It is important for the therapist to listen empathically to whatever the client reports in response to informational questions. Here we unpack what we mean by empathy and the characteristics of good listening in SD:

Empathy that is expressed should be accurate and also appropriate to client and session goals.

Accurate empathy correctly reads the client's emotions and responds accordingly (e.g, "I'm sorry you experienced this" might be appropriate for sadness or distress; "That seemed so unfair to you" might be appropriate for anger). In addition, accurate empathy includes congruence between verbal and nonverbal expressions of it.

What is appropriate empathy for this client? The degree and manner in which empathy is expressed depends upon the client. Some clients welcome expressions of empathy and others find them irritating. The first type of client might feel closer alliance with a therapist who says, "I'm so sorry" with a look of sympathy. The second type of client might prefer a therapist who simply says, "That's tough." Both clients are likely to appreciate a therapist who follows statements of empathy with, "Let's see if we can figure out a way to help you through this."

Empathy appropriate to session goals. In general, empathy deepens emotional experiences. Thus, a general rule therapists can follow is that, if clients are already experiencing intense affect, then "lighter" empathy paired with an action plan is most likely to be helpful. For example, "I'm so sorry you are going through this right now. Let's see what we can figure out today to help you." On the other hand, when a client is keeping affect at arms' length and a greater experience of affect is desired as part of SD, then deeper empathy paired with silence may be more therapeutic. For example, "When I hear you describe that, I feel so very, very sad" (followed by silence with a sad facial expression and eye contact).

Good listening involves sticking closely to what the client says, adopting client language, metaphors and imagery.

Accurate listening parrots back what the client said instead of interpreting it and reflecting it in different words (Padesky, 2019). When we repeat a client's words exactly, they know we are listening carefully. When we paraphrase a client's words, they need to compare our description to what they actually said. This process takes them out of their experience (e.g., thinking "Is that what I said?" "Is that what she heard?" or "Does she think that about me?")

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Therapists are advised to take notes during SD that record the client's exact words. This sets up the ease with which summaries can be made (Stage 3) that are accurate and closely capture a client's observations.

Pay particular attention to any idiosyncratic words or phrases, metaphors, or images the client reports. These are especially important to write down and capture. Also, these will often evoke additional informational questions because when we get more details about highly personal phrases, metaphors, images etc. we often learn more about the intersections among this client's thoughts, emotions, meanings, behaviors, values, and other dimensions of human experience that are captured more readily in these forms.

Good listening includes hearing what is not said or might be missing.

As therapists closely listen to clients, what we hear can be actively compared to expected patterns and/or evidence-based models. When something seems to be missing, ask additional informational questions to find out if the "missing" piece is significant. For example, one client said his life lacked meaning. During ten minutes of discussion of his life he never mentioned his wife or children. His therapist heard this missing piece and inquired, "How do your wife or children fit into what we are talking about?" At this point, the client began to cry and it became clear in subsequent discussions that the disconnect he felt from his family linked directly to his search for meaning. For a different client, the response might be, "That is not the type of meaning I'm talking about. I'm looking for a life's purpose beyond my family." Noticing and inquiring about possible missing pieces can help the client's story unfold in helpful ways.

Stage 3. Summaries

Summaries are extremely important in Socratic Dialogue for the following reasons:

- A great deal of detailed information is gathered during informational questioning. Clients are often answering the therapist's questions without making connections among their answers or even recalling what they said a few minutes earlier.
- During SD, therapists often are organizing the information gathered in their own minds, perhaps using an evidence-based model. If so, the therapist is prone to selection bias and might forget significant observations that don't fit with this model. And other times, therapists might be uncertain how to organize the information they are gathering and/or lose track of the potential significance of various bits of information collected.

Brief summaries can be made as information and ideas are elicited. These might be oral reflective summaries or written as notes that are read to the client to check for accuracy and completeness. Whether or not intermediate summaries are made, the goal is to make one final summary before a particular SD ends.

