

NYC Cognitive Therapy
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COGNITIVE BEHAVIOR THERAPY
FOR SUBSTANCE USE AND
CHANGING CORE BELIEFS

Can You Moderate?

When it comes to changing your relationship with alcohol, you can try to moderate your use or quit altogether. However, for most people, it is much easier to just stop drinking than it is to temper their use. To see if moderation is possible for you, answer the following questions. Be sure to answer honestly. This quiz will not be accurate if you are dishonest. If you notice yourself exaggerating the truth or trying to justify why you don't meet a certain criterion, this is a very good sign that you need to explore this further.

- _____ 1. Have you ever been physically addicted to alcohol, meaning that you experienced withdrawals when you stopped?
Yes (+5) No (0)
- _____ 2. Do you have anxiety, depression, or another mental health issue?
Yes (+2) No (0)
- _____ 3. Do you use alcohol to deal with stress?
Yes (+1) No (0)
- _____ 4. Do you have a history of trauma or PTSD?
Yes (+2) No (0)
- _____ 5. Do you drink alone?
Yes (+2) No (0)
- _____ 6. Is it common for you to black out while drinking?
Yes (+3) No (0)
- _____ 7. Do you use alcohol to deal with social anxiety?
Yes (+2) No (0)
- _____ 8. Are your close friends, your spouse, your immediate family, or the people you spend a lot of time with moderate to heavy drinkers?
Yes (+2) No (0)
- _____ 9. Do you have hobbies or interests outside of drinking?
Yes (-1) No (0)
- _____ 10. Were you raised in an environment where there was heavy drinking?
Yes (+2) No (0)
- _____ 11. Is there a history of substance use issues in your family?
Yes (+2) No (0)

- _____ 12. Have you encountered legal, probationary, school, or work trouble because of your drinking?
Yes (+3) No (0)
- _____ 13. Do you have an eating disorder or a history of one?
Yes (+1) No (0)
- _____ 14. Do you have a history of using other non-prescribed substances?
Yes (+1) No (0)
- _____ 15. Was your first drink before the age of 15?
Yes (+1) No (0)
- _____ 16. Has your drinking negatively impacted your relationships or loved ones?
Yes (+2) No (0)
- _____ 17. Do you drink every day?
Yes (+2) No (0)
- _____ 18. Do you have any medical issues?
Yes (+2) No (0)
- _____ 19. Are you a binge drinker?
Yes (+2) No (0)
- _____ 20. Have you been to an inpatient facility or detox center for drinking?
Yes (+3) No (0)
- _____ 21. Has your alcohol use been increasing to get the same effect?
Yes (+2) No (0)
- _____ 22. When you drink, do you have a hard time stopping?
Yes (+3) No (0)
- _____ 23. Have you tried to cut back on drinking and been unable to?
Yes (+2) No (0)
- _____ 24. Have you lost interest in your regular hobbies or blown off commitments or friends so you can continue drinking?
Yes (+2) No (0)

- _____ 25. Do you experience feelings of shame or guilt due to drinking?
Yes (+1) No (0)
- _____ 26. Do you have a group of supportive people in your life you can rely on?
Yes (-2) No (0)
- _____ 27. Do you have people in your life with whom you can do things that don't involve drinking?
Yes (-1) No (0)
- _____ 28. Are you willing to tell people in your life you want to cut back on drinking so they can support you?
Yes (-2) No (0)

To calculate your total score, add up your answers, making sure to subtract any points from your score that have a minus sign.

Total score: _____

Scoring Key

9 and below: You may be able to successfully moderate your drinking. You have the best shot of making this work by increasing your coping skills, working on your mental health, and being intentional about the times you choose to drink.

10–30: It's unlikely that you will be able to effectively moderate. You may be able to do it for periods of time, but it will likely be based on willpower, and you will slip back into old patterns. If you do not want to become abstinent, you will likely always fall back into drinking too much. Your alcohol use could stay the same or it could continue to get worse, and you could eventually advance to a score over 30.

31–50: It is extremely unlikely you will be able to successfully moderate. Even if you do work on yourself and heal some of the deeper issues causing you to drink, your drinking has progressed to the point where that habit is so worn down, it will be nearly impossible to moderate.

What was it like answering the questions from the quiz?

After reading through the scoring information, how do you feel about the score you received?

