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Cognitive Behavioral Therapy for SLPs: Applications for Counseling, Behavioral Change, and Clinical Supervision

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Cognitive Behavioral Therapy for SLPs: Applications for Counseling, Behavioral Change, and Clinical Supervision

William S. Evans, M.S., CCC-SLP

Disclosures:

- ***Financial:***
  I have no relevant financial relationships to disclose regarding the current presentation.
- ***Nonfinancial:***
  I took a CBT course with Daniel Beck at Boston University. He taught Aaron Beck's (his father) approach to Cognitive Therapy. The class used a text written by his sister, Judith Beck. I have found the course and materials personally useful, I am advocating this specific approach to CBT.

  I am currently a doctoral candidate at Boston University and part-time SLP at MGH.

Back-story: why CBT for SLP?

- I became interested in CBT during my clinical fellowship at MGH while working with Cognitive Rehabilitation patients.
- I was still taking my PhD coursework, so I had the opportunity to enroll in a CBT course at BU SSW.
- I have been thinking about the framework and working to apply certain aspects to my clinical practice over the past 3 years.

Learner Outcomes:

1. As a result of this activity, participants will be able to describe basic elements of CBT theory, including the interactive components of the cognitive conceptualization model.

2. As a result of this activity, participants will be able to explain several common approaches and tools used in CBT to identify and address distorted beliefs and to promote behavioral change.

3. As a result of this activity, participants will be able to describe at least 3 specific ways they would be able to incorporate relevant elements of CBT into aspects of their own clinical practice.

Outline for today's talk:

Part 1: Intro to CBT

- Overview of framework and concepts
- Overview of some great CBT tools

Part 2: Applications to SLP

- Counseling
  - Work through example of cognitive conceptualization and potential responses
- Behavioral change
  - Case example (coping cards)
- Applications for clinical supervision

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What is CBT?

- Very broad field of psychotherapy, containing lots of different specific approaches. Good evidence base.

Principles:

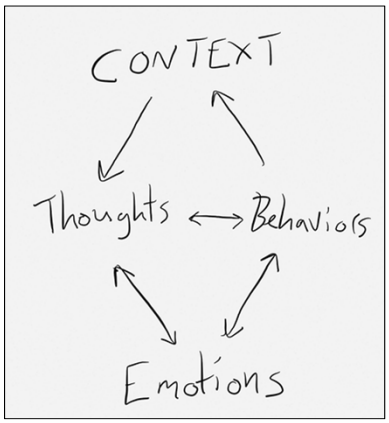
- Based on understanding of the pt in **cognitive terms** (current thinking, beliefs, problematic patterns).
- **Goal-oriented** and problem focused.
- **Pt-centered**, requires active participation.
- **Structured** therapy approach (e.g., agenda setting, homework).
- **Metacognitive** (identifying, evaluating, and responding to dysfunctional thoughts/beliefs).

- Today will focus on Aaron Beck's approach (*Cognitive Therapy*), per Judith Beck's Cognitive Therapy: Basics and Beyond.

The Cognitive Model

- The basic idea: thoughts, emotions, and behaviors all interact and affect one another.
- There is no *direct* link between the situation and emotions…

  interpretation (thoughts) and response (behavior) serve mediating roles.



"People do not become upset about things that happen so much as what they *make* of things that happen." (Beck, 1989)

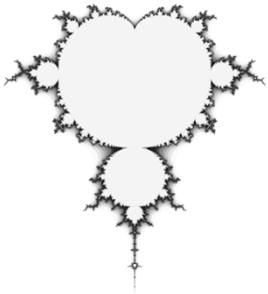
Example:

- You are on your way to a job interview, and you run into heavy traffic caused by an accident on the highway.
- What goes through your mind?
  - Thoughts…
  - Emotions…
- What do you do?
  - Behaviors…

(some of us are probably do a bit better than other in this sort of context.)

