

## Chapter 6

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# Common Hazards & Pitfalls

## Early Alcohol Use Risky

A 1990 study found that nearly half who relapsed to smoking (47%) consumed alcohol before doing so. It also found that another 5% had been under the influence of "recreational" drugs.<sup>1</sup>

Early alcohol use is clearly the most avoidable relapse risk of all. Using an inhibition diminishing substance while in the midst of early physical withdrawal is inviting relapse.



**Why ex-users may feel alcohol effects sooner** - There are a number of nicotine/alcohol interactions. Most obvious is the combined effects (or synergy) of both alcohol and nicotine stimulating the user's brain dopamine pathways and satisfying wanting for more.<sup>2</sup>

Additionally, as explained in [Chapter 4](#) ("Use relieves stress and anxiety"), as with stress, alcohol use causes urine acidification, which in turn causes the user's kidneys to accelerate elimination of the alkaloid nicotine from their bloodstream. A third interaction may leave the user feeling intoxicated sooner.

Nicotine stimulates the body's central nervous system while alcohol

- 1 Brandon, TH, et al, [Postcessation cigarette use: the process of relapse](#), Addictive Behaviors, 1990, Volume 15(2), Pages 105-114.
- 2 Tizabi Y, et al, [Combined effects of systemic alcohol and nicotine on dopamine release in the nucleus accumbens shell](#), Alcohol and Alcoholism, Sept-Oct. 2007, Volume 42(5), Page 413-416.

depresses it. Alcohol stimulates GABA production (gamma-aminobutyric acid), which produces a sedating effect<sup>3</sup> while impairing muscle (motor) control.<sup>4</sup>

Nicotine stimulates fight or flight pathways, causing release of adrenaline and noradrenaline.<sup>5</sup> This is why alcohol induced feelings of becoming sedated or even sleepy can be diminished by stimulating the body with nicotine.<sup>6</sup> Here's what to expect.

When drinking, the user soon begins noticing alcohol's gradual sedation and anesthesia type effects. The more they drink, the more sedated their nervous system becomes. The more they drink, the more acidic their urine becomes and the quicker their kidneys eliminate nicotine from their bloodstream.

Not only are they starting to feel tipsy, their nicotine reserves are declining faster than normal.

But just one powerful hit of nicotine and, in addition to an alcohol exaggerated "aaah" wanting relief sensation, nicotine kicks in their automatic in-born "fight or flight" neuro-chemical response. The mind has been fooled into believing that danger is present and begins to stimulate an alcohol-sedated body.

Adrenaline, noradrenaline and cortisol are released into the bloodstream. Their heart pounds faster and their rate of breathing increases. Digestion is suspended so that extra blood can be diverted to their muscles. Their pupils dilate, focus improves, hearing perks and stored fats and sugars are pumped into their bloodstream to provide an instant source of energy.

An alcohol-depressed nervous system has just experienced some degree of stimulation. No saber tooth tiger to fight or flee, their new found sense of alertness instead emboldens them to ask for another round. "Bartender,

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3 Koob GF, [A role for GABA mechanisms in the motivational effects of alcohol](#), *Biochemical Pharmacology*, October 2004, Volume 68(8), Pages 1515-1525.

4 Hancher HJ, et al, [Alcohol-induced motor impairment caused by increased extrasynaptic GABA\(A\) receptor activity](#), *Nature Neuroscience*, March 2005, Volume 8(3), Pages 339-345.

5 Kenneth J. Kellar, KJ, [Addicted to Nicotine, Neuropharmacology and Biology of Neuronal Nicotinic Receptors](#), National Institute on Drug Abuse website, [www.DrugAbuse.gov](http://www.DrugAbuse.gov), article updated May 19, 2006.

6 McKee SA, [Effect of transdermal nicotine replacement on alcohol responses and alcohol self-administration](#), *Psychopharmacology (Berlin)*, February 2008, Volume 196(2), Pages 189-200.

I'm ready for another drink!"

The cycle can be repeated again and again, with an increasingly sedated body gradually becoming less responsive to nicotine-induced stimulation.

What significance does this have to a recovering addict? It may mean that without nicotine periodically slapping you awake, that you may feel alcohol's effects sooner or after fewer drinks.

The solution can be as simple as learning to drink a bit more slowly, spacing drinks a bit further apart or simply drinking less.

**Co-Dependency Concerns** - Amazingly, roughly eighty percent of alcoholics smoke nicotine.<sup>7</sup> Has alcohol become central to your life? Are you chemically dependent upon it? If not an alcoholic, have you conditioned your mind to use and expect alcohol too often or to expect too much?

Even social drinkers need to take extreme care when attempting to extinguish alcohol related nicotine use cues. So, what can we do if alcohol use and its inhibition diminishing effects seem to be key factors in preventing us from breaking nicotine's grip upon our mind and life?

If unable to drink in a controlled manner or if drinking is adversely affecting our life, work, relationships or health, you may be dealing with problem drinking or even alcoholism.

As Joel sees it, "If a person says that they know that their drinking will cause them to take a cigarette and relapse back to smoking, and if they then take a drink and relapse, they are in effect problem drinkers, for they have now put their health on the line in order to drink."<sup>8</sup>

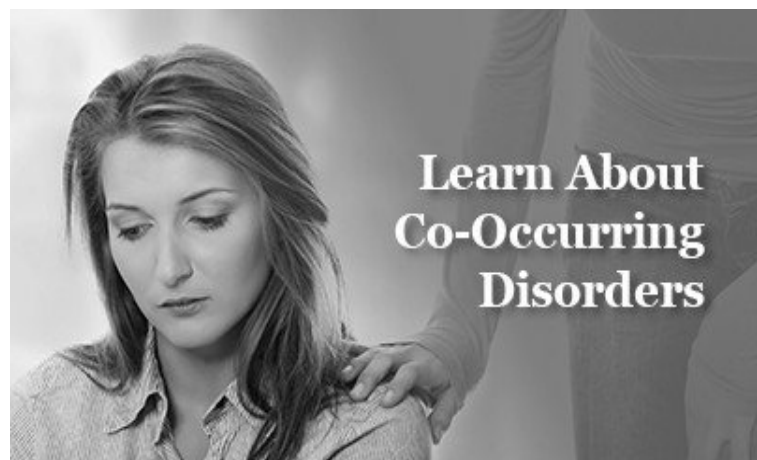


Photo SAMHSA

7 DiFranza JR, Alcoholism and smoking, Journal of Studies on Alcohol, March 1990, Volume 51(2), Pages 130-135.

8 Spitzer, J, Can people quit smoking and still drink alcohol? Joel's Library, WhyQuit.com, October 2005.

Is alcohol use your recovery roadblock? If so, while many mental health professionals remain reluctant to suggest simultaneous dual alcohol-tobacco withdrawal,<sup>9</sup> multiple studies suggest that smoking cessation may actually enhance the likelihood of long-term alcohol sobriety.<sup>10</sup>

A 2011 study reviewed 1,185 subjects who 9 years earlier had entered substance use treatment, 716 of whom had also smoked at the time, among which 14% had successfully stopped smoking within a year of substance use treatment.

It found that those who had stopped smoking within a year of entering substance use treatment had 240% greater odds of both remaining abstinent from drugs, drugs plus alcohol, or alcohol alone within the past year, than those who had continued smoking.<sup>11</sup>

The basic insights and skills needed to arrest any chemical dependency are amazingly similar. Recovering alcoholics schooled by quality treatment programs are already skilled in their use.

Research shows that while those with alcohol problems make fewer smoking cessation attempts, they are "as able to stop on a given attempt as smokers with no problems."<sup>12</sup>

Unfortunately, alcohol recovery programs have a tendency to actually destroy nicotine cessation attempts. "Many, if not most, alcohol recovery programs will inadvertently or very purposely push a new ex-smoker entering the program to smoke," writes Joel.