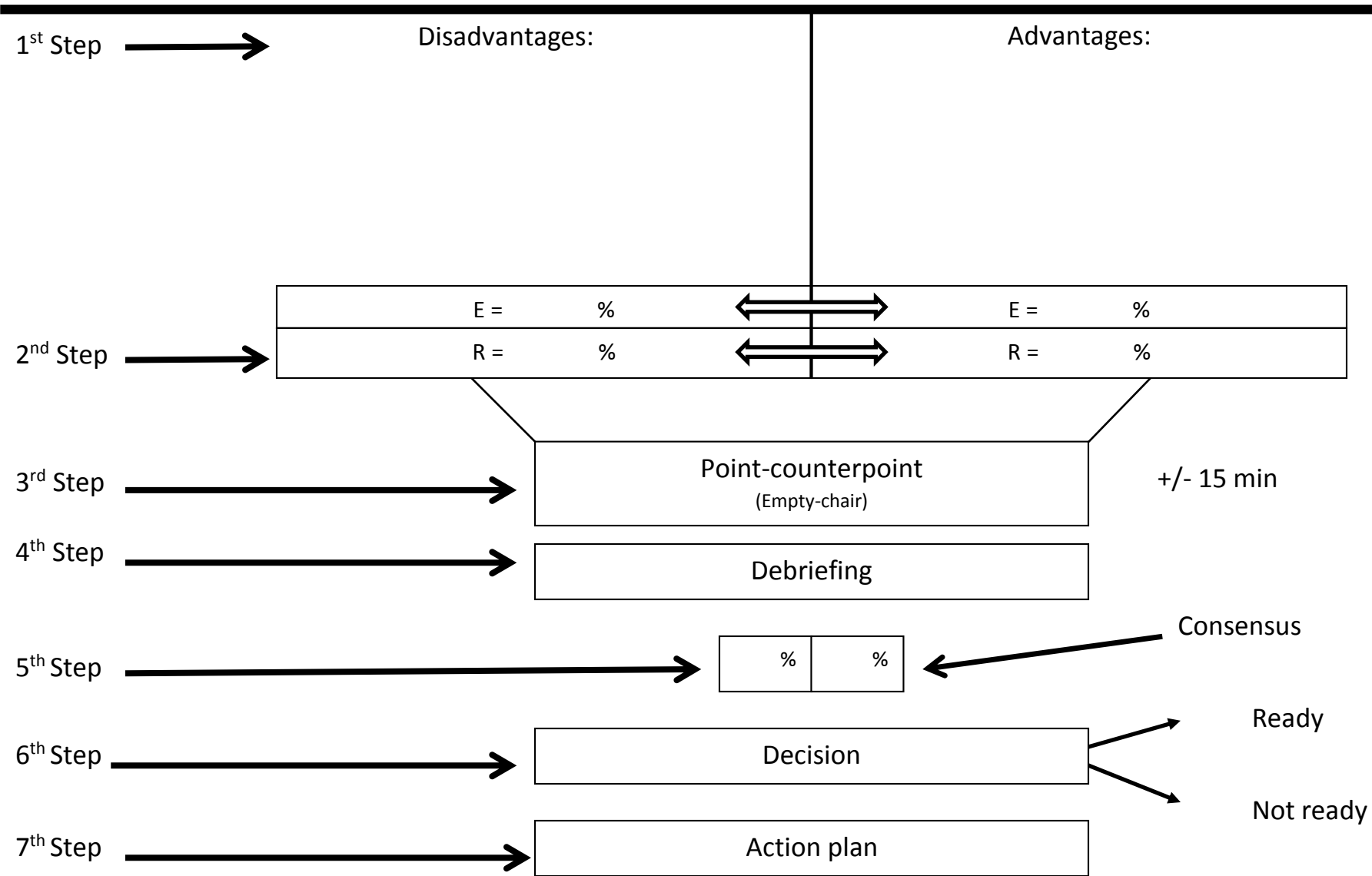
Positive Reframing Table for Habits and Addictions*

Describe the habit / addiction you want to change:

Your habit or addiction it can be almost anything—overeating, drugs or alcohol, cell phone use, internet surfing, buying things on sale, shoplifting, procrastination, internet porn, having affairs, smoking, biting your nails, etc.

Advantages What are some <i>benefits</i> of this habit / addiction?	Disadvantages What are the <i>disadvantages</i> of trying to change or give up this habit / addiction?	Core Values What does this habit / addiction say about you and your values that's <i>positive</i> and <i>awesome</i> ?

