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Cognitive Behavioral Therapy for SLPs: Practice updates

William Evans, PhD, CCC-SLP

Moderated by:
Amy Natho, MS, CCC-SLP, CEU Administrator, SpeechPathology.com

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Cognitive Behavioral Therapy for SLPs: Practice Updates

William S. Evans, Ph.D., CCC-SLP

CONTINUED

Learning Outcomes

After this course, participants will be able to:

- Describe basic elements of CBT theory, including the interactive components of the cognitive conceptualization model.
- Explain several common approaches and tools used in CBT to identify and address distorted beliefs and to promote behavioral change.
- Describe relevant research recommendations for modifying CBT for use with individuals who have communication impairments.

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Disclosures:

- *Financial:*
- I receive salary support from the Pittsburgh VA Healthcare System and the University of Pittsburgh

  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, and I have found the course and materials personally useful.

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Back-story: Why CBT for SLP?

- I first became interested in CBT in 2011.
- In my clinical fellowship at MGH.
  - Working with Cognitive Rehabilitation patients.
- Taking PhD coursework at Boston University.
  - Enrolled in a CBT course with BU SSW.
- Have been thinking about the framework and working to apply aspects to my clinical practice ever since.

CONTINUED

Outline:

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  - Case example (coping cards)
- Scope of practice and interprofessional care

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What is CBT?

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

Principles:

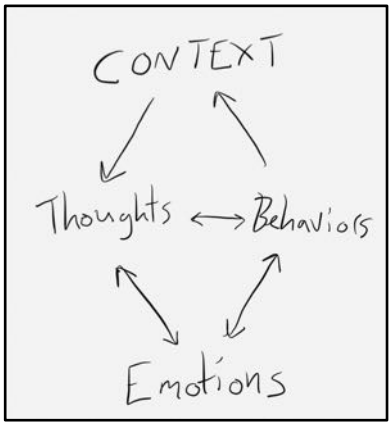
- Based on understanding of the pt in **cognitive terms** (current thinking, beliefs, problematic patterns).
- **Goal-oriented** and problem focused.
- **Pt-centered**, requires active participation.
- **Structured** therapy approach (e.g., agenda setting, homework).
- **Metacognitive** (identifying, 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 (2nd ed).

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…

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 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*.
  - 'Dysfunctional'- affects function.
  - 'Distorted'- not consistent with reality.
- 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 Therapy:

- Each session started by laying out an agenda. Therapist initiated early in treatment, but pt-initiated over time.
- Each session ends with a summary/review, outline of plan, and request for feedback.
- Homework generated in each session.

- *Rationale:*
  - Structure helps set expectations maintain focus on specific goals.
  - Feedback makes sure pt and therapist stay on the same page. Gives a chance for damage control.
  - Homework promotes generalization. Keeps pt and therapist focused on real-world change.

Identifying Beliefs: Cognitive Conceptualization

- Basic framework for laying out relationship between levels of thoughts and beliefs, emotions, and maladaptive behaviors.
- Approach: work through the thoughts/ emotions/ behaviors in a series of scenarios to get at the underlying motivating beliefs.
- Beck (2011) 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: guiding questions, not claims.
- Provide hypotheses, then *ask pts to verify*.
- Practicing this one is tricky. Easily feels false, easy to mock (e.g., pretty much any psychiatrist movie scene).

- *Keep in mind:*
  - Goal is to help the pt figure things out for themselves.
  - As you piece things together, you are basically making *conjectures*, not telling them how they feel.
  - However, play an active role in making and testing conjectures (not just 'reflecting back' their statements).

Downward Arrow

- Example of guided discovery.
- Used to move from automatic thoughts to underlying beliefs.
- Called 'downward arrow' because you follow the negative thought down 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.
- Helps pt and clinician pull out patterns over time.
- Builds up evidence to counter distorted thinking.
- Basic approach consists of a simple log listing:
  - Situation
  - Thought
  - Emotion
  - Response
  - Outcome

Thought Records

Date	Situation	Thought	Emotion	Response	Outcome

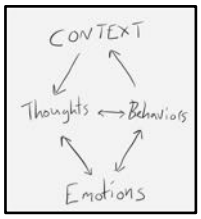
Exposure Hierarchies

- Typically used to treat anxiety disorders, phobias.
- Break difficult domain into 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: only appropriate for targets well within our scope of practice (e.g., communication participation).

Behavioral Activation

- Focuses on context and **behavioral** aspects of the CBT framework.
- Frequently and successfully used for treating depression (e.g., Thomas et al., 2013).
- 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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Modified CBT for Disordered Populations: Post-stroke Aphasia

- Kneebone (2016): "A Framework to Support Cognitive Behavior Therapy for Emotional Disorder After Stroke."
  - Proposes CBT vs. Behavioral therapy continuum depending on pt's capacity for abstraction.
  - Milder PWA can benefit from standard CBT, while more severe PWA need additional supports or behavioral focus.

