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Smoking to Death" to "Breathing in Freedom": A Case Study of Nicotine Addiction and its Ongoing Treatment

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Addiction is a multifaceted phenomenon that pertains to major aspects of our lives. It is a long, gradual procession of changes on physiological, mental, emotional and social parameters of one's life. Mainstream psychology sees addiction and its stages as an illness, and/or definitely as an ailment that requires specific treatment, since it is closely linked to high incidence of reckless behavior, that often puts oneself and others at risk. Different kinds of treatment derive from a variety of existing models to understand and deal with the phenomenon. According to the medical model [1], addiction has to do with physiological/hormonal abnormalities and deficiencies and after prolonged use/exhibition of behavior, it can cause permanent brain damage, which might render treatment at times impossible- in this case, harm reduction programs such as use of substitute substances can control negative consequences on the individual without leading to some form of cure- if substitutes are coupled with certain forms of counselling/psychotherapy, more permanent results have been reported. The psychobiological model sees addiction as a repeated series of a "triangle with a meeting point" of personal (i.e. temperament, personality, defense mechanisms), environmental (family deficiencies, social influences, spirit of the time, social milieu) and factors having to do with the characteristics of the substance or the addictive behavior per se [2-4]. Regarding this model, psychotherapeutic interventions, such as CBT, motivational interviewing, appreciative inquiry, ego psychology, depth psychology, existential approach, family therapy [1,5,6] and therapeutic community protocols [2,7], have long been applied, often with outstanding results.

All previously mentioned approaches reflect mainstream psychology values and practices, each having its benefits and drawbacks towards treatment of addiction. Parallel to these lines, the basic tenets of Process Work and Depth Psychology as a psychotherapeutic approach have been established, opening up to a totally different viewpoint about the issue. Its essence lies to the way addiction is being seen and tackled: The person addicted to a substance, behavior or relationship expresses a fundamental psychological truth/need, which has not been expressed or understood so far and which finds its way out, seeking to be fulfilled. Therefore, addiction represents "a quest for the hungry ghosts" [8], which if not "seen", "heard", "understood" and finally fulfilled, sabotages any attempt to put aside and control addictive tendencies. The addictive behavior creates a lot of shame and guilt, which in turn increases the hunger, the psychological need, which then reinforces rather than curtails the addiction. This is the reason why so many programs of weight loss, cigarette cessation, etc. prove to be inefficient in the long run. Under this light, the process work therapist becomes "a loving witness" [9,10] maybe for the first time in the addicted person's life, a witness who navigates him/her through shame and critical self-talk towards a more differentiated, ego- syntonic, satisfied and safe mode of operation- it is via this inner state that any attempt to treat the addiction can have the desired results.

The present article will depict a case study of nicotine addiction coupled with a dual diagnosis and with severe health conditions. A presentation of the therapeutic plan and the level of change so far during this ongoing psychotherapy course will take place together with major issues underlying the addiction. Subsequently, a discussion on the nature, the process and the treatment of addictions will shed light on a human malaise which puts considerable toll on people's lives as personal, financial and professional impasses become more and more apparent especially during the Covid-19 years.

Case study: Mr. A. was referred to me by his lung specialist, who had foreseen that her patient would benefit enormously by a psychotherapy intervention to combat his nicotine addiction, which at the time seemed to have been an integral part of Mr. A's identity, putting him on an enormous risk of death from suffocation (Mr. A. suffers from Chronic Obstructive Pulmonary Disease). Apart from his lung specialist, Mr. A. sees a psychiatrist, an endocrinologist and a cardiologist on a regular basis.

Mr. A. lives with his mother and has a married sister. He reports being particularly attached to both of them. He is a painter with a degree from the Greek University of Fine Arts. As his main profession, he works in a high school, while during afternoons and weekends he develops his true passion, painting. He suffers from a

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serious lung condition which seriously endangers his life without any prior notice. He is closely monitored by his physician and he tries to avoid any further hospitalization. He used to smoke 3 packs a day, but during his treatment he manages to smoke no more than 1 pack a day and his condition is characterized as relatively stable.

Mr. A. is a homosexual who has not come out in his family and his work environment. He has a "distance"-in a way "platonic"- intimate relationship with a physician who, in order to be with him, puts as a prerequisite complete cessation of cigarette smoking. Although Mr. A. keeps on "promising" to me himself and his partner that he will quit or will not smoke more than 5 cigarettes a day, most of the times he fails to keep his promise.

The treatment plan was based on the following interventions- in reality a combination of linear and systemic interventions (having complete medical coverage in the background)

1. Mr. A. is seen with the lenses of a person who has very good reasons to smoke despite the fact that whenever he does so, he moves closer to death due to the Chronic Obstructive Pulmonary Disease he suffers from-in other words, he is not just "a smoker, possibly with suicidal tendencies"(a diagnosis I came up with in the beginning) but an active agent in his life who tries to express deep rooted truths about himself, truths that cannot be expressed otherwise (the deceased father, a former policeman, was very much against homosexuals, and his mother still expects him to « find a nice lady to get married». On top of that, Mr. A. lives in Greece and experiences considerable discrimination for people with diverse identities, despite recent changes in the Greek Law, i.e. the cohabitation contract among people of the same sex.