Desired or feared action:



Consensual Role-Play

Consensual Role-Play (CRP) is a 7-step decision-making method designed to help patients deal with ambivalence, challenge safety behaviours (e.g. avoidance) and facilitate behavioural experiments (e.g. taking the elevator in the case of claustrophobia) (De Oliveira, 2012). Used transdiagnostically, CRP typically takes around 30-40 minutes, and can be repeated as many times as necessary regarding the same or different decisions (Fig. 4.5). In introducing the rationale to the patient, the therapist explains to him/her that the most important thing is what he/she learns and not the decision itself. Assuring that he/she will not be pressured to make the decision decreases the patient's defensiveness, freeing him/her to elicit any concern and therefore, not try to please the therapist.

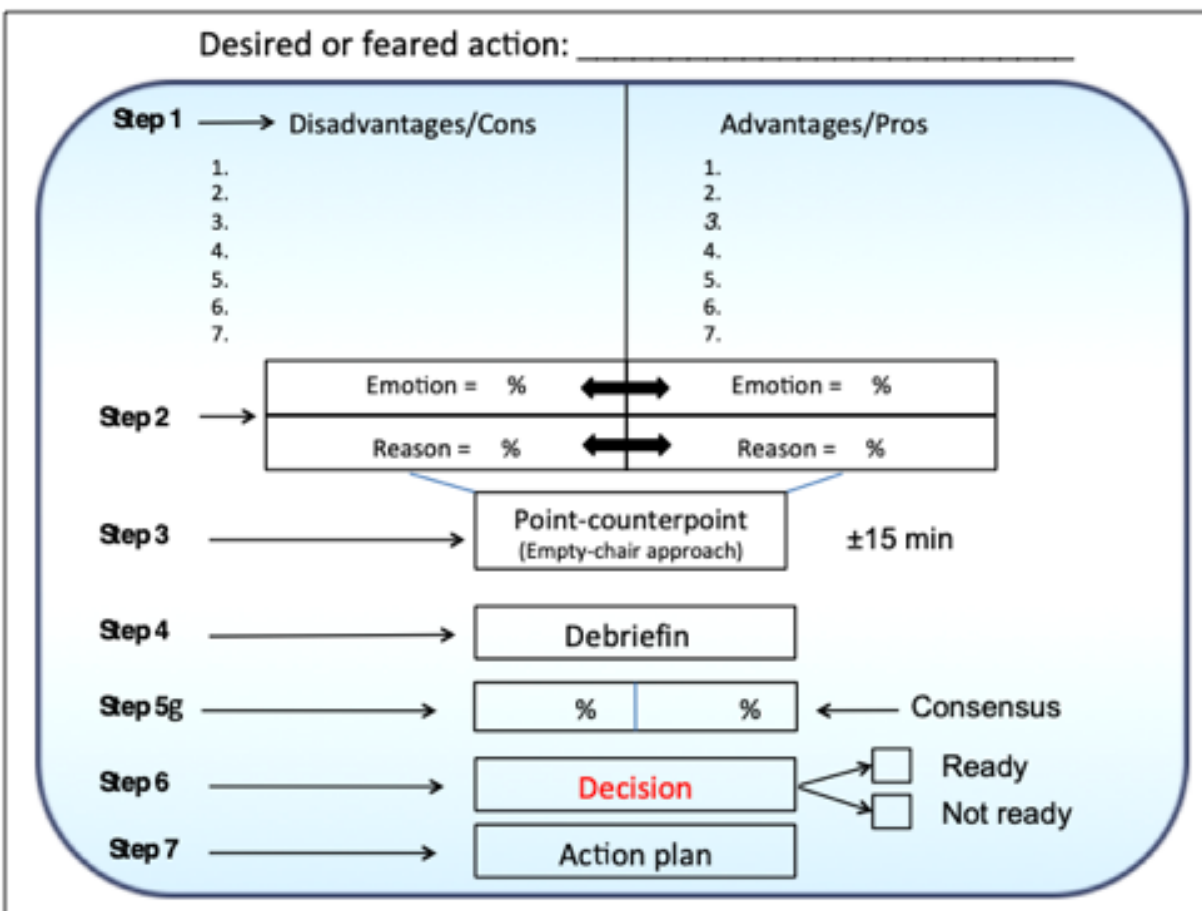


Fig. 4.5 – Consensual Role-Play, a decision-making approach (Copyright: Irismar Reis de Oliveira).