Modified CBT for Disordered Populations: Post-stroke Aphasia

- Kneebone (2016): Key framework elements
  - Modifying distorted and dysfunctional thinking
  - "Boosted CBT"
  - Cognitive Rehabilitation
  - Caregiver involvement

Modified CBT for Disordered Populations: Post-stroke Aphasia

- Modifying distorted and dysfunctional thinking ("Disputation")
  - Traditional techniques (guided discovery, downward arrow, positives/negatives, etc.) affected by cognitive flexibility and language ability.
- Recommendations:
  - Use concrete examples
  - Simplify language and reduce abstraction
  - Help pt internalize specific clinician-provided coping self-statements.

Modified CBT for Disordered Populations: Post-stroke Aphasia

- **"Boosted CBT."** Based on CBT literature with older individuals.
- Use memory and learning techniques:
  - Pt note-taking during session, audio recording, home practice logs, reminder calls, etc.
- Designed to increase retention of counseling content and facilitate practice in the context of memory impairment.

Modified CBT for Disordered Populations: Post-stroke Aphasia

- **Cognitive Rehabilitation:**
  - Incorporating compensatory strategy training to support CBT.
  - Inverse of recommendation to incorporate CBT to support cognitive rehab!

Modified CBT for Disordered Populations: Post-stroke Aphasia

- Care-giver involvement:
  - Complicated. Can provide pre-morbid info and support acquisition and practice of coping responses at home.
  - However, caregiver stress and burden already high.
  - Also, pt locus-of-control paramount.
  - Recommendations: case-by-case…

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Applications for SLPs: Counseling

- Counseling is in our scope of practice:
  - *"SLPs counsel by providing education, guidance, and support. Individuals, their families and their caregivers are counseled regarding acceptance, adaptation, and decision making about communication, feeding and swallowing, and related disorders.*
  - *The role of the SLP in the counseling process includes interactions related to emotional reactions, thoughts, feelings, and behaviors that result from living with the communication disorder, feeding and swallowing disorder, or related disorders."* (ASHA, 2016)

Applications for SLPs: Counseling

- Within-scope counseling activities include…
  - *"Discuss, evaluate, and address negative emotions and thoughts related to communication or feeding and swallowing disorders."*
  - *"Refer individuals with disorders to other professionals when counseling needs fall outside of those related to (a) communication and (b) feeding and swallowing."* (ASHA, 2016)
- 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 CBT is good for SLP:

- 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:
  - Empathy
  - Familiarity with structured frameworks/tools
  - Experience with pt/family education
  - Strategy training

Counseling Caveats:

- CBT tools/ framework don't replace presence or 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.)

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 (2011).

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 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"		

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Responding to Bob:

- Given the 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, positive and complex. For example:

"My abilities have changed a lot, but I can still accomplish challenging things that are important to me if I just figure out the right way to go about them."

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Homework: Applying Cognitive Conceptualization on Your Own

- Think of a patient, client, or parent/caregiver you have been working with who seems to present with difficulties exacerbated by maladaptive beliefs.
- 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 use a "?". You are laying out *hypotheses* to test.
- If you are brave, try out this same process with yourself!

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Applications for SLPs: Behavioral Change

- Two main approaches to what we do:
  - Compensate for deficits via strategies/external aids or
  - Target impaired systems directly via stimulation and drilling.
- CBT framework and tools support both approaches.
- *Claim:* Every single change we might hope to implement occurs at the point where their thoughts/emotions/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 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 closed 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 her 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).

Introduce, 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).
2. Internal Distractions (anxiety, worries, going off on tangents).
3. 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.

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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 his/her 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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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, often recommend CBT tx *before* cognitive rehabilitation if the pt's presentation includes significant affective/psychiatric components.
  - Helped many pts create a baseline of emotional self-regulation skills so they can focus on systematic cognitive skill training with SLP.
- In VA Pittsburgh PIRATE intensive aphasia program, often refer pts to psychology for adjustment disorder, offer to co-tx initially.

CONTINUED

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?
  - ***Most important:*** **do I feel comfortable with the content of my sessions?**

CONTINUED

Scope of Practice, continued:

- In stroke, helpful "Step Care" models have been developed (Kneebone, 2016b):
  - **Level 1:** "sub-threshold" mood difficulty. Mild/transitory mood symptoms typical to most stroke survivors. SLPs can address independently.
  - **Level 2:** Mild/moderate symptoms of impaired mood which interferes with rehab. Addressable by SLP with psychology support (consult/supervision).
  - **Level 3:** Severe persistent mood disorder. Diagnosable and require specialized intervention. Pharmacology, suicide risk assessment. Outside SLP scope!

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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.

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Acknowledgements:

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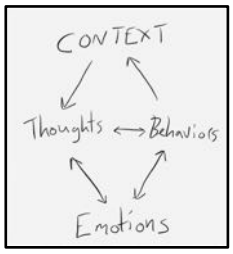
CBT cheat sheet:

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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