Thoughts:

- CBT proposes 3 different levels of thoughts/beliefs:
  - Automatic thoughts
  - Intermediate beliefs
  - Core beliefs



Automatic Thoughts

- Closest to conscious awareness.
- Quick thoughts in response to the context.
- Inner monologue.

"When X happened, what was the first thing that ran through your mind?"

Intermediate Beliefs

- 'Rules to live by'. Created over time.
- They can often be phrased as if/then statements:

"If things get difficult, it's best to just give up."

"If I can't get it 100% right, it's not worth trying."

"If I ask for help, I'm telling them I can't do it."

Core Beliefs (Schemas)

- The most basic beliefs we hold about ourselves, others, and the world.
- Rigid and set in childhood.
- Can be 'triggered' by world context.
- Aaron Beck claims most basic negative core beliefs are about feeling helpless or unlovable:
  - "I am not good enough."
  - "I am broken/defective."
  - "I am unlovable."

Distorted/Dysfunctional Beliefs

- Major goal of CBT is to alter *distorted and dysfunctional thinking*.
- Note: definitions of 'dysfunctional' and 'distorted' have to take pt context and goals into account.

- How do therapists identify and alter distorted thinking?
- Let's talk about some of the tools they use…

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CBT tools and techniques:

Structured therapy:

- Agenda Setting
- Homework

Identifying beliefs:

- Cognitive conceptualization
- Guided discovery (pt locus of control, Socratic techniques)
- Downward arrow

Modifying beliefs/ supporting change:

- Positive vs. negative evidence.
- Hypothesis testing with behavioral experiments
- Thought records
- Exposure hierarchies
- Behavioral activation, Activity logs
- Coping cards

Structured Approach:

- Each session started by laying out an agenda. Therapist initiated with pt feedback earlier in treatment, but ideally over time this becomes pt-initiated.
- Each session ends with a summary/review, outline of plan, and request for feedback.
- Homework generated in each session.
- Rationale:
  - Structure helps pt know what to expect, and helps both pt and therapist stay focused on specific goals.
  - Feedback makes sure pt and therapist stay on the same page and gives a chance for damage control.
  - Homework promotes generalization and keeps pt and therapist focused on real-world applications.

Identifying Beliefs: Cognitive Conceptualization

- The basic framework for laying out relationship between levels of thoughts and belief, emotions, and maladaptive behaviors.
- The basic idea is to work through the thoughts/emotions/behaviors in a series of related scenarios to get at the underlying motivating intermediate and core beliefs.
- Beck (1995) has a great worksheet.

  (we will go over a case example of this later).

Guided discovery

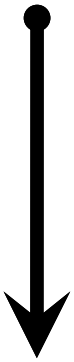
- CBT relies on pt-centered discovery process.
- Socratic technique relies on guiding questions instead of statements.
- Statements phrased as hypotheses, which pts are then asked to verify.
- Practicing this one is tricky. Easily feels false, easy to mock (e.g. pretty much any psychiatrist movie scene).

- *Best thing to keep in mind here:*

  your goal is to help the pt figure out what is going on. As you piece things together, you are basically making *conjectures*, not telling them how they feel.
- On the other hand, you should be making and testing conjectures with them, not just reflecting their statements.

Downward Arrow

- An example of guided discovery, used to move from automatic thoughts to underlying beliefs.
- Called 'downward arrow' because you grant them the negative as 'true', then follow it to its source.



Example:

"Ok, let's assume you're right and say that if you're late, you'll never get the job. What does that mean to you? …"

"If that's true, so what?"

"What's so bad about…"

"What does that mean *about* you?"

Positives vs. Negatives:

- Like Downward Arrow, starts by granting them the negative:

"Ok, it is important to remember you are doing X for a reason: what are some of the benefits of X? Ok, now what are some of the negatives?"

Examples: Alcohol use, Maladaptive strategies/behaviors.