Description of CRP

Step 1: The patient is encouraged to list advantages/pros and disadvantages/cons of implementing the desired/necessary, but unpleasant/feared, action/behavior.

Step 2: The patient is helped to confront the dissonance between “reason” and “emotion” (Padesky, 2004), giving a percentage weight to the advantages of implementing the action (versus percentage for the disadvantages) according to reason, and percentage weight to the disadvantages of implementing the action (versus percentage for the advantages) according to emotion. Some patients are unable to discern between reason and emotion (e.g., alexithymia). In this case, the therapist asks him/her to distinguish “the internal voice that says ‘go’” from the “internal voice that says ‘don’t go’” (see Table 4.1 for useful questions in Step 2).

Step 3: By means of the empty chair approach (Carstenson, 1955), the patient is encouraged to reach a consensus between “the rational self” (Chair 1) and “the emotional self” (Chair 2) in a ±15-minute dialogue, making emotion speak to reason and vice-versa.

Step 5: The patient, now activating his/her “consensual self” (Chair 3), and the therapist debrief and check what was learned from steps 1 through 3.

Step 4: The therapist asks the patient (“consensual self”) to reassess the weight of advantages vs. disadvantages, the goal being to attain a consensus between the rational and emotional selves.

Step 6: The therapist asks the patient if he/she is ready to make the decision, that is, if he/she is ready to implement the unpleasant/feared action/behaviour.

Step 7: If the answer is “yes,” the therapist helps the client design an action plan (Greenberger & Padesky, 1995) in order to increase the chances of success in implementing the action, so that not only can he/she organize what to do, as well as how and when, but also anticipate obstacles, find solutions, and follow-up the outcomes.

Action Plan: _____

Proposed actions:

- a. _____
- b. _____
- c. _____
- d. _____

Possible obstacles to actions:

- a. _____
- b. _____
- c. _____
- d. _____

Solutions to obstacles:

- a. _____
- b. _____
- c. _____
- d. _____

When to implement proposed actions:

- a. _____
- b. _____
- c. _____
- d. _____

Follow-up:

- a. _____
- b. _____
- c. _____
- d. _____

Fig. 4.6 – Action Plan (Copyright: Irismar Reis de Oliveira).

Table 4-1. Useful questions to be asked to the patient during Step 2 of the Consensual Role Play (CRP), assuming that the emotions are negative (e.g., fear, anxiety, shame).

Question Number	Patient chooses disadvantages/emotion	Patient chooses advantages/reason
1	<p>What do you think carries more weight in your decision to ... (action): _____ the advantages or the disadvantages?</p> <p>Answer: The disadvantages.</p>	<p>What do you think carries more weight in your decision to ... (action): _____ The advantages or the disadvantages?</p> <p>Answer: The advantages.</p>
2	<p>When you say, the weight of the disadvantages is greater, are you thinking emotionally or rationally?</p> <p>Answer: Emotionally.</p>	<p>When you say, the weight of the advantages is greater, are you thinking emotionally or rationally?</p> <p>Answer: Rationally</p>
3	<p>So, the disadvantages, emotionally speaking, seem to weigh more. How much more? Sixty, seventy, eighty, ninety, one hundred per cent?</p> <p>Answer: 75% (leaving 25% for advantages, emotionally speaking).</p>	<p>So, the advantages, rationally speaking, seem to weigh more. How much more? Sixty, seventy, eighty, ninety, one hundred per cent?</p> <p>Answer: 80% (leaving 20% for disadvantages, rationally speaking).</p>
4	<p>And rationally speaking, what seems to weigh more, the advantages or the disadvantages?</p> <p>Answer: The advantages.</p>	<p>And emotionally speaking, what seems to weigh more, the disadvantages or the advantages?</p> <p>Answer: The disadvantages.</p>
5	<p>How much? Sixty, seventy, eighty, ninety, one hundred?</p> <p>Answer: 90% (leaving 10% for the disadvantages, rationally speaking).</p>	<p>How much? Sixty, seventy, eighty, ninety, one hundred?</p> <p>Answer: 70% (leaving 30% for the advantages, emotionally speaking).</p>

Clinical Case Example

Mary-Ann, aged 52, is a married teacher with a 9-year history of panic attacks and severe agoraphobia, complicated by several other phobias (closed spaces, planes, thunder, crowds) and alcohol abuse. She completely stopped working (previously, she had multiple interruption periods because of frequent panic attacks at the workplace) and was put on sick-leave 1 year ago. Her panics, agoraphobia, and alcohol consumption increased progressively, making her more and more reclusive.