*WomensHealth.gov*

9 Jacques D, et al, Quit smoking? Quit drinking? Why not quit both? Analysis of perceptions among Belgian postgraduates in psychiatry, Psychiatria Danubia, November 2010, 22 Supplement 1:S120-3.

10 Gulliver SB, et al, Smoking cessation and alcohol abstinence: what do the data tell us? Alcohol Research & Health, 2006 Volume 29(3), Pages 208-212.

11 Tsoh JY, et al, Stopping smoking during first year of substance use treatment predicted 9-year alcohol and drug treatment outcomes. Drug and Alcohol Dependence, April 1, 2011, Volume 114(2-3), Pages 110-1188.

12 Hughes JR, et al, Do smokers with alcohol problems have more difficulty quitting? Drug and Alcohol Dependence, April 28, 2006, Volume 82(2), Pages 91-102.

"Over the years I have in fact had actively drinking alcoholics in smoking clinics - people who made it abundantly clear that they knew they had drinking problems and smoking problems but wanted to treat the smoking first."

"I really do try to get them into alcohol treatment concurrently but cannot force them to do it. On more than one occasion I have seen the person successfully stop smoking, stay off for months and sometimes longer, and finally get into AA, only to be assigned a smoking sponsor who tells the person that he or she can't get off smoking and drinking at once, and who actually encourages the person to smoke again."

"Note the sequence here," says Joel. "The ex-smoker has been off nicotine for an extended time period but the smoking sponsor says that the person can't stop both at once. It is unfortunate that most alcohol and drug treatment programs just don't recognize smoking as another drug addiction."

Joel uses heroin to show the insanity of such advice. "You will not often see an AA sponsor say that you can't give up drinking and heroin at once, so if you have been off heroin for six months and now want to stop drinking, you should probably take heroin for a while until you get alcohol out of your system."<sup>13</sup>

Many of the lessons in FFN-TJH can be applied to arresting alcohol dependency. In fact, a number of them, such as a "one day at a time" recovery philosophy have deep roots in alcohol recovery programs.

**Confronting alcohol related crave triggers** - As discussed in detail in [Chapter 11](#), if a drinker, you have likely conditioned your brain to expect nicotine while consuming alcohol. In fact, you may have created multiple alcohol related use cues. Encountering one of those use cues may cause a brief crave episode that can take up to 3 minutes before peaking in intensity. In that alcohol diminishes inhibitions, it the exception to the rule that we should try to quickly meet, greet and extinguish all learned nicotine use associations.

Regarding alcohol, it's prudent to allow ourselves a few days to get our

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13 Spitzer, J, [Can people quit smoking and still drink alcohol?](#) Joel's Library, WhyQuit.com, October 2005.

recovery legs under us and move beyond peak withdrawal before drinking. Even then, due to diminished inhibitions, the smart move is to consider breaking drinking down into more manageable challenges that present fewer potential crave triggering cues.

Use associations between alcohol and nicotine can involve multiple cues. We may have use cues associated with entering a drinking location, engaging in a drinking related activity, sitting down, seeing alcohol containers, hearing ice cubes hit a glass or the sound of a bottle or can opening, picking up a drink, tasting that first swallow, or beginning to sense the onset of alcohol's inhibition diminishing effects.

We may have developed nicotine-alcohol use associations where the use cue is encountering a drinking acquaintance, friend or another nicotine user, being around lots of other users, seeing ashtrays, cigarette packs and lighters within easy reach, seeing a cigarette machine or visible packs or cartons for sale behind the bar, or even sight of a jug filled with free matches.

Use cues could be associated with engaging in conversation while drinking, or having conversation shift gears into debate or argument as alcohol's inhibition diminishing effects begin to be felt.

Impaired judgment and diminished inhibitions may have established nicotine use cues associated with hearing music, feeling the beat, singing karaoke, dancing, playing games, flirting, fear, rejection, acceptance, partying, joy, sadness or beginning to feel drunk and turning to nicotine to stimulate the body's nervous system.

So how do we tackle alcohol-nicotine use associations? Consider the benefit of learning to use alcohol and extinguish your primary alcohol-nicotine use associations in the safest environment available (usually your home), away from other potential use associations.

Once able to drink alcohol without using nicotine it's time to extinguish other nicotine-alcohol use associations. Consider not using any alcohol during your first encounter with other potential alcohol-nicotine use situations, or limiting alcohol use so as to allow yourself greater conscious and rational control.

Consider drinking a bit slower than normal, spacing drinks further apart or drinking water or juice between alcoholic drinks. Combine your intelligence with baby steps. Have an escape plan and a backup plan and be prepared to deploy both.

Since half of all fatal vehicle collisions involve alcohol use, if you do drink, make sure that driving a vehicle is not part of the plan.

### **Avoiding Blood Sugar Swing Symptoms**

Hypoglycemia is a big word for what occurs when our "blood sugar (or blood glucose) concentrations fall below a level necessary to properly support the body's need for energy and stability throughout its cells."<sup>14</sup>

Causes of low blood sugar in non-diabetics include skipping or delaying meals, eating too little, increased activity or exercise and excessive alcohol.<sup>15</sup>

Warning signs include an inability to concentrate, anxiety, hunger, confusion, weakness, drowsiness, sweating, trembling, warmness, nausea, dizziness, difficulty speaking and blurred vision.<sup>16</sup>

Each hit of nicotine served as a spoon pumping stored glucose into our bloodstream via our body's fight or flight pathways. It allowed us to skip breakfast and possibly lunch without experiencing low blood sugar or hypoglycemic type symptoms.

One of recovery's greatest challenges is learning to again properly feed and fuel our body. It's not a matter of consuming more calories but learning to spread them out more evenly over our entire day, by eating smaller portions of healthy foods more frequently.



14 hypoglycemia. (n.d.). Dorland's Medical Dictionary for Health Consumers. (2007). Retrieved from <http://medical-dictionary.thefreedictionary.com/hypoglycemia> on August 22, 2008.

15 National Institutes of Health, [Hypoglycemia](#), National Institute of Diabetes and Digestive and Kidney Diseases, NIH Publication No. 03-3926, March 2003.

16 Hepburn DA, et al, [Symptoms of acute insulin-induced hypoglycemia in humans with and without IDDM. Factor-analysis approach](#), Diabetes Care, November 1991, Volume 14(11), Pages 949-957.

As an aid in blood sugar stabilization, unless diabetic or otherwise prohibited by your health or diet, we recommend devoting the money you would have spent in purchasing nicotine toward purchase and use of some form of natural fruit juice for the first 72 hours.

Juice will not only help stabilize blood sugar levels, it will aid in accelerating removal of nicotine from our blood. But don't over do it or go beyond three days as juice tends to be rather fattening. Make sure it's 100% natural juice, no sugar added and avoid fruit soda drinks and aides.

Cranberry juice is excellent. A 2008 study examined the effects of drinking 480 milliliters or 16 ounces of unsweetened, normal-calorie cranberry juice (280 calories) upon blood sugar. Analysis found that while low-calorie cranberry juice (38 calories) and water produced no significant changes in blood sugar levels, that normal-calorie cranberry juice resulted in significantly higher blood glucose concentrations within 30 minutes, which were no longer significant after 3 hours.<sup>17</sup>



As for fruit juices accelerating nicotine removal, the heart pumps about 20% of our blood through our kidneys. Our kidneys filter approximately 50 gallons or 189 liters of blood daily. This results in removal of about two quarts of waste products and extra water, which pass to the bladder as urine.<sup>18</sup>

The word "renal" means "of or relating to the kidneys." "Renal clearance" is defined as the volume of blood from which a chemical such as nicotine is completely removed by the kidney in a given amount of time (usually a minute).<sup>19</sup>

A controlling factor in determining renal clearance rate is the pH level of

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17 Wilson T, et al, [Human glycemic response and phenolic content of unsweetened cranberry juice](#), Journal of Medicinal Food, March 2008, Volume 11(1), Pages 46-54.

