The Biodyne Model of Substance Abuse Treatment

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The Nicholas & Dorothy Cummings Foundation
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The first session with substance abusers: A step-by-step guide.

2000

San Francisco: Jossey-Bass
Nicholas A. Cummings and Janet L. Cummings

Refocused psychotherapy as the first-line intervention in behavioral health.

2012

Routledge
Who Is the Substance Abuser?

- The cultural point of view: It’s all relative
- The patient’s point of view: It ain’t me
- The family’s point of view: Blame the addict for all trouble
- The medical point of view (cravings/withdrawal)
- The psychological point of view (learned behavior)
The Biodyne point of view

An addict is someone who persists in his/her substance use/abuse despite a set of circumstances/consequences which would have caused a non-addict to quit.

All addiction is GARDLIC.

We treat GARDLIC before ONION.
Who Is the Pusher?

- The addict may very well also be a pusher. He/she has to pay for his/her drugs somehow.

- The pusher may be someone at the school or the workplace.

- The pusher may be a kindly, well-intended physician.

- The pusher may be an unscrupulous physician.
Some Facts about Addiction

- It is impossible to hide drug abuse from a knowledgeable clinician.

- Addiction results in physiological changes that are permanent for forever discernible.

- Drug preference varies according to gender, ethnicity, socio-economic status, and individual physiology.
• Drug addiction can include the medication a doctor gives as a substitute.

• It is possible to reveal the addiction on the first session in spite of the patient’s denial.

• Addiction is to the same class/family of drugs.

• Addicts have a preference for a drug even before they have tried it.
Children can be born addicted.

While addicts typically have a preferred drug, they will use “any port in a storm.”
Causes

- Genetic influences.
- Prenatal influences
- Environmental influences
Physiological Changes

- The body ceases to produce its own anxiolytic, antidepressant, or analgesic chemicals.
- Brain cells are permanently altered to respond to the same chemical in the future.
- The liver is altered and may be damaged permanently.
The addict continues to imbibe after a series of consequences, any of which would constitute trouble of such dire proportions that a non-addict would deem the chemical effect not worth it.

Another word for “addiction” is “trouble.”
Signposts

- Any DUI
- Frequent auto accidents, moving violations, or both
- Two or more bone fractures in a 3- to 5-year period
- Spousal battery, physical abuse of children, or both

“I’ve lost everything”
• Amotivational syndrome
• Tweaking
• Unusual physique
• Paranoia
• Missed adolescence
Treatment Models

- The Medical Model

Because addiction is physiological, the treatment should be medical.

Titration
Substitution
The Behavioral Model

Addictive behaviors are learned responses which can be un-learned.

Addicts can be turned into social drinkers/users.
The Abstinence Model

The highest level of drug tolerance achieved becomes the minimum daily requirement.

Drugless detox whenever possible.

In order to recover, the addict must achieve abstinence long before he/she is ready to do so.
The Pre-addictive Group

- Designed to soften the patient’s resistance.
- Addicts don’t need to “hit bottom” before they enter recovery.
- The patient attends a psycho-educational group, and decides for him/herself whether or not he/she is addicted.
- 5 consecutive daily meetings for 2 hours each.
- The number of patients who enter a 20-week program is increased by 50%.
The Outpatient Addiction Group

- 20 weeks (meets weekly for 2 hours)
- Patient can have up to 5 individual sessions during the 20 weeks.
- Attendance is required.
- Abstinence is required.
The group enforces the group rules.

“Three strikes and you’re out.”

Lack of abstinence or an unexcused absence results in a “fall.”

If a patient has not been abstinent, he/she reports this to the group and is dismissed from the rest of the session. He/she is given a “fall.”

Group votes on absences.
• If a patient “falls out” of the group, he/she can begin again when the next group begins.

• Patients are connected to AA or some other ongoing support before they graduate from the group.

• Patients may attend a second 20-week group if necessary.

• Denying treatment may be the MOST THERAPEUTIC thing we can do for a patient.
The Implicit Contract

- Beware the “casual aside.”

- Read the health questionnaire. Many patients will accurately report their substance use on the form, but deny when asked by the clinician.

- Do NOT see the patient as a victim. Any empathy can imply to the addict that the clinician sees the substance abuse as justified.
Leverage

- The spouse/partner/parent
- The court
- Suspended driving privileges
- Employment probation
Motivating the Patient

- Even AA tells us that bottom is relative or non-existent.

- We can’t wait for the patient to “hit bottom.”
We must be aware of two things:

1. The addict patient is not here to change.

2. The secret of reaching the patient is through the obstinacy that is part of the patient’s denial.

ADDICTION = DENIAL
• We talk like the patient, so the patient will talk like a therapist.

• We issue the “challenge.” We must seem highly skeptical!

  “Prove me wrong!”

  The amount of time given depends on the longest the patient has been able to abstain during the past two years.
• A variation of the challenge –

We can elicit a long-lost wish or goal.

We talk about a former patient with a similar wish, who succeeded after cleaning up his/her life.

When the patient starts to get excited, we express skepticism about the patient’s willingness/ability to abstain and issue the challenge.
“No, you’re not an addict.”

Mobilizing rage in the service of health

Leveraging the blackout

Blackouts are the early stage of brain damage.
The Games Addicts Play

- The Woe-Is-Me Game

The patient’s self-pity justifies his/her addiction and lures non-addicts into the game.

This is a way of “dangling onion.”

Many “problem of the week” patients are addicts playing this game.
• **The Victim Game**

  The patient views his/her misfortunes as pervasive and permanent.

  Again, this is a way of “dangling onion.”
The Rescue Game

The addict spends a lot of time/energy/resources rescuing very unworthy people.

He/she has the expectation that those people will in turn rescue him/her, or that there is some cosmic score-keeping system that will make sure he/she gets rescued when he/she messes up.
The Blame Game

The addict holds someone else responsible for his/her troubles.
The Feeling Game

Counterfeit feelings can be mistaken for genuine contrition.

Counterfeit feelings substitute for true empathy.
The Insight Game

“All insight is soluble in alcohol and drugs.”
● The Rubber Ruler (or Rubber Yardstick) Game

This is the way in which the patient measures his/her substance use.

Gross under-reporting

Differences that don’t exist (e.g., beer vs. martinis)
The Vending Machine Game

Life is viewed as a vending machine. You put your money in, and get your commodity out.

The patient expects instant return on anything he/she does right.
The File Card Game

or The Electronic Alert Game

The patient has made the decision that he/she will be justified in relapsing if . . . .

The patient responds to that difficult event with apparent indifference, but instantly and severely relapses.
The Musical Chairs Game

Cross-addiction

Examples: Valium for alcohol
gambling for alcohol
beer for martinis
The Special Person Game

Addicts believe they are special persons, and someday this will be seen by everyone else.

He/she will do something great some day.

He/she will be the first addict to become a social user.