Besides escitalopram 10 mg/d, Mary-Ann had 12 trial-based cognitive therapy (TBCT) sessions, overall, similar to those described in the Common Language for Psychotherapy (CLP) procedures TBCT entry (De Oliveira, 2011b). Sessions 1 through 6 were successfully dedicated to help her overcome panics and agoraphobia. She had no more attacks after session 4, and was able to resume physical exercises and walking on the streets, going to malls, initially with her daughter and then by herself. Having moved from her city to Salvador for treatment also seemed to help her abstain from alcohol because of reduced exposure to drinking opportunities. Her worst fear, however, remained taking the elevator and being in closed spaces. In session 5, merely mentioning that she could try taking the elevator in the therapist's presence made her cry and declare that this was an impossible action. In session 7, however, the therapist proposed the CRP to help her in this regard, being careful to explain that the main intent was not convincing her to take the elevator, but to help her understand what was behind this. Fig. 4.6 illustrates Mary-Ann's CRP. As in step 6, she decided that she was not ready, the therapist proposed an action plan to help her gather information that might prepare her to make the decision later (Fig. 4.8) In session 8, although anxious, Mary-Ann accepted the exposure and spent 40 minutes in the elevator with the therapist, her SUDs having decreased from 90% to 20% anxious, with several oscillations in between, depending on how many people entered the elevator.

