TREATING NICOTINE DEPENDENCY

An application of the Chemotion/EMDR protocol a,b

by

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b The Chemotion/EMDR protocol is based on individual case studies and should be considered an experimental approach. It is not supported by outcome studies or comparison studies to other treatment protocols.

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Introduction

Chemotion1 employs a Gestalt technique2 to evoke the trauma-coded information that is reenacted through nicotine dependency. According to the Accelerated Information Processing Model that is the basis for EMDR3, this information is held in state-specific, excitatory condition where it is assembled with negative affects and cognitions and is more likely to be evoked by a triggering stimulus. In the Chemotion/EMDR protocol, this triggering stimulus is the drug of dependency, referred to as a traumaphor, which is placed in an empty chair.

In the general population, the prevalence of nicotine dependency is 29%. 72% of the population has tried cigarettes. Smoking peaks between 18 and 25 and begins early, as 36% of 12th graders smoked daily in 1997. There is considerable comorbidity of nicotine dependency and psychiatric disorders, with 44% of neurotics, 55% of depressives, and 56% of panic disordered individuals smoking4.

The Chemotion model hypothesizes that nicotine dependency is a trauma reenactment5,6 and indicates a trauma history in the smoker. The model also suggests smokers have a defected reality testing ego function and an incompletely differentiated self- and object-representation. Finally, the model suggests smokers have a more-or-less dissociated 'suppressor' or 'protector' ego state.

Chemotion: Trauma Induction, Resilience, Trauma Reenactment, and Dissociation

Chemotion is a psychodynamic model. Trauma, which is understood as a range of vicissitudes from less than good-enough parenting through poor and bad parenting to overtly abusive parenting, is believed to defect healthy organization and differentiation of the self. Resilience is a measure of the brain's innate capability to process trauma to an adaptive resolution; resilience is distributed from poor to good across the general population. Individuals with chemical dependency disorders including nicotine dependency will be found to have a combination of poor to moderate resilience and to have experienced moderate to severe trauma.

The experience of trauma induces a splitting in the self-object representation (Figure 1). A part, or ego state, fails to differentiate to object constancy. This part is trauma-coded for situation (image plus action), cognition, and affect. This part is also affectively charged by the unresolved emotions of the self that were assembled with the trauma-induced part at the time of its creation. The incompletely differentiated part may be visualized as an elaborated neural network to which are assembled additional dysphoric experiences coded by the same affect. This part becomes one unit in the core around which the self reorganizes in adolescence in preparation for socialization, reproduction, and child-rearing in adulthood.

In adolescence and adulthood, the trauma-induced, incompletely differentiated part manifests itself in behaviors that reenact the inducing trauma. When these behaviors involve ingestion of a substance, the result is often dependency. The substance is called a traumaphor, because its use suggests similarities with the inducing trauma. The traumaphor provides the means by which the trauma is reenacted. Trauma reenactment expresses the inducing trauma in a disguised form that includes

the situation (image plus action), cognition, and affect of the traumatizer as well as the unmetabolized affect of the self.

When the unmetabolized affect of the self is particularly dysphoric, dissociation may occur. The painful affect is removed from the normal stream of consciousness by a suppressing energy. This energy may elaborate secondary characteristics and acquire a measure of autonomy as a covert ego state (Figure 2).

Chemotion and Nicotine Dependency

In cases studied to date, nicotine dependency has been shown to reenact childhood traumas of destruction of the self through disaffirmation and beating, of abandonment and betrayal, and of incest. The destruction of the throat, lungs, and heart caused by smoking reenacts in adulthood the destruction of the child's authentic self through trauma. Participants in the study verbalized the cognition of the traumatizer, "You are not important," when asked in the Gestalt component to state what the traumaphor was saying to them. Participants verbalized the affect of the traumatizer, which was indifference and intimidation. Participants also verbalized the unmetabolized affect of the self, anger, that was being reenacted through smoking. Finally, the action of a covert, protector ego state could be observed in participants. This ego state's function was to remove the experience of terror, fear, or anxiety from the normal stream of consciousness.