Behavioral Experiments

- A technique for modifying beliefs by testing hypotheses.
- Helps pt generalize from clinic to their day-to-day.
- Can practice in session via role-playing.

Examples: Asking for help, self-advocating communication needs during conversation.

Thought records

- Another technique for raising metacognition during day to day.
- Helps pt and clinician pull out patterns over time, build up evidence for countering distorted thinking.
- Basic approach consists of keeping a simple log that lists:

situation, thought, emotion, response, outcome

Thought records

Date	Situation	Thought	Emotion	Response	Outcome

Exposure Hierarchies

- Used to treat anxiety disorders, phobias.
- The idea is to break difficult domain into graduated levels of difficulty, then expose pt to lower levels to promote habituation to aversive stimuli/situation.
- Example: heights
  - What would be a “100” on the heights scale? What would be a “5”?

Disclaimer: This approach described for the sake of completeness. As an SLP, please proceed with ample caution here…

Behavioral Activation

- Focuses on situation and behavioral aspects of the CBT framework.
- Frequently used for treating depression.
- Help pt set up hierarchy of meaningful and engaging activities.
- Keep track using activity log.
  - Date, time, activities, mood.

Coping cards

- External aid. 3x5 index card.
- Usually in pt's own handwriting.
- Types include pattern/response, behavioral activation steps.
- Designed to help bring strategies and new ways of thinking into the moment of potential breakdown.
- Often used for treating anxiety/panic disorders, countering automatic thoughts, behavioral activation plans.

I love these!

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Applications for SLPs: Counseling

- Counseling is in our scope of practice

  *"…counseling individuals, families, coworkers, educators, and other persons in the community regarding **acceptance**, **adaptation**, and decision making about communication and swallowing." (ASHA, 2007)*

- Unfortunately, we don't get a lot of training…

Pts and their families often experience…

- Loss, grief.
- The need to cope with altered expectations.
- 'Activation' of negative core beliefs.
- *Shifts* in core beliefs.
- Maladaptive coping responses.

Reasons I think CBT is a good counseling tool for us:

- Present focused
  - Acknowledges the impact of the past and childhood experience without a need to focus on it.
- Pt centered.
  - Relies on pt-identified problems and goals.
- Structured and builds on our strengths as SLPs.
  - Strengths being empathy, familiarity with structured frameworks/tools, experience with pt/family education and strategy training.

Counseling Caveats:

- CBT tools/ framework don't replace presence and empathy.
- It can be easy to want to 'fix' things once you have a toolbox, which is why pt locus of control is so important.
- Take their lead in this domain.

  (we have plenty of other things to work on.)

Scope of Practice and the the Team Approach:

- Although counseling is in our scope of practice, remember we're definitely **not in this alone**. Always consider referrals.
- At MGH, we often recommend CBT tx *before* cognitive rehabilitation if the pt's presentation includes significant affective/ psychiatric components.
  - Helps many pts create a baseline of emotional self-regulation skills so they can focus on systematic cognitive skill training with us.
- We will also refer current pts to CBT if we determine that a large portion of the pt's current difficulties are affective and related to distorted beliefs.

Scope of Practice, continued:

The argument for addressing emotions and beliefs:

- When a pt's beliefs and emotions interact directly with a deficit in one of our target domains, this relationship **Needs** to be addressed for tx to be effective.
  (although not necessarily by us alone.)

- My litmus questions for determining scope:
  - How much of the pt's emotional difficulties relate *directly* to the targeted cognitive-linguistic deficits?
  - Contributing vs. Causative role?
  - Do affective concerns overshadow cognitive-linguistic concerns?
  - Do I feel comfortable with the content of my sessions?
    - If not, would a referral be appropriate?

Case Example: Cognitive Conceptualization for SLPs.

- The basic idea behind Cognitive Conceptualization is to work through the thoughts/emotions/behaviors in a series of related scenarios to get at the underlying beliefs.
- The following will use a framework modified from Beck (1995).