18 Wilson T, et al, [Human glycemic response and phenolic content of unsweetened cranberry juice](#), Journal of Medicinal Food, March 2008, Volume 11(1), Pages 46-54.

19 [renal clearance](#). (n.d.). The American Heritage Dictionary of the English Language, Fourth Edition. Retrieved August 20, 2008, from Dictionary.com website.



urine produced by our kidneys.<sup>20</sup> The more acidic our urine, the quicker nicotine is removed from the bloodstream.

A 2006 study found that drinking one liter of full-strength grapefruit juice (34 ounces or about 2 pints) will increase the rate by which the kidneys remove nicotine from blood plasma by 88%, as compared to when drinking 1 liter of water (231 milliliters of nicotine-free blood produced per minute using grapefruit juice vs. 123 milliliters of blood when drinking water).<sup>21</sup>

The study found that even if the grapefruit juice was half-strength that nicotine's renal clearance rate increased by 78% (219 milliliters per minute).

The pH scale ranges from 0 to 14 with 7 being neutral. The further below 7 a substance is, the greater its acidity. The higher a substance is above 7, the greater its alkalinity. According to the FDA,<sup>22</sup> the below fluids have the following pH ranges:



- Cranberry juice 2.3 - 2.5
- Grapefruit juice 2.9 - 3.3
- Pineapple juice 3.3 - 3.6
- Orange juice 3.3 - 4.2
- Apple juice 3.4 - 4.0
- Prune juice 3.9 - 4.0
- Vegetable juice 3.9 - 4.3
- Tomato juice 4.1 - 4.6
- Milk 6.4 - 6.8

Depending upon urinary flow rate, renal clearance of nicotine may be as high as 600 milliliters per minute in acidic urine having a pH of 4.4, to as low as just 17 milliliters per minute in alkaline urine having a pH of 7.0.<sup>23</sup>

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20 Tucker GT, Measurement of the renal clearance of drugs, British Journal of Clinical Pharmacology, December 1981, Volume 12(6), Pages 761-770.

21 Hukkanen J, et al, Effect of grapefruit juice on cytochrome P450 2A6 and nicotine renal clearance, Clinical Pharmacology and Therapeutics, November 2006, Volume 80(5), Pages 522-530.

22 U.S. Food & Drug Administration, Approximate pH of Foods and Food products, Center for Food Safety & Applied Nutrition, April 2007.

23 Benowitz NL, et al, Nicotine chemistry, metabolism, kinetics and biomarkers, Handbook of Experimental Pharmacology 2009; Volume 192), Pages 29-60.

Aside from juices, adding extra fruit and vegetables to your diet will aid in helping stabilize blood sugars, and may aid in helping diminish weight gain.

A 2012 study found that the odds of successful smoking cessation for 14 months among the one-quarter of study participants consuming the greatest amount of fruits and vegetables daily was three times greater than among the one-quarter consuming the least.<sup>24</sup>

What we don't know is if most within the greater fruit and vegetable group were simply more health conscious to begin with, and thus more motivated.

But don't overdo it. Remember, our primary objective is to stabilize blood sugar during the most challenging portion of recovery, so as to avoid needless symptoms.

### **Your Blood Caffeine Level Will Double**

Caffeine is a mild central nervous system stimulant found in coffee beans, tea leaves and cocoa beans. The question during early recovery is, can you handle a doubling of your normal daily caffeine intake without experiencing "caffeine jitters" or other symptoms of over-stimulation?



Nicotine somehow doubles the rate by which the body depletes caffeine. What's that mean? It means that if we were drinking two cups of coffee while using nicotine, once nicotine use ends, that the stimulant effect of those two cups might now feel like four.

According to a 1997 study, "continuous caffeine consumption with smoking cessation has been associated with more than doubled caffeine plasma levels. Such concentrations may be sufficient to produce caffeine toxicity symptoms in smoking abstinence conditions."<sup>25</sup>

24 Haibach JP, et al, A Longitudinal Evaluation of Fruit and Vegetable Consumption and Cigarette Smoking. Nicotine & Tobacco Research, May 21, 2012.

25 Swanson JA, et al, The impact of caffeine use on tobacco cessation and withdrawal, Addictive Behavior, Jan-Feb 1997, Volume 22(1), Pages 55-68.

The study found "a significant linear increase in caffeine sputum levels across 3 weeks post cessation," and that "three weeks after cessation, concentrations reached 203% of baseline for the caffeine user."

An earlier study found that the clearance rate of caffeine from blood plasma averaged 114 milliliters per minute in nicotine smokers and 64 milliliters per minute in non-smokers.<sup>26</sup>

Symptoms of caffeine intoxication have been seen with as little as 100 milligrams of caffeine daily, and may include restlessness, nervousness (anxiety), excitement, insomnia, a flushed face, increased urination and gastrointestinal complaints.

Intoxication symptoms seen when more than 1 gram of caffeine is consumed per day include muscle twitching, rambling flow to thoughts and speech, irregular or rapid heartbeat, irritability and psycho-motor agitation.<sup>27</sup>



Most of us can handle a doubling of our daily caffeine intake without getting the jitters. But how

can we tell whether the anxieties we feel are related to nicotine cessation or to too much caffeine? It isn't easy.

Experiment with an up to 50% reduction in daily caffeine intake if at all concerned. Be careful not to reduce normal caffeine intake by more than 50% unless you want to add the symptoms of caffeine withdrawal to those of nicotine withdrawal.

Caffeine withdrawal symptoms can include headache, fatigue, decreased energy, decreased alertness, drowsiness, decreased contentedness, depressed mood, difficulty concentrating, irritability, and a foggy mind. Symptoms typically begin 12 to 24 hours after caffeine use ends, reach

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26 Joeres R, Influence of smoking on caffeine elimination in healthy volunteers and in patients with alcoholic liver cirrhosis, *Hepatology*, May-June 1988, Volume 8(3), Pages 575-579.

27 American Psychiatric Association, Caffeine Intoxication, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Version, Page 232.

peak intensity at 20 to 51 hours, and normally last 2 to 9 days.<sup>28</sup>

The following is a sampling of the number of milligrams (mg) of caffeine "typical" in various substances:<sup>29</sup>

- 85mg coffee - 8 ounces drip brewed
- 80mg "energy drinks"
- 75mg coffee - 8 ounces percolated
- 40mg espresso - 1 ounce servings
- 40mg tea - 8 ounces brewed
- 28mg tea - 8 ounces instant
- 26mg baker's chocolate - 1 ounce
- 25mg iced tea - 8 ounces
- 24mg some soft drinks - 8 ounces
- 20mg dark chocolate - semi sweet - 1 ounce
- 6mg cola beverage - 8 ounces
- 5mg chocolate mild beverage
- 4mg chocolate flavored syrup
- 3mg coffee - decaffeinated

The stimulant effects of a 24mg soft drink before bed or a 20mg chocolate bar could now feel like two sodas or two chocolate bars. Consider a modest reduction of up to one-half if experiencing difficulty falling to sleep.

Look at it this way, if we were a big caffeine user, it's cheaper now. We get twice the stimulation for half the price.

## Crutches

A crutch is any form of reliance that is leaned upon so heavily in supporting or motivating recovery, that if suddenly removed would significantly elevate risk of relapse.

Why lean heavily upon any person, place, thing or activity? Why risk sudden removal? Why



28 Juliano LM, et al, A critical review of caffeine withdrawal: empirical validation of symptoms and signs, incidence, severity, and associated features, Psychopharmacology, October 2004, Volume 176(1), Pages 1-29.

29 National Institute of Health, Caffeine, National Toxicology Program, webpage updated 04/23/08, <http://cerhr.niehs.nih.gov/common/caffeine.html>

allow our freedom, healing and possibly our life to rest upon the presence of a source of support whose reliability is beyond our ability to control?