According to the Chemotion model, nicotine dependency expresses two dynamics: it reenacts childhood trauma as to situation (image plus action), cognition, affect of traumatizer, and unmetabolized, archaic affect of self; and it is the behavioral manifestation of a more-or-less autonomous suppressor ego state that dissociates terror/fear/anxiety out of the normal stream of consciousness.

The Chemotion/EMDR Protocol for Treating Nicotine Dependency

The protocol identifies harm reduction as the goal of treatment, rather than abstinence. This formulation avoids activating the 'protector' ego state, which would prevent clients from entering treatment. Once in treatment, the client may achieve a reduction of harm to zero.

An assessment instrument based on the Addiction Severity Index7 is included as an appendix to this paper. The tool uses subject's and interviewer's rating scales to assess: polysubstance abuse; chronicity of nicotine dependence; consequences of nicotine dependence; compulsivity with nicotine; obsessivity with nicotine; level of denial about nicotine; relationships; abuse; and resources.

In the Gestalt component, the client is asked to place cigarettes in an 'Empty Chair' acccording to a protocol1 in which the following directions are given:

A. "Place your cigarettes in that empty chair." (An empty, unoccupied chair is placed directly in front of participant)

B. "Tell me what you see."

C. "What does it look like?"

D. "How big is it?"

E. "What color is it?"

F. "How heavy is it?" (If by this point in the protocol the client is producing only literal imagery and not imaginal associations, shift the image in the chair to "the power of the cigarettes" and repeat the above steps.)

G. "Does it have a smell?"

H. "What are the cigarettes saying to you right now?" (If the client has difficulty with this instruction, have the client move to the empty chair and 'be' the cigarettes.)

I. "What are the cigarettes doing right now?"

J. "What are the cigarettes thinking about you right now?"

K. "What do the cigarettes feel for you right now?"

L. "What are you feeling right now?"

M. "What do you want to do to the cigarettes?"

N. "What are your feelings for the cigarettes?"

O. "What do you want to say to the cigarettes?"

P. "When you say those words, what is the cigarette's response?"

Q. "What are the cigarettes saying to you right now?" (If the client is unable to engage in this dialogue, the therapist can take the part of the cigarettes and verbalize a response.)

R. "In the past, going back from right now as far back as you can remember, who has spoken to you like the cigarettes?"

S. "In the past, going back from right now as far back as you can remember, who has treated you like the cigarettes?"

T. "As you look at them right now, what is the gender of the cigarettes?"

Based on this dialogue, the clinician can arrive at a case formulation that specifies the client's trauma reenactment including the identity of the traumatizer, what action of traumatizer is being repeated, and what affect of the traumatizer is being reenacted. The formulation will identify as well what archaic, unmetabolized affect of the self is being reexperienced through smoking.

EMDR is now employed to desensitize and reprocess the traumas being reenacted through nicotine dependency. The initial target image is the cigarettes or the power of the cigarettes. A Negative Cognition, Positive Cognition and VOC, Affect, SUDs, and Body Referent are chosen as specified by Shapiro3. Secondary or nested images are processed as they arise.

The presence of a 'Protector' ego state is indicated by a VOC stuck at less than complete validity, especially when the cognition is factually correct, e.g., "I can reduce my smoking" for a client who has indeed cut down on her consumption. Another indicator is temporary improvement followed by relapse. The 'Protector' ego state can be evoked employing EMDR or light trance and following standard protocols for uncovering covert ego states8. The mission of the covert ego state must be understood. This is usually to remove over-whelming terror, fear, or anxiety from the normal stream of consciousness. EMDR can be utilized to process targets specific to the ego state.

Resolution involves negotiation of an agreement in which the executive ego state agrees to take over responsibility for experiencing the painful affects and developing healthy coping strategies.