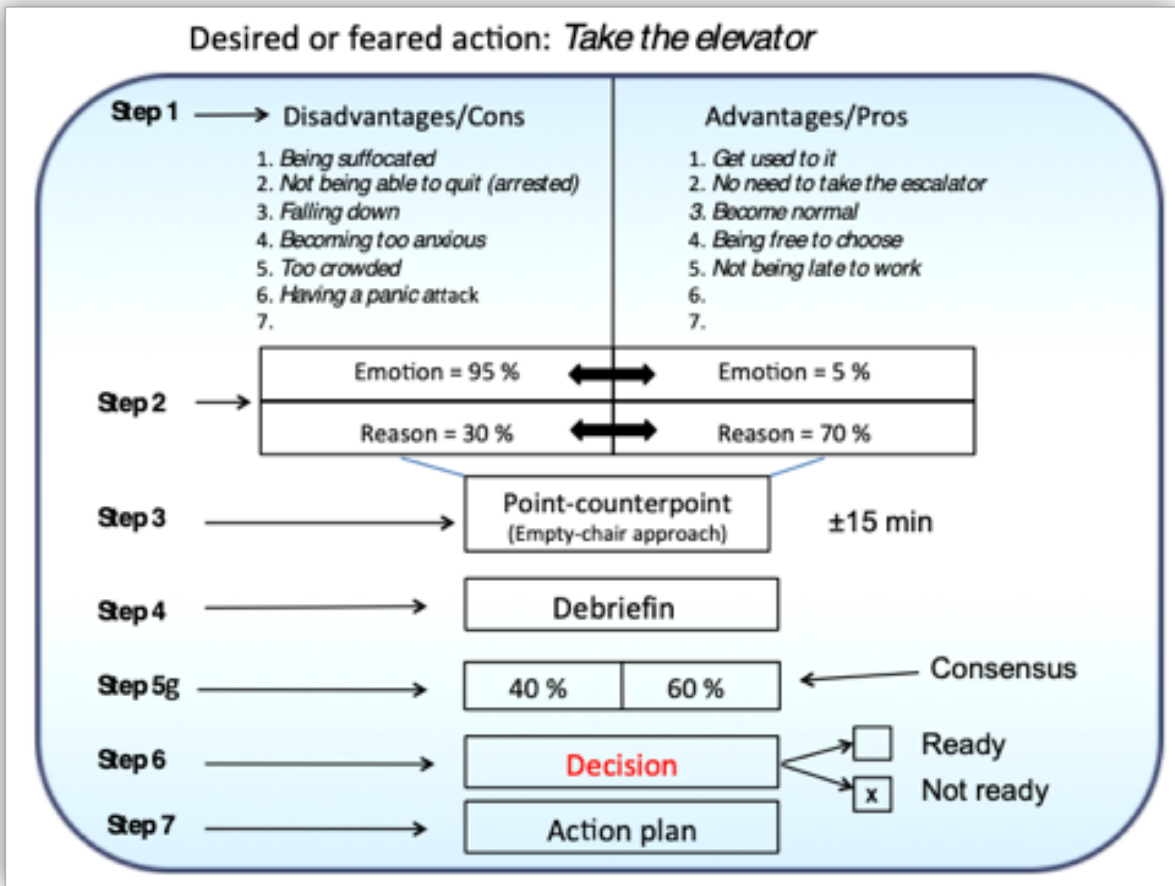


Fig. 4.7 – Mary-Ann’s Consensual Role-Play (Copyright: Irismar Reis de Oliveira).

Action Plan: *Take the elevator*

Proposed actions:

- a. *Searching for elevator risks on the Internet;*
- b. *Taking panoramic elevators in the mall with my daughter and then by myself;*
- c. *Continue other exposures that make me feel stronger;*
- d.

Possible obstacles to actions:

- a. *I do not have access to the Internet where I am staying;*
- b. *Not sure if there is an elevator with panoramic view there;*
- c. *None;*
- d.

Solutions to obstacles:

- a. *Call my friend Rita and ask her to do the search;*
- b. *If not panoramic view, ask my daughter to take me to another mall a little farther;*
- c. *No problem;*
- d.

When to implement proposed actions:

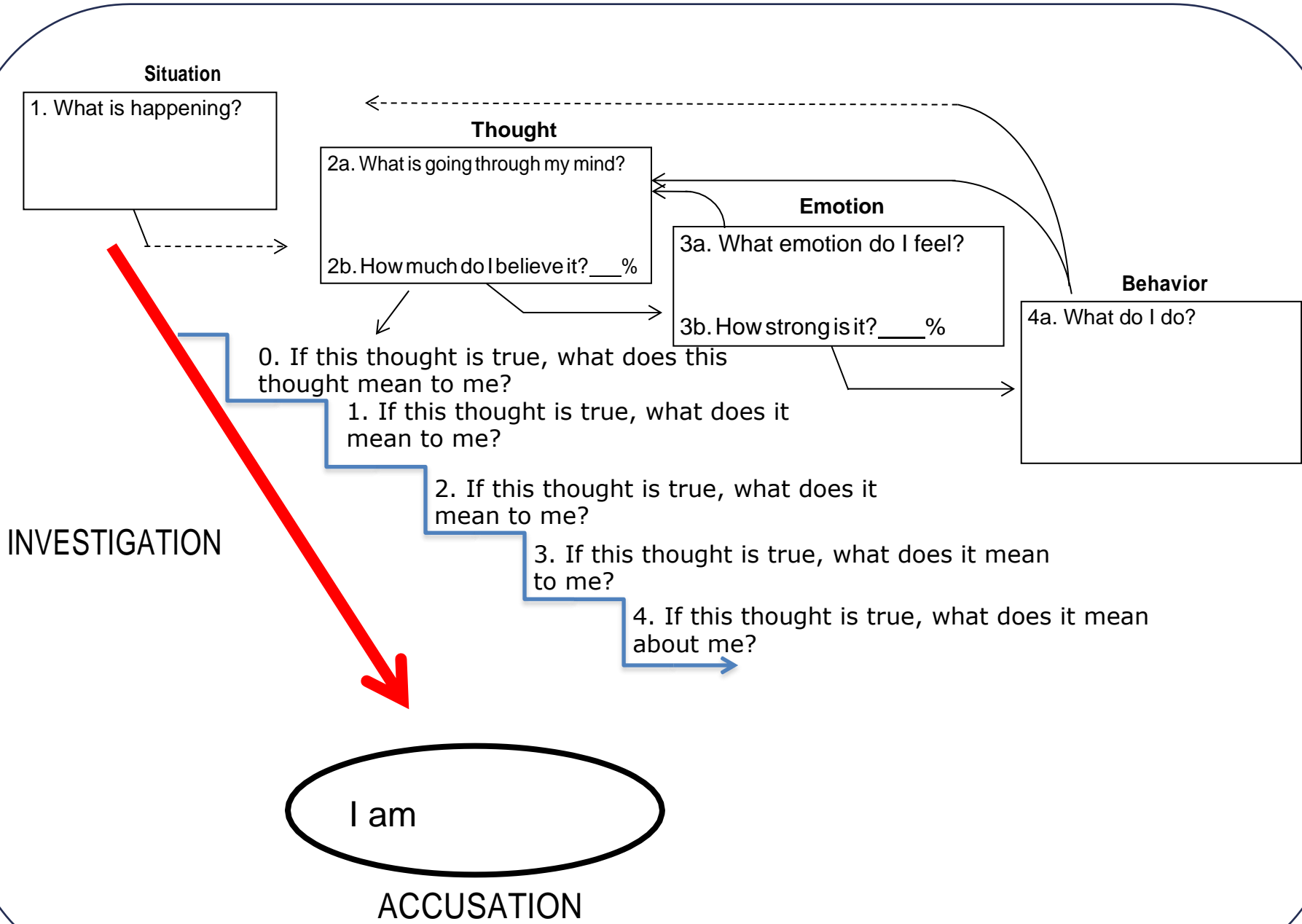
- a. *Call Rita tonight;*
- b. *This Saturday;*
- c. *Today and during the week;*
- d.