**Recovery buddies** - People can serve as crutches. Creating and leaning heavily upon the expectation that some other person will behave in a supportive manner is dangerous.

While great when our expectations are fulfilled, what happens when they're not? Why tie our fate to the actions or inactions of others, to their sympathies, time demands, comments, emotions, lack of dependency recovery understanding or indifference?

While there's nothing wrong with enjoying their support when it's there, picture your recovery standing entirely on its own.

Picture your core motivations and resolve actually strengthening during moments when those who we thought would be supportive are not. Take pride in the fact that you are standing and saying "no" to wanting without use of any crutches.

Waiting for another nicotine dependent person to join us in recovery is a delay tactic. We're waiting for a crutch.

While wonderful when able to share coming home with a spouse, significant other, family member, friend or co-worker, serious drug recovery programs never partner two new ex-users together.

Such programs understand that risk of relapse during early recovery remains high. Partnering newbies with newbies increases likelihood that should one relapse that the other will follow suit. Instead, effective programs partner new ex-users with stable long-term ex-users.

Successful recovery isn't about learning from someone who may know less about successful cessation than we do. It isn't about coming together to commiserate or share addiction war stories.

Success is not dependent on being able to lean on a person who ended nicotine use with us, but understanding what's required to stand on our own. It's about abiding by the [Law of Addiction](#) (Chapter 2).

While obedience to the [Law](#) provides 100 percent odds of success, how many smokers have ever heard of it? Statistically, only 1 in 8.7 who attempt recovery succeed in remaining nicotine-free for six months.<sup>30</sup>

That doesn't mean that two new ex-users navigating recovery together can't both succeed. We see it all the time. In fact, it is impossible for either to relapse so long as neither allows nicotine back into their body.

Romeo and Juliet is the tragic tale of a love so great that it would rather be dead than apart.

Each year millions surrender life itself rather than stop smoking. But this isn't Romeo and Juliet being played out on some grand scale. It isn't love reaching for a deadly chemical but physical dependence upon one.



What are the odds that nicotine addiction won't be the cause of ending a marriage or other long-term relationship in which both are smokers and both refuse to stop unless the other stops too?

Statistically, roughly half of adult smokers smoke themselves to death. The death toll is staggering. Smoking is blamed for 20% of all deaths in developed nations.<sup>31</sup> Here in the U.S., the average female claimed by smoking loses 14.5 years of life expectancy, while the average males loses 13.2.<sup>32</sup>

Waiting on our partner to be our "recovery buddy" often proves deadly. One partner needs to be brave, go first, and blaze a trail home that the other can eventually follow.

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30 Polito, JR, [Does the Over-the-counter Nicotine Patch Really Double Your Chances of Quitting?](#) WhyQuit.com, April 8, 2002.

31 Wald NJ and Hackshaw AK, [Cigarette smoking: an epidemiological overview](#), British Medical Bulletin, January 1996, Volume 52(1), Pages 3-11.

32 Centers for Disease Control, [Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Economic Costs - United States, 1995-1999](#), Morbidity and Mortality Weekly Report, April 12, 2002, Volume 51, Number 14, Pages 300-303, at Page 301.

There were a number of times during my thirty-year struggle where I wanted others to pick me up and carry me home. I waited, and waited and waited for dear friends to stop with me. Finally, I got my wish.

My best friend and I became "recovery buddies" in 1984. I recall two things about that experience. It was the only time during our friendship that we'd ever yelled at each other. I also recall that within an hour of learning that he had relapsed, that I relapsed too.

But the story had a healthy ending. Jim attended a 2002 recovery seminar I presented at the high school from which my daughters graduated.

Standing on the auditorium stage, I shared this crutch and "buddy system" lesson and our mutual failure 18 years earlier. I recall hoping that as a seasoned ex-user that I could now lend a hand in showing Jim the way home. He succeeded. And he's still free today.

As Joel's "Buddy Systems" article proclaims, "Take heart ... your primary focus needs to be on your own [success] now." "Soon you will be the seasoned veteran." "Many programs use the phrase, 'To keep it, you have to give it away,'" writes Joel. "No where is this more true than when dealing with addictions."<sup>33</sup>

**Alcohol or other drugs** - Joel's crutches article tells the story of one of his clinic participants turning to alcohol. "Boy did I ever drink my brains out, today," she enthusiastically proclaimed, "But I did not smoke!"

"She was so proud of her accomplishment," recalls Joel. "Two whole days without smoking a single cigarette, to her being bombed out of her mind was a safe alternative to the deadly effects of cigarettes."

"Just 24 hours earlier I had made a special point of mentioning the dangers of replacing one addiction with another," writes Joel. "In [stopping] smoking one should not start using any other crutches which might be dangerous or addictive."

Using alcohol, illegal drugs or addictive prescription medications as nicotine cessation crutches also elevates the risk of relapse due to diminished

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33 Spitzer, J, Buddy Systems, April 29, 2000, <http://www.ffn.yuku.com/topic/12760>

inhibitions while using them.

It can foster psychological associations that can present problems when unable to obtain or use them. And let's not forget the risk of establishing a chemical dependency upon them, and trading one dependency for another.

As Joel notes, "In many of these cases the end result will be a more significant problem than just the original problem, smoking. The new addiction can cause the person's life to end in shambles, and when it comes time to deal with the new dependence he or she will often relapse to cigarettes."<sup>34</sup>

Some Internet sites teach users to "do whatever it takes" to stop. Advice such as this is disturbing. "I guess that can be translated to taking any food, any drug, legal or illegal, or participate in any activity, no matter how ludicrous or dangerous that activity might be," writes Joel.

"Does the comment smoke crack cocaine, or shoot up heroin, or drink as much alcohol as it takes, or administer lethal dosages of arsenic or cyanide make any sense to anyone as practical advice to stop smoking," asks Joel? "If not, the comment 'do whatever it takes' loses any real concept of credibility."

"As far as stopping smoking goes, the advice should not be 'do whatever it takes to stop smoking,' but rather, 'do what it takes to stop,' " suggests Joel. "What it takes to stop is simply sticking to your commitment to Never Take Another Puff!"<sup>35</sup> And to be a bit more inclusive, to never take another puff, dip, chew, vape, patch or lick.

**Exercise programs** - At first blush, some crutches appear harmless. For instance, consider an exercise program that was started on your first day of recovery. But imagine your mind so tying the program to successful recovery that you became totally convinced that it was the primary reason you were succeeding.

What would happen if your exercise facility suddenly closed or if bad weather, transportation problems, illness or injury made exercise impossible?

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34 Spitzer, J, Replacing Crutches, WhyQuit.com, Joel's Library, 1987.

35 Spitzer, J, "Do whatever it takes to quit smoking" March 19, 2003, <http://www.ffn.yuku.com/topic/12855>



Exercise is always beneficial and I am in no way trying to discourage activity or exercise. However, while beneficial, exercise is not a nicotine dependency recovery requirement.

View your program in terms of the direct benefits it provides, not as a primary source of recovery motivation. In your mind, see your recovery remaining strong with or without it, and your ability and willingness to exercise as a benefit rather than a requirement.

**Internet support** - The Internet can also become a crutch. While online support groups such as [Freedom](#)<sup>36</sup> or [Turkeyville](#)<sup>37</sup> can be extremely supportive, take care not to lean too heavily upon them.

What if your computer crashes and you can't afford a new one? What if your Internet service provider has problems and its servers crash for a week? Worse yet, what if the company hosting your online support site goes bankrupt or abruptly discontinues service? Picture your recovery and resolve remaining strong even without a computer.

Hope for the best yet prepare for the worst. Consider printing your favorite articles. If keeping an online recovery journal, diary or log, be sure to print or save a copy every now and then.