Cognitive Conceptualization:

Background/History:		
Situation 1:	**Situation 2:**	**Situation 3:**
Automatic thoughts:	**Automatic thoughts:**	**Automatic thoughts:**
Emotions:	**Emotions:**	**Emotions:**
Behaviors:	**Behaviors:**	**Behaviors:**
Take-away	***Take-away***	***Take-away***
Coping Strategies:		
Intermediate Beliefs ("If __ then__"):		
Core Beliefs:		

Background/History:

- Bob is a male graduate student in his late 20's, currently on medical leave from a local university. He was hit by a car while biking accident approximately 8 months ago, and now suffers from symptoms consistent with Post-Concussion Syndrome, including headaches, difficulties with concentration/ complex attention, executive functioning, fatigue, and multi-modal sensory processing difficulties. Emotionally, he endorses feelings of anxiety, anger, and depression.
- Historically, Bob was an excellent student, and has always worked hard to achieve success in everything he attempts. Growing up, his parents were supportive but held him to high expectations. Neuropsychological testing estimated most of his premorbid intellectual abilities in the superior range.

Situation 1: Got confused while working on disability paperwork.	**Situation 2:** Email from other lab member asking question about research project.	**Situation 3:** Grocery shopping with parents. Got overwhelmed by attention demands.
Automatic thoughts: "This should be easy for me, but I can't do it now."	**Automatic thoughts:** "I'm not sure if I get this. I shouldn't answer too quickly or they will expect too much from me."	**Automatic thoughts:** "I can't handle this. Everything is overwhelming now."
Emotions: Frustration, shame	**Emotions:** Fear, shame	**Emotions:** Anxiety, frustration
Behaviors: Gives up and goes to bed. Has not gone back to it.	**Behaviors:** Doesn't answer email.	**Behaviors:** Forgets to use list strategy, has to leave store.
Take-away I'm broken	***Take-away*** I can't do what I did before	***Take-away*** I'm not good enough
Coping Strategies: Gives up, removes himself or avoids difficult situations.		
Intermediate Beliefs: "If things get difficult, it's best to give up."		
Core Beliefs: "I'm broken"		

Responding to Bob:

- Given the series of scenarios, it seems like he feels "broken", whereas before he was "whole" (i.e., perfect).
- If this is true, we could try to slowly break down that dichotomy over time by challenging/ reframing comments he makes that reference these beliefs.
- The goal would be to get from "broken" to something more realistic and complex. For example:

"My abilities have changed a lot, but I can pursue the same basic goals and do most of the same things if I just figure out better ways to go about them."

Homework: applying cognitive conceptualization on your own.

- Two options:
  - Think of a patient, child or parent you have been working with who seems to present with difficulties caused by maladaptive beliefs.
  - Or use yourself (for the brave).
- First, write a short case history. Fill in the details you think might be relevant.
- Second, think of 3 problematic situations and write them down in the cognitive conceptualization template. Work from there, trying to fill in the other sections.
- If you aren't sure of a specific response, thought, or behavior, you should still put it down, but preface it with a "?". You are laying out hypotheses to test.

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Applications for SLPs: Behavioral change.

- Two main approaches to what we do: compensate for deficits via strategies/ external aids or ameliorate systems directly via targeting stimulation and drilling.
- CBT framework and tools support both approaches.
- My Claim: Every single change we might hope to implement occurs in the mental space where their thoughts/ emotions/ and behaviors interact.

CBT support for drill-based approaches:

- Pt buy-in for tx is always crucial.
- Negatively affected by depression, negative thoughts and beliefs (e.g., fixed mindset).
- Affects home practice and follow-through.
- Pts need *realistic* reasons to feel hopeful, which CBT can help provide.

CBT for compensatory strategies:

- Strategies have to make it into the moment of the potential breakdown to have any true functional impact.
- This means that we have to be aware of the *cognitive content of that moment* (thoughts, emotions, default responses), so we can support the change we're trying to train.