Follow-up:

- a. *Rita sent me an Internet search informing that the risk of having an elevator accident was much lower than riding a car;*
- b. *I didn't because my daughter wasn't available;*
- c. *No problem;*
- d.

Fig. 4.8 – Mary-Ann's Action Plan (Copyright: Irismar Reis de Oliveira).

Downward Arrow



List of Core Beliefs

Helpless core beliefs

I am incompetent
I am ineffective
I can't do anything right
I am helpless
I am powerless
I am weak
I am vulnerable
I am a victim
I am needy
I am trapper
I am out of control
I am a failure
I am defective [i.e., I do not measure up to others]
I am not good enough [in terms of achievement]
I am a loser

Unlovable core beliefs

I am unlovable
I am unlikeable
I am undesirable
I am unattractive
I am unwanted
I am uncared for
I am different
I am bad [so others will not love me]
I am defective [so others will not love me]
I am not good enough [to be loved by others]
I am bound to be rejected
I am bound to be abandoned
I am bound to be alone

Worthless core beliefs

I am worthless
I am unacceptable
I am bad
I am a waste
I am immoral
I am dangerous
I am toxic
I am evil
I don't deserve to live

© 2011, Beck, J.S. *Cognitive Behavior Therapy: Basics and Beyond* (2nd ed.).

TBCT Form Trial 1 - Shortened Version

Briefly describe the situation:

Inquiry: <i>Establishing the Accusation</i> <i>(Core Belief)</i>	Prosecutor's Plea: <i>Evidence that Supports the Accusation</i>	Defense Attorney's Plea: <i>Evidence that Does Not Support the Accusation</i>	Juror's Verdict: <i>Debriefing</i>				
			Fact or Distortion?				
			<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%; text-align: center;">Prosecutor</th> <th style="width: 50%; text-align: center;">Defense</th> </tr> </thead> <tbody> <tr> <td style="height: 150px;"></td> <td style="height: 150px;"></td> </tr> </tbody> </table>	Prosecutor	Defense		
Prosecutor	Defense						
<p>How much do you believe your initial belief? ____%</p> <p>What initial emotion(s) does this belief make you feel?</p> <p>How strong is it? ____%</p>	<p>How much do you believe the accusation? ____%</p> <p>How strong is your emotion now? ____%</p>	<p>How much do you believe the accusation? ____%</p> <p>How strong is your emotion now? ____%</p>	<p>Verdict:</p> <p>If the defense attorney is right, what do you think s/he is trying to prove about you? "I am _____"</p> <p>What final emotion(s) does this belief make you feel?</p> <p>How strong is it? ____%</p>				

Table A.4: Preparation for the appeal (one belief form)

Positive new core belief: I am _____. (Please, write down here at least one piece of evidence supporting the new core belief. Also, write how much you believe it, daily, in the space between parentheses)

Week of: _____

Date: (%)	Date: (%)	Date: (%)
1	1	1
2	2	2
3	3	3
Date: (%)	Date: (%)	Date: (%)
1	1	1
2	2	2
3	3	3
Date: (%)	Date: (%)	Date: (%)
1	1	1
2	2	2
3	3	3
Date: (%)	Date: (%)	Date: (%)
1	1	1
2	2	2
3	3	3