Remove as much risk as possible from all sources of support. Create dependability and longevity by preserving what you deem valuable.

**Extra food** - Food can become an "aaah" wanting satisfaction crutch, as can other oral hand-to-mouth substitutes for cigarettes, e-cigarettes, cigars, pipes, oral tobacco or replacement nicotine products. In fact, any new emotion producing activity or significant lifestyle change can be leaned upon as a crutch.

"If you are going to develop a crutch," writes Joel, "make sure it is one which you can maintain for the rest of your life



36 Freedom from Nicotine - <http://www.ffn.yuku.com>

37 WhyQuit's Facebook Group - <https://www.facebook.com/groups/whyquit/>

without any interruption, one that carries no risks and can be done anywhere, anytime."

"About the only crutch that comes close to meeting these criteria is breathing. The day you have to stop breathing, smoking will be of little concern. But until that day, to stay free from cigarettes all you need to do is - Never Take Another Puff!"

Consider building your recovery so as to enable it to stand entirely on its own. If you now realize that you have developed a crutch, picture continuing on and succeeding even if it's suddenly removed. You'll be fine. The next few minutes are all we can control and each is entirely do-able.

## Cessation Products

**Open lies and hidden truths** - Over the years I've written much on this topic. Two key points need making. First, any smoking cessation product manufacturer whose marketing suggests that few smokers succeed in stopping on their own has already lied to us.

Truth is, each year more smokers succeed by going cold turkey than by all other methods combined.<sup>38</sup> Truth is, while approved cessation products clobber placebo inside clinical trials, that they get clobbered just as badly by cold turkey in real-world use.<sup>39</sup>

Second, what logic is there in paying money to extend nicotine withdrawal for weeks or months when it takes less than 72 hours to rid the body of all nicotine? What sense does it make to buy and use a prescription product that poses risk of death, when our objective is longer life?

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38 Polito, JR, [Are those who quit smoking paying with their lives because of NRT's failure?](#) British Medical Journal, February 7, 2012, Page 344, e866; also see Cancer Council Australia, [Most Australians still quit smoking unassisted](#), Oct. 8, 2010 (survey found that 69% of Australians quit smoking cold turkey); also see Chapman S, MacKenzie R (2010) [The Global Research Neglect of Unassisted Smoking Cessation: Causes and Consequences](#). PLoS Med 7(2): e1000216. doi:10.1371/journal.pmed.1000216 ("Research shows that two-thirds to three-quarters of ex-smokers stop unaided").

39 Doran CM, et al, [Smoking status of Australian general practice patients and their attempts to quit](#), Addictive Behaviors, May 2006, Volume 31(5), Pages 758-766 (88% of successful family practice patients stopped smoking cold turkey with cold turkey doubling success rates for NRT and Zyban); also see Polito, JR, [Replacement Nicotine's Killing Fields](#), WhyQuit.com, February 11, 2012, <http://whyquit.com/pr/021112.html>

**Cold turkey is fast, free, effective and smart** - We nicotine addicts have been lied to by so many for so long that it's growing harder and harder to believe anyone.

Clearly, the most damaging and deadly lie of all is being told by those seeking to increase their product or procedure's market share by falsely suggesting that few nicotine addicts succeed in going cold turkey, that you need to be a super-hero to do so.

Billions in marketing have been spent during the past three decades in getting us to fear our natural recovery instincts. I submit that it has already cost millions their lives. Both direct and indirect cold turkey bashing not only foster diminished expectations upon being hearing the falsehood that your current attempt is twice as likely to fail, but a cessation confidence crisis for all still using.

Never in history have a greater array of approved smoking cessation products promised to double success rates. Skyrocketing cigarette taxes and prices, the smoke-free air movement sweeping the globe, and a steady stream of new studies on the negative effects of smoking, never in history have the coercive pressures upon smokers to stop been greater.

The latest magic cure varenicline (Chantix and Champix) has been widely used since 2006. Since then, millions of brave and highly motivated users have given it a try. Also, according to the CDC, more than 2.5 million U.S. smokers smoked themselves to death between 2004 and 2010.

Yet, during the six years between 2004 and 2010, decline in the U.S. adult smoking rate was just one percentage point, from 20 percent to 19 percent.<sup>40, 41, 42</sup>

Today, up to three quarters of all smokers continue to stop entirely on their own without use of any product, procedure, website or book.<sup>43</sup> And that's despite billions spent trying to get them to purchase replacement nicotine (NRT), rather risky Chantix or Champix pills,<sup>44</sup> stop smoking scapolomine

40 Spitzer, J, "[Do whatever it takes to quit smoking](http://www.ffn.yuku.com/topic/12855)" March 19, 2003, <http://www.ffn.yuku.com/topic/12855>

41 CDC, [Cigarette Smoking Among Adults - United States, 2007](#), November 28, 2008, MMWR Vol57, No. 45.

42 CDC, [Vital Signs: Current Cigarette Smoking Among Adults Aged >18 Years --- United States, 2005--2010](#)

43 Chapman S, MacKenzie R., [The global research neglect of unassisted smoking cessation: causes and consequences](#), PLoS Med. 2010 Feb 9;7(2):e1000216.

44 Polito, JR, "[Will Chantix really help me quit smoking?](http://WhyQuit.com)" WhyQuit.com, August 25, 2006.

shots invented by a quack now doing hard time for fraud, magic herbs or to motivate smokers to undergo hypnosis, acupuncture or laser therapy.

A 2006 Australian study followed smoking patients of 1,000 family practice physicians. It found that 88% of all successful ex-smokers succeeded by going cold turkey, and that those going cold turkey were twice as likely to succeed as those using the nicotine patch, nicotine gum, nicotine inhaler or Zyban (bupropion).<sup>45</sup>

We nicotine addicts make extremely easy prey. While normal to dream of painless cures, we must not close our eyes to actual results in an arena where the most ridiculous or even fraudulent cessation scheme imaginable should statistically generate success testimonials from 10-11% of users at six months and 5% at one year.<sup>46</sup>

These figures reflect the generally accepted odds of successful smoking cessation by those stopping entirely "on-their-own." It's why so many of us are eventually claimed by our addiction. It's the reason for FFN-TJH, to share basic recovery insights needed to turn darkness to light.

Pretend that together we concoct a new magic cessation product that we name Billy Bob's Lima Bean Butter. Unless our product somehow undercuts natural cessation (as seen with NRT), 10-11 percent who use it should succeed and still be smoke-free at 6 months.

The beauty/horror of cessation fraud is that nearly all who succeed will deeply believe that our butter was responsible for their success. In fact, we won't be able to convince them otherwise. It would be a waste of breath to try.

It gets worse. We can dramatically inflate our 10-11 percent success rate by creating a study in which our butter gets used in conjunction with other high quality recovery interventions, that have themselves proven to double or even triple success rates.

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45 Doran CM, et al, Smoking status of Australian general practice patients and their attempts to quit, Addictive Behaviors, May 2006, Volume 31(5), Pages 758-766; also see Polito, JR, Cold Turkey Twice as Effective as NRT or Zyban, WhyQuit.com, May 19, 2006.

46 Polito, JR, Does the Over-the-counter Nicotine Patch Really Double Your Chances of Quitting? WhyQuit.com, April 8, 2002.

For example, we could combine our butter's use with coping skills development, behavioral therapy, or individual or group counseling, all of which have their own proven effectiveness.

Combining high quality counseling or support with use of Billy Bob's Lima Bean Butter would guarantee newsworthy results. Unfortunately, this success rate inflation tactic has been used in nearly all NRT, bupropion (Zyban) and varenicline (Chantix or Champix) clinical studies to date.

Imagine regular AA meetings where alcoholics come together to educate and support mutual successful ongoing recovery. Imagine the group's support dynamics achieving a rather impressive recovery rate of 35 percent at six months.