The best summaries use client's exact language and capture all the relevant and significant observations made by the client during SD. Points that will be listed in the final summary can be constructed as SD is in progress so information is not forgotten. If summaries are compiled from notes the therapist makes while SD proceeds, these can be collaboratively organized with the client when it is time to make the main summary of the SD. Ideally, the final summary will eventually be written by the client in their own words (and handwriting, if possible, because ideas written in one's own handwriting often evoke greater emotional resonance). This can take the form of writing on a whiteboard or paper in session or transcribing a summary into the client's therapy notes, whether in written or electronic formats (e.g., photo).

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When good summaries are made, these increase the likelihood that discoveries made during SD will be remembered and used to sustain and advance therapy progress. They also offer a rich resource to help clients answer analytical and synthesizing questions.

Stage 4. Analytical and Synthesizing Questions

Analytical and synthesizing questions provide the prompts for clients to make, solidify and deepen discoveries made during SD. Both types of questions are usually asked. Often Synthesizing questions are asked first. Synthesizing questions ask clients to put various concepts or observations together in order to discover something:

- Reading over this summary, can you think how these ideas might fit together?
- How do these observations you've made fit with your belief that…?
- What did you notice about your anxiety in this approach experiment?
- What links do you see between your thoughts and moods?
- How does what you noticed in this imagery exercise inform the behavioral experiment you plan to do this week?

Analytical questions ask clients to figure out how to use the discoveries made during SD to help themselves and make further therapy progress:

- How could you use these ideas to help yourself this week?
- Given all the things you told me, which of these behaviors do you think would be best to address first?
- Based on what we've discovered today, what do you think would be the best way to put this progress into your practice this week?
- What ideas from this summary do you think could make the biggest difference for your progress? What else do we need to know before you can move forward? What would be the first stage?

There are dozens of useful analytical and synthesizing questions that can be asked. Therapists can consider which questions will lead to discoveries that are most likely to promote client hope, progress toward goals, confidence, and improved well-being.

Whatever questions are asked, a written summary (Stage 3) makes it much more likely that the client can provide meaningful answers. Written summaries provide ideas for the client to draw on to answer analytical and synthesizing questions.

A Note regarding "Yes, but…"

When clients say "Yes, but…" during SD this is most often a signal that the therapist has either just given advice or drawn conclusions for the client during SD instead of guiding client discovery. Clients rarely say, "Yes, but…" when making their own discoveries. We recommend therapists examine their own behavior and words that precede this client protest. Often backing up to the missed stages of SD (most likely summaries and analytical/synthesizing questions) and filling in the gaps, will improve therapy alliance and progress. Once all four stages of SD are completed, the client can be asked, "How can you use these ideas to help yourself this week?"

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Use of the Socratic Dialogue Rating Scale

Only sections of a therapy session in which Socratic Dialogue is employed should be rated using this scale. Most sessions will have one or more sections that employ Socratic Dialogue.

Commonly, SD is used in therapy to:

1. debrief learning assignments completed between sessions (to extract learning from these and apply that learning to future client practices)
2. test out particular beliefs that trigger or maintain issues targeted in therapy
3. examine the advantages and disadvantages of specific behaviors or beliefs
4. debrief behavioral experiments, imagery exercises, role plays and similar learning exercises done in session

These are the sections of the session that should be rated using this form whether the therapist is obviously using SD here or not. Try to rate only these sections of the session no matter how well or poorly the therapist performs at other times during the session.

If SD is not employed at all during a session, all items will be rated zero. Even though therapists are likely to ask questions, listen with empathy, make summaries or even ask analytical or synthesizing questions at some point during most therapy sessions, rate these instances only if clearly a part of an attempt to use Socratic Dialogue or one of the four times above when SD is expected to be used.