Example: coping cards for cognitive strategies

Coping Pattern/ Response Card in Cognitive Rehab

Case Hx and current situation:

- Beth is a 36 year-old event planner who was in a car accident 8 months ago that involved a close-head injury. She was briefly hospitalized at the time for a fracture. She experienced nausea, headaches, and difficulties with short-term memory and concentration at the time, but was told that these symptoms would probably resolve on their own in the first 3 months. She has been back at her family's business for the past 6 months, and has been struggling with her job demands, even with a very reduced workload. She currently experiences increased difficulty with concentration, short-term memory, organization, and time management, and she is easily overwhelmed. She is used to holding herself to a very high standard of excellence based on premorbid level of ability, which has been increasing their feelings of stress and anxiety, and has led to increased procrastination and frustration. She also endorses feelings of anger and guilt, as she feels that she is letting her family down and 'should' be able to do her job.

- She is currently in cognitive rehabilitation with an SLP, focusing on functional strategies to compensate for attention, working memory and executive functioning deficits.

Session Scenario:

Beth describes a breakdown from the last week where she missed a work deadline (Lists of dates and options for several venues).

Approach, give rationale for Pattern/Response coping card.

Try to lay out the Pattern in terms of Situation, Thoughts, Emotions, default coping response, and then generate a better set of responses.

"When I feel overwhelmed I 'hit the wall' and totally break down."

"I'm afraid I can't handle it--when this would have been easy before."

"Then I procrastinate by trying to 'calm' myself through playing solitaire, which sometimes helps for a little while. "

"I try to do too many things at once and I feel stressed."

"I get angry, I can feel my face flush and my anger rise. I go into my office and close the door."

(Front)

Pattern: Too many things at once.

- Notice heart start to race, feel flushed.
- Think "I can't handle this".
- Start to feel anxious, frustrated, and overwhelmed.
- Shut down. Go in office, procrastinate.

(Back)

Response:

- Take a few deep breaths.
- Think "Assess, Breakdown, Complete" (ABC).
- Focus on Just One Thing.
- Pick ONE thing from my planner and write it down at the top of a clean page.

Attention Strategies for the Overwhelmed:

Are you overwhelmed? First, try to notice as *soon* as it begins to happen.
What is going on right now? If you are overwhelmed, you probably have too many Blocks in the Box.

What is filling up your attention capacity *right now*?

Possible Causes:

1. External Distractions (things in the environment like noises, talking, or lighting).

1. Internal Distractions (anxiety, worries, going off on tangents).

1. Taking on too much at one time (thinking about a whole project or your whole day all at once).

Things you can do about it:

1. **If you can, eliminate environment distractions.** Modify your work environment or change where you are working.

2. **Take it easy on yourself.** Use stress reduction strategies (example: take 3 deep breaths).

3. **Slow down.** Once you're overwhelmed, slowing down is one of the best ways to get the number of "blocks" down to a place where you can handle them.

4. **Break things down.** Remember: *Assess, Breakdown, Complete.* Make a short list, and only focus on one piece at a time.

Homework: coping cards.

- Is there anyone on your caseload right now you might be able to help with a coping card?
- Why? What is the problematic situation? What is there pattern?
  - (You can use the cognitive conceptualization template.)
- What responses do you think will help them the most?
  - (You will want to work with them on this to maximize their agency, but it doesn't hurt to go in with some likely suggestions.)

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Applications for clinical supervision

- What are some distorted beliefs that might be experience by new clinicians?
- How do you pick up on them?
- How could you respond?

Applications for clinical supervision

- What are some distorted beliefs that might be experience by new clinicians?
  - Beliefs about what a 'good' clinician should be able to do at a their level of training, inaccurate perceptions regarding current ability, etc.
- How do you pick up on them?
  - Their comments and language use, body language, responses to criticism, etc.
- How could you respond?
  - Cognitive restructuring, Thought records, hypothesis testing, etc.