Now imagine someone trying to package and sell the program over-the-counter to alcoholics for \$200 as a stand-alone, in-home, personal recovery tool, while suggesting that users would experience similar odds.

How long would it take for allegations of consumer fraud to begin flying once it was noticed that 93% buying and trying the program were relapsing to alcohol within six months (over-the-counter NRT's six-month rate is 7%)?

Pfizer's five original varenicline studies broke records for the number of counseling sessions, with up to twenty-five. To this day, Pfizer marketing continues to award full credit to varenicline.<sup>47</sup>

While approved smoking cessation products clobber placebo users inside clinical trials rich in support and counseling, real-world performance has been a disaster.

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47 Chantix Lisa commercial - You Tube <http://youtu.be/Suwx2d0H7XM> "In studies, 44% of Chantix users were quit during weeks 9 to 12 of treatment compared to 18% on sugar pill;" also see [www.Chantix.com](http://www.Chantix.com) where the site's homepage stated on August 5, 2012, "Proven to Work 44%" "In studies, 44% of CHANTIX users were quit during weeks 9 to 12 of treatment (compared to 18% on sugar pill)." Contrast Polito, JR, [Is a 14% Chantix success rate worth risking death?](http://www.WhyQuit.com) June 14, 2011 WhyQuit.com Press Release at <http://whyquit.com/pr/061411.html> reviewing the 2011 Hughes Chantix study. Also see the five original Pfizer Chantix studies which include Gonzales D et al, [Varenicline, an a4b2 Nicotinic Acetylcholine Receptor Partial Agonist, vs Sustained-Release Bupropion and Placebo for Smoking Cessation: A Randomized Controlled Trial](http://www.JAMA.com). JAMA. 2006, Volume 296(1) Pages 47-55, during which participants received up to 14 counseling/support sessions lasting up to 10 minutes each by week 12 of varenicline use, with up to an additional 11 counseling/support sessions between weeks 13 and 52 of follow-up.

California,<sup>48</sup> Massachusetts,<sup>49</sup> Minnesota,<sup>50</sup> Quebec,<sup>51</sup> London,<sup>52</sup> Western Maryland,<sup>53</sup> Nottingham,<sup>54</sup> Australia,<sup>55</sup> the United States,<sup>56</sup> and England,<sup>57</sup> it should bother all of us that after nearly three decades of widespread use that real-world cessation surveys continue to show that those buying and using approved products fail to perform better than those stopping entirely on-their-own.

Such cessation method surveys are inexpensive, quick and easy to generate. And successful ex-users have absolutely no reason to lie about how they finally achieved success.

But NRT stakeholders quickly dismiss such surveys as "unscientific." They argue that we can't trust smokers and ex-smokers to correctly remember the method they used, and whether or not it brought them success.

Frankly, what cannot be trusted and should be dismissed as unscientific is all smoking cessation clinical trial findings whose validity is grounded in use of placebo controls.

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48 Pierce JP, et al, Impact of Over-the-Counter Sales on Effectiveness of Pharmaceutical Aids for Smoking Cessation, Journal of the American Medical Association, September 11, 2002, Volume 288, Pages 1260-1264.

49 Alpert, HR, Connolly GN, Biener, L, A prospective cohort study challenging the effectiveness of population-based medical intervention for smoking cessation, Tobacco Control, Online First, January 10, 2012.

50 Boyle RG, et al, Does insurance coverage for drug therapy affect smoking cessation? Health Affairs (Millwood), Nov-Dec 2002 Volume 21(6), Pages 162-168.

51 Gomez-Zamudio, M, et al, Role of pharmacological aids and social supports in smoking cessation associated with Quebec's 2000 Quit and Win campaign, Preventive Medicine, May 2004, Volume 38(5), Pages 662-667.

52 SmokeFree London, Tobacco In London, Facts and Issues, [see Figure 14], November 26, 2003.

53 Alberg AJ, et al, Nicotine replacement therapy use among a cohort of smokers, Journal of Addictive Diseases, 2005, Volume 24(1), Pages 101-113.

54 Ferguson J, et al, The English smoking treatment services: one-year outcomes, Addiction, April 2005, Volume 100 Suppl 2, Pages 59-69 [see Table 6 where consistent with Doran 2006, 25.5% of those stopping without medication were still not smoking at 1 year versus 15.5% of NRT and 14.4% of bupropion users].

55 Doran CM, et al, Smoking status of Australian general practice patients and their attempts to quit, Addictive Behaviors, May 2006

56 Hartman AM. What does US national population survey data reveal about effectiveness of nicotine replacement therapy on smoking cessation? Paper presented at World Conference on Tobacco or Health, 12-15 July 2006, Washington, DC. Full Text available [http://whyquit.com/NRT/studies/Hartman\\_NCI\\_NRT.pdf](http://whyquit.com/NRT/studies/Hartman_NCI_NRT.pdf) (see PDF pages 33 to 38); also see Pierce JP, et al, Quitlines and nicotine replacement for smoking cessation: do we need to change policy? Annual Review of Public Health, April 2012, Volume 33, Pages 341-356 (see Table 1 indicating that among light smokers of less than 15 cigarettes per day that 26% who stopped unassisted succeeded at 3 months versus only 19% who used NRT or prescription medication, and also that among heavy smokers of greater than 15 cigarettes that 15% of unassisted succeeded versus 9% who used NRT or prescription products).

57 UK NHS, Statistics on NHS Stop Smoking Services in England, April to December 2007 [see Table 6], April 16, 2008.

**Placebo isn't a recovery method and it isn't cold turkey** - Let me ask you, if I hand you a piece of nicotine gum or a nicotine lozenge, how long will it take you to tell me whether or not it really contains nicotine or is instead a nicotine-free placebo look-a-like?

Not all of us can do it. However, 3 to 4 times as many of us will be correct as guess wrong, and that's within one week of attempting to stop smoking.<sup>58</sup>

Pretend for a moment that while still hooked and using, that we hear about a new nicotine gum study at a nearby medical school that is offering participants three months of free nicotine gum. There's only one catch. Half signing up for the study will be randomly assigned to receive nicotine-free placebo gum instead.

Would we stick around and allow ourselves to be toyed with for the next 3 months if convinced that we had been given placebo gum instead of the real thing? Neither did they.

In study after study, 80 to 90 percent of study participants report a history of prior stop smoking attempts. Those attempts taught them to recognize the onset of their withdrawal syndrome. The more prior attempts they had made, the more expert they became at recognizing withdrawal's onset. If true, what validity would there be in our gum study finding that twice as many nicotine gum users succeeded in stopping smoking as those chewing placebo gum?

Imagine the lack of intellectual integrity required to label victory by default, victories rooted in frustrated expectations, as having been "science-based." It's why use of placebo controls in smoking cessation studies has served as a license to steal.

As I wrote in a letter to the Canadian Medical Association Journal published in November 2008, "pharmacologic treatment of chemical dependency may

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58 Dar R, et al, [Assigned versus perceived placebo effects in nicotine replacement therapy for smoking reduction in Swiss smokers](#), Journal of Consulting and Clinical Psychology, April 2005, Volume 73(2), Pages 350-353 (3.3 times as many correctly determined assignment); also see Rose JE, [Precessation treatment with nicotine patch significantly increases abstinence rates relative to conventional treatment](#), Nicotine & Tobacco Research, June 30, 2009, where 4 times as many placebo patch users correctly determined their placebo assignment as guessed wrong, and did so within one week of quitting.

be the only known research area in which blinding is impossible."<sup>59</sup>

You cannot fool cessation savvy nicotine addicts as to whether or not brain dopamine pathway wanting is being satisfied or not.

A June 2004 study was entitled "The blind spot in the nicotine replacement therapy literature: Assessment of the double-blind in clinical trials."<sup>60</sup> It teaches that anyone asserting that NRT studies were blind is not being honest, as far more study participants correctly determine their assignment as guess wrong.