Signposts that a therapist is trying to use SD include:

- A series of questions is asked of the client that appear to be aimed at testing beliefs or extracting learning from a client experience in or outside of therapy
- Summaries are made (oral or written) of data or observations collected and these summaries are used to evaluate beliefs or plan future learning assignments
- Clients are asked, after a detailed discussion, "What do you make of this?" or "How can you use these ideas to help yourself this week?"

Rate these as instances of SD, even if one or two of the four stages of SD are missing. It may be clinically significant that a therapist frequently uses some stages of SD without the others. Research will help us determine if and how various types of partial SD use impact therapy effectiveness.

Rating Tips

When listening to a session recording, it can be helpful to mark the timings of sections that include SD just in case you need to return to review those sections during ratings. When doing research, you may choose to only rate one particular instance of SD (e.g., debriefing learning assignments) that is likely to be present for all sessions in the study. Alternatively, supervisors may decide to only rate the best instance of SD in a session (e.g., for therapists in training). If you are rating all sections of SD in a therapy session, it is likely that one instance will be better or worse than the others. Base your ratings on the most typical performance and, when this rating falls between two ratings, rate the higher or lower number based on the outlier instance.

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Rating Scale

We have chosen to use a 0 – 4 rating scale for the SD. Our scale numbers indicate the following:

COMPETENCE RATING		EXAMPLES
Needs Significant Improvement	0	Feature is absent or used highly inappropriately
Needs Improvement	1	Some competence; many problems and inconsistency
Competent	2	Competent with minor problems and/or inconsistencies
Strengths in Evidence	3	Skillful use with minimal problems/inconsistencies
Outstanding Strength	4	Excellent performance, even facing clinical challenges

Maximum score on the SD scale is 16 (4 X 4). We expect a minimum competence score will be 8, an average score of 2 per item.

Please note that scores are expected to include the entire range available unless all therapists rated are either extremely novice or expert. That said, few extreme scores of 0 or 4 are anticipated. An approximate normal distribution of scores across the range is expected.

Socratic Dialogue Rating Form (provided in a separate document)

To provide feedback for therapists being rated, use the Socratic Dialogue Rating Form (2020). It contains self and rater scoring for each item as well as space to highlight strengths and improvement needed. There are also ratings for client difficulty and an overall therapist skill rating to capture total therapy performance and not just Socratic Dialogue.

Therapists can also use the Socratic Dialogue Rating Form for self-rating.

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Socratic Dialogue Rating Scale

Use the rating most closely matched to therapist performance.

Item 1. <u>Informational Questions</u>: Given the session context, informational questions asked were appropriate, asked with genuine curiosity, engaged the client, and pursued until sufficient detail was obtained.

The sense that informational questions are setting up a potentially effective line of Socratic Dialogue is the important thing, even if later stages of SD do not prove to be as fruitful as expected. Try to ascertain what would be appropriate given the therapy situation in which SD is employed.

For example, Q's used in debriefing behavioral activation exercises would be expected to minimally include some questions to flush out the general idea that activities and moods are related and also, more specifically, links between mood and pleasure and mastery (and possibly overcoming avoidance).

<u>Key features</u>

Informational questions are expected to be:

<u>Content</u>

- pertinent to topic explored
- appropriately encompassing of most relevant information
- have some relationship either with an evidence-based treatment model, a clinically relevant case conceptualization or a general therapy model (e.g., linking situations, beliefs, behaviors, moods, and/or physical reactions)
- For higher ratings, approach a topic from more than one angle or perspective

<u>Process</u>

- asked with curiosity and keen interest
- questions asked seem to engage the client (especially for higher scores)

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Item 2. Empathic Listening: Therapist showed signs of appropriate empathy both verbally and nonverbally (e.g., vocal inflections, facial expressions). Therapist used accurate reflections that incorporated client language (including imagery and metaphors, when present) without too much interpretive drift from what the client actually said.

Rate therapist on how well they (1) show positive signs of listening with empathy during SD and (2) make reflections that accurately capture what the client said. Empathy can be "light" or "heavy" depending upon what seems most therapeutic in this session as long as it accurately matches the mood expressed. For higher scores, reflections will incorporate client language and imagery/metaphors (when present) and adhere closely to what the client actually said.