2. The underlying frustration, shame and rage which constitute the background of his psychological milieu, while initially untouched, is gradually and carefully experienced and expressed in the therapeutic situation. Mr. A. smokes, gets seriously ill-"smokes to death"- feels guilty and shameful, and as an attempt to deal with these feelings, he smokes again, sustaining the vicious circle. The frustration comes from the fact that both on a family as well as on a societal level, Mr A. has to hide in order to materialize his true self to its fullest, a realization that influenced him deeply and for which he feels like doing a series of small "secret" revolutions. Cigarette smoking is therefore treated as an act of rebellion against all kinds of establishments. When Mr. A. smokes, he is free, he is himself, he can rebel against the "authorities" that cannot understand and accept his true nature, his authentic self. On the other hand, in therapy's safe and warm milieu , which lacks any kind of criticism, Mr A. can "become whole" again, he fully experiences his identity, he feels heard and understood. One of my main goals is to provide him with the "loving witness" he supposedly never experienced fully in his life before [10]. It is in this state of mind and "psychological environment" that he can explore his addiction with clarity and unprecedented boldness, adding to his identity and taking him away from a person who is sick, addicted, overweight, a failure as a painter, etc. etc. Tackling his real essence enables him to put aside the voices full of critical comments that accompany him at all times, and give him good reasons to enjoy life away from any kind of addiction.

In reality, the treatment plan follows both linear and systemic approaches: initially, using a CBT approach, Mr. A. started to keep a calendar of his day and his smoking behaviour, which was sending me via e-mail (in an attempt to "re-create" conditions of a therapeutic community). Then, the main emphasis has been placed on intrapsychic processes and on the meaning smoking has for him, despite his dire state of health. Lately, what is clearly unravelling is the meaning smoking has for his family; that is, Mr. A. experiences strong cognitive and emotional dissonance [11], according to which he both wants to cover psychological needs of both his mother and his sister while at the same time cover his own needs for recognition, acceptance and love of his diverse status. In order to deal with this inner complexity of contradictory feelings and cognitions, he "smokes to death"-it is not a primary death wish he has which drives him to smoke with no limits although he fully recognizes the severity of his health condition; rather, it is his quest for real life, his quest to "breathe freely" while avoiding conflict with his family at all costs. With regard to his "impossible" family situation, the family members depict a co-addictive behaviour-on the one hand they check his medicines, criticize him strongly about smoking, worry too much when his health takes a negative turn, but at the same time they cover him financially and buy his cigarettes, so as not for him to experience withdrawal and then become agitated or at times violent. In this family, due to considerable enmeshment, personal emotional boundaries seem to be non- existent when all family members interact [5]; on the other hand, the sound, stable therapeutic relationship Mr. A. has managed to establish with me offers glimpses of an autonomous, differentiated self [12]. Further proof for this came recently via a telephone call I received form his sister who wanted to talk secretly with me about Mr. A's condition(which was obviously met with refusal on my part, unless Mr. A. would give his informed consent); this incident can be seen both as an autonomous move on the part of another family member ,i.e. the sister, while at the same time an act to maintain the family status quo, namely breach of coalitions, inability to express needs openly and "come-back" moves, in a family system that seems to be endangered by the inner autonomy being painstakingly and gradually acquired by Mr A. via his psychotherapeutic treatment. To move a step further, Mr. A is viewed and experienced mainly through appreciative lenses, as a person capable of experiencing his own thoughts and feelings, as well as the psychological lies he tells himself, who "works" digilently to improve his mental health (and therefore need to smoke less), but his " achilles' heel" lies in the fact that he does not want to make an open conflict with his family, telling them who he really is and what kind of support he needs in order to control his smoking (and sometimes drinking) behaviour. This is the point in time where, along with continuing the in-depth individual work with Mr. A., the need for a systemic intervention with the whole family arises more clearly [13,6]. At the same time, Mr. A. explores his potential both as a teacher and as a painter and is gradually led to move away from the frequent "as-if" position of being a victim towards a person who has been solving inner and outer conflicts, has been moving away from the predominant feelings of anger, shame, guilt and fear, a person with good reality testing, in control of his fate, who at the same time manages to keep close to the significant others in his life.

The case study mentioned above has not been in any way inclusive of all vissititudes, difficulties, diagnostic outcomes and psychological complexities that Mr. A.'s treatment entails. Nevertheless, it poses interesting questions regarding the treatment of addictions: What lies beneath an addicted behaviour? What unmet needs and desires manage to find their way out, causing at the same time irrevocable damages and /or unprecedented risks? How can these needs finally be expressed and met avoiding the downfall and the malaise, and in reality ceasing the addiction? How can this take place in the presence of conflict without psychological disintegration

or emotional sanctions? How can the environment (family and social) help or hinder this expression? What if addiction is viewed as the ultimate way towards differentiation- despite its numerous addictive demonstrations? What if we show irreverence [14] to the one-way, linear mainstream psychology treatment- or rather, how can we combine both linear and systemic approaches, both medical and psychological interventions? What if, in order to understand our world and act with wisdom towards positive outcomes, we move from the Theory of Relativity and Quantum Mechanics towards the principles of Chaos Theory [15], where multiple facets of reality can simultaneously exist and be experienced, where a large number of scientists with contradictory approaches come and work together, where humanity is preserved during healing, during following protocols?

The present article has attempted to shed light on and act as a bridge towards a new paradigm, towards applying the "magical **AND**" [16] in the treatment of addiction. It remains to be applied on a large scale in diverse social milieus and offers numerous chances for future research.

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