This might surprise you, but those wanting to stop smoking cold turkey have never been invited to compete in clinical trials against self-selecting smokers seeking months of free replacement nicotine, bupropion or varenicline.<sup>61</sup>

Unlike those going cold turkey, those seeking free "medicine" joined the study in hopes of diminishing, not meeting, greeting and defeating their withdrawal syndrome.

Why are there no head-to-head clinical studies pitting medicine against cold turkey? Because if honest competition had occurred there would be no need for this explanation.

Nearly all cessation researchers have accepted funding and/or personal payments from the pharmaceutical industry. It is not reasonable to expect financially conflicted researchers to bite the hand that feeds them, as they would never receive any pharma money or research projects again.

The industry cannot permit intellectually honest studies as they would cost it billions in profits. Smoking cessation clinical trial research is increasingly void of scientific integrity. Most calling themselves researchers are now

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59 Polito JR, [Smoking cessation trials](#), Canadian Medical Association Journal, November 2008, Volume 179, Pages 1037-1038; also see original online e-letter selected for publication, Polito JR, [Meta-analysis rooted in expectations not science](#), E-Letter, Canadian Medical Association Journal, July 17, 2008; and a follow-up e-letter rebutting pharmacology meta-analysis editors' suggestion that blinding issues in drug addiction studies are no different than concerns seen in other studies, Polito JR, [Why cessation blinding concerns differ from other clinical trials](#), E-Letter, Canadian Medical Association Journal, November 9, 2008.

60 Mooney M, et al, [The blind spot in the nicotine replacement therapy literature: Assessment of the double-blind in clinical trials](#), Addictive Behaviors, June 2004, Volume 29(4), Pages 673-684.

61 Polito, JR, [Flawed research equates placebo to cold turkey](#), WhyQuit.com, March 12, 2007.



little more than glorified salesmen.

We have now seen more than 200 placebo-controlled smoking cessation NRT, bupropion and varenicline studies, when nearly all agree that placebo affords study participants the worst possible odds of success.

Today, the National Institute of Health's clinical trials registry identifies more than 200 new smoking studies that are using placebo controls.<sup>62</sup>

Why? It's simple. It's all about money.

How many study participants assigned to placebo are facing their final cessation opportunity before experiencing a smoking induced heart attack, stroke, or being diagnosed with terminal cancer or emphysema?

Instead of subjecting them to the worst cessation method known (placebo), why not instead use the best proven treatment as the study's control, and then see how the new method being evaluated compares to the best?

Principle 32 of the World Medical Association's (WMA) Declaration of Helsinki commands that the "benefits, risks, burdens and effectiveness of a new intervention must be tested against those of the best current proven intervention" and that placebos should not be used unless "compelling and scientifically sound methodological reasons" are demonstrated.<sup>63</sup>

How many desperate study participants who were down to their final opportunity have smoking cessation researchers needlessly killed? Do they care or was money more important?

One reason researchers use placebo instead of the "best current proven intervention" is that placebo promises the greatest margin of victory possible and the biggest news headlines.

Also, in pitting cessation products against each other, unless a tie, one must win and one must lose. Think about GlaxoSmithKline, maker of Nicorette gum, the Commit nicotine lozenge, the Nicoderm CQ patch and

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62 National Institute of Health, [www.ClinicalTrials.gov](http://www.ClinicalTrials.gov), visited December 2008, search: placebo + smoking

63 World Medical Association, [Declaration of Helsinki, Ethical Principles for Medical Research Involving Human Subjects](#), Adopted by the 18th WMA General Assembly, Helsinki, Finland, June 1964, and last amended by the 59th WMA General Assembly, Seoul, October 2008.

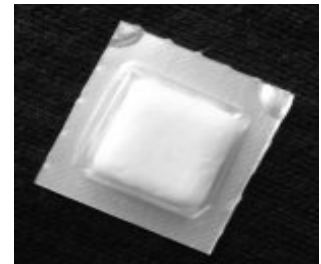
Zyban. Would you want any of your products losing to another?

Pharmaceutical companies avoid risk of defeat in head-to-head product competition by use of a control that isn't a real cessation method. This way, no company economic interest gets harmed.

Unfortunately, the lives of clinical trial participants are being sacrificed by a near ethic-less headline seeking smoking cessation research industry that's driven by income and study funding.

**What Big Pharma doesn't want us to know** - Clinical smoking cessation studies reflect the worst junk-science ever perpetrated upon humans.

Regretfully, real scientists turned their heads as financial stakeholders redefined "cessation" from meaning ending nicotine use to replacing it. They remained silent as the pharmaceutical industry re-labeled a natural poison "medicine" and termed its use "therapy."



And why total silence when seeing apples compared to oranges? What sense does it make to compare the accomplishment of someone who has stopped using nicotine to stimulate brain dopamine pathways, to someone who continues stimulation by use of NRT, e-cigarettes, smokeless tobacco, Zyban, Chantix or Champix?

But who has greater fault, those paid or profiting by knowingly engaging in nicotine shell games, or government agencies that continue to hide population level cessation method findings, findings that would aid users in making informed, intelligent and reasoned decisions?

Until recently, I struggled trying to understand why government health officials actually discourage natural cessation. For years, I toyed with the possibility that health bureaucrats had grown lazy, don't read cessation studies, are generally stupid or simply don't care.

It wasn't until July 2012 that I learned about the CDC Foundation. Established by Congress in 1995, it's a non-profit organization in which corporations such as GlaxoSmithKline and Pfizer partner with the CDC, by

making financial donations towards projects that the industry wants the CDC to study.

Online documents at [www.cdcfoundation.org](http://www.cdcfoundation.org) suggest that the amounts actually paid by cessation product makers are secret. What isn't secret is the partnership between the CDC and the industry.

What percentage of over-the-counter (OTC) NRT users are still not smoking at six months or one year? Would this be important to know? I challenge you to locate an answer to this important question on any government, commercial or health website advocating NRT use.

A March 2003 study, conducted by paid NRT industry consultants, combined and averaged all seven OTC NRT patch and gum studies.<sup>64</sup> OTC studies are important because their design is as close as possible to the way these products are used in the real world. Study participants simply walk into the pharmacy, purchase or are given the product, and then use it without any formal counseling, education or support.

**Conclusion: "NRT appears no longer effective in increasing long-term successful cessation in California smokers."**

*Journal of the American Medical Association, Volume 288, Number 10, Pages 1260-1264, Sept. 11, 2002*

Researchers found that only 7% of OTC study participants were still not smoking at six-months. That's right, a product with a 93% failure rate. It's actually worse. The same industry consultants also published a November 2003 study which found that as many as 7% of successful gum nicotine users were still hooked on the gum at six months.<sup>65</sup> Obviously these were two different studies. Even so, the math leaves you wondering if anyone actually breaks free from nicotine by chewing it.

What are the odds of success during a second or subsequent NRT attempt? Do the user's odds improve or get worse the second time around? Again, I

<sup>64</sup> Hughes, JR, Shiffman, S, et al., [A meta-analysis of the efficacy of over-the-counter nicotine replacement](#), Tobacco Control, March 2003, Volume 12, Pages 21-27.

<sup>65</sup> Shiffman S, et al, [Persistent use of nicotine replacement therapy: an analysis of actual purchase patterns in a population based sample](#), Tobacco Control, September 2003, Volume 12(3), Pages 310-316.

challenge you to locate an answer to this rather important yet elementary question on any government or health organization website advocating use of replacement nicotine by nicotine addicts.

The pharmaceutical industry, government health agencies and health non-profits have known since as early as 1993 that if you have already tried and failed while using the nicotine patch, that your odds during a second patch attempt drop to near zero.<sup>66</sup>

Unlike cold turkey, where each failed attempt actually increases the odds of eventually self-discovering the [Law of Addiction](#), the odds of success for the repeat NRT user dramatically decline with each failure. Why would anyone hide this data?