Treatment also involves installation and/or strengthening of important resources. The Reality Testing ego function is defected in nicotine dependents. They are unable to distinguish what is inside them (trauma with associated, unprocessed affects) from what is outside them (the traumaphor, the means for reenacting the trauma). One approach (Errebo, private communication) is to ask the client for an image to fill the 'hole' in the Reality Testing function and to install it9. Another often defected resource is the ego function of Synthesis that allows the client to hold an ambivalent comprehension of the traumatizer. The client can be asked for an image that allows her to hold the positive and negative qualities of the traumatizer as they have been elicited in counseling. This image is then installed. Nicotine addicts often lack healthy affect coping skills. These are resources that can be identified or taught and then installed. Coping skills are comprised of: affect recognition, including set-up and triggers; affect tolerance; and affect modulation. Once installed, subsequent successful employment of these skills can be strengthened. Finally, EMDR can be used to enhance self-worth and self-efficacy in the client achieving harm reduction or abstinence.

The clinician is encouraged to monitor the client's self-reported smoking status as the best indication of successful processing of the psychodynamic issues impelling the smoking. Achievement of a stable level of harm reduction that is acceptable to the client is considered a successful treatment outcome. Relapse to a prior or higher level of harm indicates incomplete processing and the need for further treatment. The clinician can use olfactory cues to assess the veracity of the client's self report.

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Affect Management Skills Training and the Chemotion/EMDR Treatment Protocol for Nicotine Dependency

by John Omaha, M.A.

You have received the Chemotion/EMDR treatment protocol for treating nicotine dependency. The protocol mentions affect management skills, but I want to expand on what's in the protocol.

The primary, unresolved, archaic affect that is reexperienced through nicotine is fear. This may be more or less dissociated out of awareness. The smoker reexperiences this affect vicariously through the nicotine and thus does not have to actually experience the fear.

I believe it is absolutely essential to build affect management skills in the client for fear before attempting the Chemotion/EMDR protocol. Also, in order to create a win/win situation that will allow the client to stay engaged in counseling, I never speak about smoking cessation. The reason is that if the client considers stopping smoking, unconsciously he knows this means he will have to face the unresolved, archaic fear, and since he has not skills to do so, he will leave counseling. Therefore, I always present this work in terms of harm reduction. I ask the client to set a level of harm that is acceptable to her. This is a win/win situation now, and it facilitates client engagement.

I have an assessment form which is in your handout. After completing that, I introduce EMDR and do a safe place installation. Then, I begin counseling with affect management, and if I need an introduction, I simply ask the client what affects come up when they consider cutting down smoking. Usually they will produce the response of fear. I then ask them for a time they felt fearful or anxious at a SUD of 3-4. I have them replay the situation with 12-14 saccades, and I ask what comes up. Usually the experience gets richer on one or more of the BASK dimensions. In any case, I replay it again, this time asking them to notice where in her body she feels the fear. Now we have a Physical Sensation, the first skill. I ask the client to verbalize a PC of "My body tells me when I am feeling fear" or "My stomach (chest, whatever) tells me when I am feeling afraid." I assess the strength of this PC using the VoC.

Next we replay the scene and this time I have the client visualize a grounding cord attaching the tip of his spine to the center of the earth. This allows the client to stay grounded and present while experiencing fear. Grounding Cord is the second skill. Again install a PC "I can stay grounded and present while I am feeling afraid." Rate VoC.

The third skill is Symptom as Signal. For this I have her replay the scene, become aware of the sensation, and then use that sensation as a signal to drop the grounding

cord. Again, install PC "My stomach (chest, etc.) is a signal to ground myself." Assess VoC.

The fourth skill is Witnessing Self. Replay the scene, become aware of the sensation, use it as a signal to ground, and then allow yourself to "just watch yourself feeling fearful." I have him explore his body and mind, noticing what other sensations, what thoughts, what memories come up. Install PC "I can just watch myself feeling afraid." Assess VoC.

The fifth skill is Garbage Chute (or Affect Modulation). Replay scene, become aware of sensation, use it as a signal, ground yourself, just watch yourself, and now, because "you have control" and/or "because this level of fear is uncomfortable" visualize a garbage chute and dump 50% of the fear down the chute. I ask her to feel it leaving her chest or stomach or wherever her physical sensation was. Install PC "I can modulate my fear" or "I can dump half my fear". Assess VoC.