Supervision Scenario:

- You have been supervising Michelle, a second year graduate intern, in your adult outpatient practice. She is bright, hard working, and conscientious, often preparing thoughtful and detailed treatment plans and materials in advance for the days she will be in your clinic. Both your patients and colleagues generally give her positive feedback.
- For the past two months, Michelle has been helping you work with a particular high-level pt suffering from MCI/ dementia. This pt has a good social support and case management, and still lives alone at home. Your treatment with this pt has been focusing on attention and memory strategies, as day-to-day tasks continue to become more difficult for them in these domains.
- You have noticed that Michelle responds very differently to this pt compared to others on your caseload, which mostly consists of individuals with acquired brain injuries. Michelle appears to become stressed and anxious when they work together, especially compared to the generally warm and comfortable way she works with some of your aphasia pts who are improving. She spends a disproportionate amount of time preparing and modifying materials for this pt, which has met with mixed success.
- Recently, Michelle has expressed overt frustration with this pt while working on a memory strategy that is becoming increasingly difficult for them to apply. When you brought up your concerns about this afterwards, you were surprised to hear Michelle reply, “If they’re not going to get better they shouldn’t be here.”
- **What do you think might be going on here from a CBT perspective?**

Applications for clinical supervision: Mentorship.

- What are some distorted beliefs that you might experience as a **mentor**?
- What contexts elicit these beliefs and what are likely responses?
- What CBT strategies and approaches apply here to support more productive responses?

Supervision Homework

- Think of a supervisor experience you have had where you feel that the tools or framework of CBT could apply.
- What happened and how did you respond?
- What is one way you could respond differently in the future?

Ok, let's assume I've sold you on CBT…

What next? How to implement?

1. Acquire more training:
   - Numerous courses and workshops available.
2. Make alliances:
   - Find quality CBT practitioners in your area. Contact them. Refer and coordinate tx.

Conclusion:

- CBT has a wide range of applications for speech language pathologists.
- CBT is an excellent framework for improving the quality of SLP-appropriate counseling, and for addressing some difficulties in clinical supervision.
- CBT has a number of associated tools and approaches well-suited to support behavioral change in functional cognitive-linguistic domains.

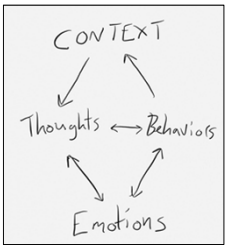
Acknowledgements:

Thanks to Daniel Beck, Diane Parris Constantino, and Carmen Vega-Barachowitz for their help and support in developing this work.

CBT cheat sheet:

Theory & Framework:

- Interaction between thoughts, emotions, behaviors, and context.
- Levels of belief:
  - Automatic thoughts
  - Intermediate beliefs
  - Core beliefs



Tools:

Identifying beliefs:

- Cognitive conceptualization
- Guided discovery (pt locus of control, Socratic techniques)
- Downward arrow

Modifying beliefs:

- Positive vs. negative evidence.
- Hypothesis testing with behavioral experiments
- Thought records
- Coping cards!
- Behavioral activation, Activity logs
- Exposure hierarchies

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References:

Beck, J. (1995). *Cognitive Therapy: Basics and Beyond*. The Guilford Press. New York.

Beck, D. CP795. "Cognitive and Behavioral Treatment". BU School of Social Work. Fall 2011.

For an example of CBT for working with PWS:

Menzies, R. G., Onslow, M., Packman, A., & O'Brian, S. (2009). Cognitive behavior therapy for adults who stutter: a tutorial for speech-language pathologists. *Journal of fluency disorders*, *34*(3), 187-200.

For more information and training:

Beck Institute for Cognitive Behavior Therapy and Research
www.beckinstitute.org

Academy of Cognitive Therapy
www.academyofct.org