The highest ratings on this item require a therapist to accurately reflect the most relevant client statements using the client's exact language, pick up on and reflect or even ask the client to further develop metaphors and imagery introduced by the client, and notice any missing elements in the client narrative and reflect on the potential importance of learning more about these. Also, at the highest ratings, therapists check with clients to make sure reflections are accurate and complete.

Key features

Ratings on Empathic Listening look for:

Content

- expressions of empathy that are appropriate to mood(s) expressed
- accurate reflections that stick closely to client language
- noticing and inquiring about missing elements in the client narrative

Process

- Verbal and nonverbal expressions of empathy are congruent
- Therapist checks accuracy and completeness of reflections with client

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Item 3. Summaries: Therapist initiates summaries at appropriate times throughout SD. These summaries accurately highlight the most important client observations or learning in the client's own words and, when possible, are collaboratively created with the client. The most important summaries are collaboratively written down in session. Both therapist and client leave the session with these written summaries in their written or electronic notes.

To receive a rating greater than zero, therapist needs to make at least one summary during SD that accurately captures SD discussions. For higher scores, brief (minor) summaries will made during SD (even in the form of verbal reflections that summarize two or more points) and toward the end of each SD process in the session a more formal and complete (major) summary of the discussion is made either orally or in writing.

The highest ratings on this item require a therapist to collaborate with the client during major summaries to make written summaries that capture the most relevant information in the client's own words. When practical, therapists aim to ensure the client's copy of the summary is written in their own handwriting or on their own electronic device. Summaries are written in a format that makes it easy to use this information to promote future client learning and therapy progress.

Key features

Ratings on Summaries consider how well these:

Content

- summarize key observations and/or learning during SD
- use client language

Process

- collaboratively construct at least portions of one or more summaries ("Let's make a summary" vs therapist saying "This is what we learned")
- major summaries must be written down to receive score of 2 or higher
- if written on paper, client copies summary in own handwriting to take home

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Item 4. Analytical/Synthesizing Questions: After a period of SD, Analytical or Synthesizing Q's are asked that require the client to consolidate SD learning and/or apply what was discussed to their therapy issue(s). Analytical and/or Synthesizing Q's asked link closely to relevant evidence-based models, the case conceptualization, and/or the treatment plan in ways that seem likely to support positive therapy outcomes.

To receive a rating greater than zero, the therapist needs to ask at least one analytical and/or synthesizing question that has some relevance to the treatment model, treatment plan or case conceptualization used for this client; e.g., Analytical: "How could you use these ideas to help yourself?" Synthesizing: "What do you make of this?" "How does X fit with Y?" If a written summary has been made, therapist will ideally prompt the client to refer to the written summary prior to answering the question(s). If there is no written summary, questions will pertain to either an oral summary or, in the absence of the summary, to the preceding discussions or guided therapy experiences (e.g., imagery, role play, behavioral experiments).

These questions are phrased in language readily understood by the client. The therapist demonstrates interest in the answers and allows sufficient time for the client to think of one or more answers. The highest ratings on this item require a therapist to: ask follow-up questions to help the client think through the implications in as much detail as helpful, give credit to the client for discoveries made, and refrain from offering their own synthesis or analysis in place of a client response. Ideally, clients and therapists write down useful client answers as either a separate entry into their therapy notes, an addition to a written summary and/or as part of a learning assignment so discoveries made can be used to promote client learning and progress.

Key features

Ratings on Analytical/Synthesizing Questions reflect:

Content

- best Q's are relevant to clinical model, treatment plan or conceptualization
- client is referred to ideas in the summary, if one has been made
- credit is given to client for discoveries made

Process

- therapist expresses curiosity and interest
- there is sufficient silence/time allowed for client to consider answers
- Important discoveries are written down or recorded for future use

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