After this Affect Management Skills Training, move on to the Chemotion/EMDR protocol, exploring first the associations of memories, affects, cognitions, and sensations that come up for the client when she puts the nicotine or the "power of the nicotine" in the empty chair. Continue with part two, Traumaphor-focused Processing of the traumas being reenacted and affects being reexperienced through the nicotine.

If at any time in treatment you become aware that the client is feeling afraid, immediately repeat the skill set for the fear that he is presently feeling.

If the client appears dissociative (getting tired during processing, eyelids fluttering, etc.) you can do a light trance and ask to speak to the "one who holds the fear." You may well find a poorly (or well) developed child ego state. Have the client tell this ego state that she has learned the necessary skills to manage fear now, and that she wants to alleviate some of the child ego state's burden. This child may be very happy to go and play in the safe place. You may want to give the child ego state a "sentinel" job of alerting client to the possibility of fear arising, say when preparing to go to a party or other social event.

Near termination, remind the client of her harm reduction target. Calculate with her how much time she is facing between cigarettes. For example, if she smoked 16 per day (ca. one per hour) and her target is 8 per day, she will have to go two hours between cigarettes. Set this up as a target situation. Apply the skill set. Install the PC "I can go two hours between cigarettes." Assess the VoC. You want this to be a seven.

If you are seeing your client on an on-going basis and nicotine harm reduction is a part of therapy (a very good idea, I think) then strengthen all successes in harm reduction. Assist the client in resetting the harm reduction target.

Also, at termination, I like to do an Optimal Future Self Visualization. Nancy Napier originated this. What does the client's optimal future self, a non-smoker or a low harm smoker, look like, feel like, act like, think like? If you want the protocol, I will send it.

I hope that this information helps you and your clients. Please let me know how the protocol works for you.

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HISTORY: NICOTINE DEPENDENCY PROGRAM

GENERAL INFORMATION

NAME _____DATE OF INTERVIEW _____

ADDRESS _____CITY _____

STATE _____ ZIP _____ TELEPHONE _____

DATE OF BIRTH _____

RACE

1. WHITE/CAUCASIAN
2. BLACK/AFRICAN-AMERICAN
3. AMERICAN INDIAN
4. ASIAN or PACIFIC ISLANDER
5. ALASKAN NATIVE
6. HISPANIC
7. NONE

RELIGIOUS PREFERENCE

1. PROTESTANT
2. CATHOLIC
3. JEWISH
4. ISLAMIC
5. CHRISTIAN _____
6. OTHER _____

ORIENTATION AS TO TIME AND PLACE: INTERVIEWER ASK CLIENT TO PROVIDE:
FACILITY STREET NAME_____ PRESENT DATE & TIME _____
COGNITIVE FUNCTIONS: INTERVIEWER PROVIDE CLIENT WITH YOUR AGE _____
CLIENT'S RATING SCALES:

SUBJECTIVE UNITS OF OBSESSIVITY (SUP)

0 - NOT AT ALL OBSESSED
1 - SLIGHTLY OBSESSED
2 - MODERATELY OBSESSED
3 - CONSIDERABLY OBSESSED
4 - EXTREMELY OBSESSED

SUBJECTIVE UNITS OF IMPORTANCE

0 - NOT AT ALL IMPORTANT
1 - SLIGHTLY IMPORTANT
2 - MODERATELY IMPORTANT
3 - CONSIDERABLY IMPORTANT
4 - EXTREMELY IMPORTANT

SUBJECTIVE UNITS OF COMPULSIVITY (SUP)

0 - NOT AT ALL COMPULSIVE
1 - SLIGHTLY COMPULSIVE
2 - MODERATELY COMPULSIVE
3 - CONSIDERABLY COMPULSIVE
4 - EXTREMELY COMPULSIVE

INTERVIEWER'S RATING SCALE:

0 - NONEXISTENT
1 - POOR
2 - FAIR
3 - GOOD
4 - EXCELLENT

NICOTINE AND OTHER DRUG USE

AGE, FIRST USE OF NICOTINE _____ FORM _____

AGE, FIRST USE OF OTHER DRUG _____ DRUG _____

NICOTINE: DAYS OF USE, PAST 30 _____ YEARS OF USE _____

ALCOHOL: DAYS USE, PAST 30 _____ YEARS OF USE _____

OTHER DRUG(S) USED: _____

DAYS OF USE, PAST 30 _____ YEARS OF USE _____

NICOTINE, USUAL FORM OF USE: _____

AMOUNT OF USE PER DAY (PACKS): _____ WEEK: _____ MONTH: _____

LENGTH OF LAST PERIOD OF VOLUNTARY ABSTINENCE: _____

HOW LONG AGO DID THIS ABSTINENCE END: _____

HOW MANY TIMES HAVE YOU ATTEMPTED TO QUIT _____

HOW MANY TIMES IN YOUR LIFE HAVE YOU BEEN TREATED FOR NICOTINE DEPENDENCY _____

CONSEQUENCES OF NICOTINE DEPENDENCY

PHYSICAL _____

MEDICAL _____

EMOTIONAL _____

MENTAL _____

SOCIAL _____

RELATIONSHIP_____

HOW MUCH HAVE YOU SPENT ON NICOTINE DURING THE PAST 30 DAYS

_____

RATE YOUR OBSESSIVITY WITH NICOTINE (SUP) _____

RATE YOUR COMPULSIVITY WITH NICOTINE (SUP) _____

HOW TROUBLED OR BOTHERED HAVE YOU BEEN WITH YOUR NICOTINE DEPENDENCY IN THE PAST 30 DAYS _____

HOW IMPORTANT TO YOU NOW IS TREATMENT FOR YOUR NICOTINE DEPENDENCY _____

NICOTINE HARM REDUCTION GOAL: _____

AFFECTIVE HISTORY AND PRESENT STATUS

Sibship pattern _____

RELATIONS WITH MOTHER

Who cared for you as an infant _____

Were you nursed _____ Did mother work _____ Your age then _____

Earliest memory of mother _____

_____

Describe a pleasant memory of mother _____

_____

Describe a troubling memory of mother _____

_____

Describe a time you were angry with your mother _____

_____

What did you do with your emotions _____

RELATIONS WITH FATHER

Earliest memory of father _____

_____

Describe a pleasant memory of father _____

_____

Describe a troubling memory of father _____

_____

Describe a time you were angry with your father_____

_____

What did you do with your emotions _____

Did either parent use or drink _____ Who _____ Problems_____
_____
Was there physical abuse
_____What_____

Was there verbal abuse
_____What_____

Was there sexual abuse
_____What_____

ASSESSMENTS

Based on client's ability to name facility street and present date and time, rate

client's ORIENTATION AS TO TIME AND PLACE _____

COGNITIVE FUNCTION (Record client's memory of interviewer's stated age):
_____

Interviewer, rate client's cognitive function _____

PRESENT PSYCHOLOGICAL STATUS

Is client obviously **Is client obviously**

depressed/withdrawn (Y/N) _____ **hostile (Y/N) _____**

Presence of characterological disorder (Y/N) _____

Type (narcissistic, borderline, etc.) _____

Severity rating _____

Presence of neurosis (Y/N) _____ Severity rating _____

Presence of psychosis (Y/N) _____ Schizophrenia (Y/N)_____

Presence of dissociativity (Y/N) _____

Assess client's overall motivation for treatment _____

Internal locus (Y/N) _____ External locus (Y/N) _____

Assess client's environmental support for cessation _____

Comment_____

Does client possess ego strengths/internal resources to:

Tolerate strong emotion (Y/N) ____ Rating _____ Comment _____

Accept change (Y/N) ____ Rating _____ Comment _____

Assess client's level of denial _____ Comment _____

Assess client's level of acceptance _____ Comment _____

Assess level of secondary gain _____ Comment _____

Assess level of secondary loss _____ Comment _____

Resources needed _____

_____

_____

SPLITTING AND REENACTMENT

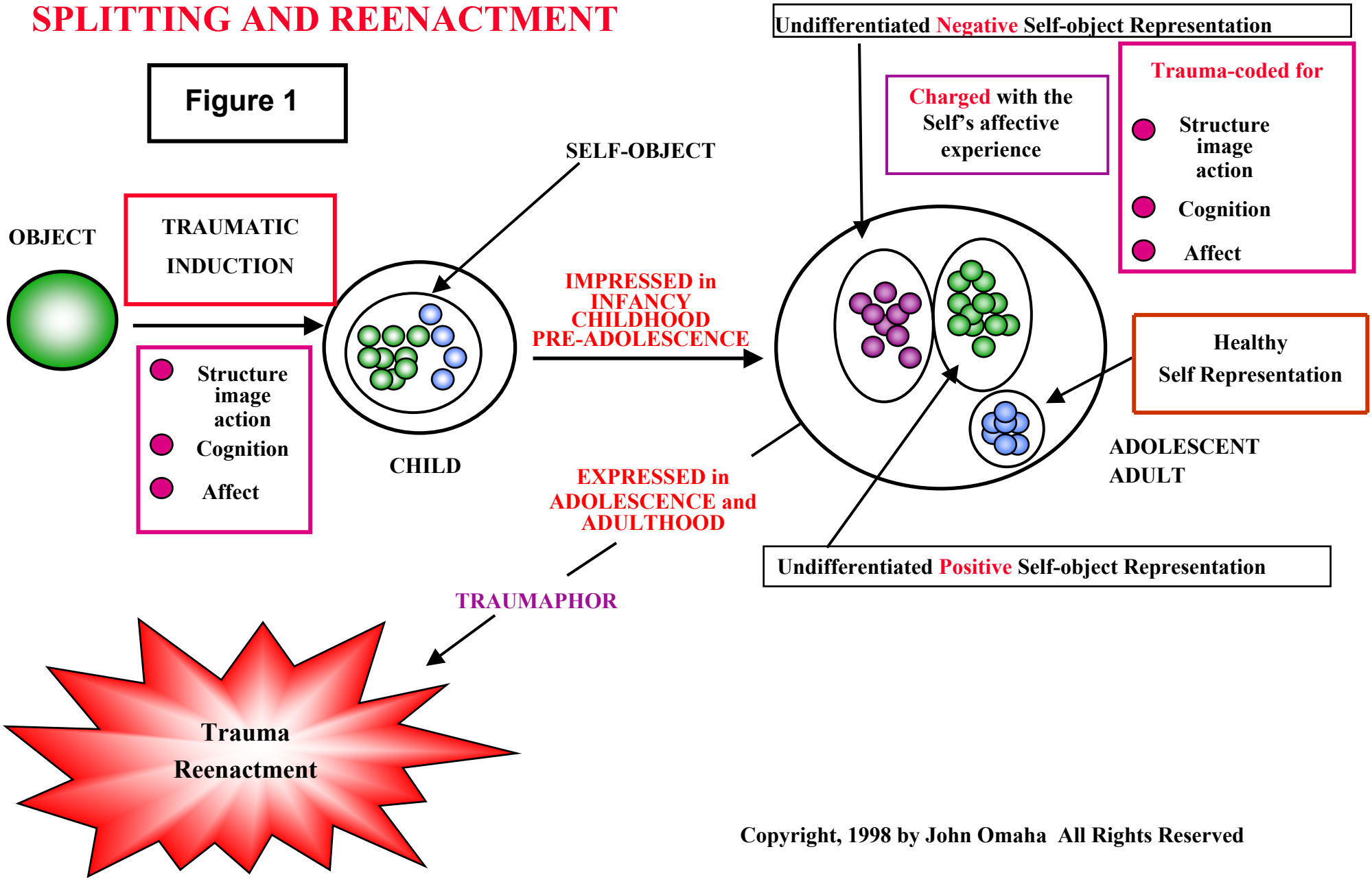

Figure 2.