Nicotine addicts are also not told that by 2003 at least 36.6% of all continuing nicotine gum users were chronic long-term users of greater than 6 months.<sup>67</sup> Unlike the gum, which traps nicotine, the nicotine lozenge fully dissolves, delivering up to 25% more nicotine. We have no reason to believe that the percentage of current NRT users now hooked on the cure isn't climbing.

Let me share the first paragraph of an email I received. "I'm a 24 year old male who smoked cigarettes for about 6 years until stopping 2 years ago. Unfortunately, I did so by switching to Nicorette. In a horror story that I'm sure you've heard dozens of times, I'm now horribly addicted to the gum."

If able to get our brain's dopamine pathways adjusted to functioning without nicotine while at the same time continuing to use it, we should be extremely proud, because we are in fact super-heroes. But if among the 93 out of 100 first time OTC NRT users who quickly relapse, or among the nearly 100% who fail during a second or subsequent attempt, your brain dopamine pathways are functioning as designed.

They made a circuitry-activating event (nicotine's arrival) extremely difficult, in the short term, to forget or ignore. Hence, we need to navigate

66 Tonnesen P, et al, [Recycling with nicotine patches in smoking cessation](#), *Addiction*, April 1993, Volume 88(4), Page 533-539; also see Gourlay S. G., et al, [Double blind trial of repeated treatment with transdermal nicotine for relapsed smokers](#), *British Medical Journal*, 1995 Volume 311, Pages 363-366.

67 Shiffman S, et al, [Persistent use of nicotine replacement therapy: an analysis of actual purchase patterns in a population based sample](#), *Tobacco Control*, September 2003, Volume 12(3), Pages 310-316; also see Bartosiewicz, P, [A Quitter's Dilemma: Hooked on the Cure](#), *New York Times*, May 2, 2004.

withdrawal once use ends.

Replacement nicotine use defies the very purpose of withdrawal and recovery, the time needed to move beyond nicotine's influence. NRT users are not breaking free because of weeks or months spent toying with replacement nicotine, but in spite of having done so. Their success is testimony to their drive and determination.

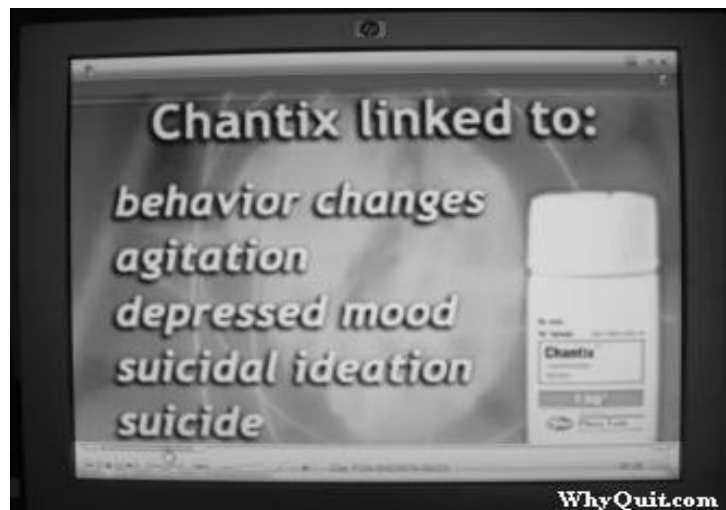
Core dreams and desires for freedom are not altered by standing in front of any weaning product or even Billy Bob's Lima Bean Butter. It is "us" doing the work.

So long as we keep our day #1 dreams vibrant and alive long enough to become entirely comfortable within nicotine-free skin, we'll eventually be free to award full credit to any product or procedure we desire.

But should FFN-TJH serve as a tool in aiding your recovery, do understand that it was "you" who put its lessons to work, you who did all the lifting, and the glory is 100 percent yours!

**Varenicline - Chantix & Champix** - A few words of caution about varenicline (Chantix and Champix). Never in the history of cessation products have we seen such a wide array of serious side effects, including death.

We cannot accurately predict who will and will not sustain harm. What can be asserted with confidence is that varenicline is not the magic cure or nearly as effective in real-world use as marketing suggests.



So far, only 3 studies have pitted varenicline against NRT, Aubin 2008, Tsukahara 2010 and Dhelaria 2012. In each, varenicline failed to show statistical significance over NRT when assessing the percentage of users

within each group who were not smoking at 24 weeks.<sup>68</sup>

The Aubin study notes that two varenicline users experienced severe depression, with suicidal ideation causing one to be hospitalized 11 days after ending use.

It found that among 376 Chantix users and 370 patch users that the likelihood of a Chantix users experiencing vomiting was 5.5 times greater, that decreased sense of taste was 5.3 times greater, abdominal pain x5, disturbances in attention x4.5, nausea x4, flatulence x4, constipation x3, headaches x2, dizziness x2, diarrhea x2, with 2.3 times as many Chantix users complaining of fatigue.

Does it make any sense to assume significantly increased risks, including risk of death, without significantly offsetting greater odds of success?

England's Stop Smoking Services may offer the highest caliber government sponsored cessation services of any nation. Services include free individual or group counseling and support. Take a look at the below table showing 2011 UK NHS 4 week rates that's similar from year to year.<sup>69</sup>

The only long-term English evidence is from an April 2005 study that examined one-year success rates.<sup>70</sup> That study did not include varenicline as it wasn't yet on the market. It found that while 25.5% of those who attempted to stop without using any pharma product were still smoke-free at one year, that only 15.2% of NRT users and 14.4% of bupropion (Zyban) users were still not smoking.

Bringing together all we so far know suggests that when examining one-year rates, that varenicline will likely perform similar to NRT but well behind cold turkey.

DA another one of these dumbass threads on't expect any researcher to ever

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68 Aubin HJ, et al, Varenicline versus transdermal nicotine patch for smoking cessation: results from a randomized open-label trial, Thorax, August 2008, Volume 63(8), Pages 717-724; Tsukahara H, et al, A randomized controlled open comparative trial of varenicline vs nicotine patch in adult smokers: efficacy, safety and withdrawal symptoms (the VN-SEESAW study), Circulation Journal, April 2010, Volume 74(4), Pages 771-778; and Dhelaria RK, Effectiveness of varenicline for smoking cessation at 2 urban academic health centers, European Journal of Internal Medicine, July 2012, Volume 23(5), Pages 461-464.

69 UK NHS, Statistics on NHS Stop Smoking Services in England, April to December 2007 [see Table 6], April 16, 2008.

70 Ferguson J, et al, The English smoking treatment services: one-year outcomes, Addiction, April 2005, Volume 100 Suppl 2, Pages 59-69 [see Table 6].

include a copy of FFN-TJH or Joel's book as part of any fair, open-label study pitting cold turkey against varenicline or NRT. Doing so would produce a cold turkey victory that would destroy the industry's golden goose. Also, any researcher bold enough to conduct such a study would never receive pharma industry study funding again.

**Joel's poll suggestion** - Joel has also written extensively on pharma industry cessation products. He was warning about nicotine gum's ability to foster relapse or become a crutch, as early as 1984.<sup>71</sup>

He encourages those contemplating using industry products to take their own poll of all successful long-term ex-users who have remained nicotine-free for at least a year.<sup>72</sup> He encourages us to believe our own survey findings.

Joel reminds us that smoking declined from 42% to 23% over the past 40 years, but that the drop-off stalled in the 1990s. He finds it curious because that's when pharma industry NRT started experiencing widespread use.

"Nicotine gum was first approved for use in America in 1984, by prescription only. In 1991 and 1992, four patches were approved for prescription use. In 1996 all controls broke loose as the gum and two of the four patches went over-the-counter and Zyban (bupropion) was just coming into the fray."<sup>73</sup>

"Lets hope not too many miracle products for smoking cessation get introduced in the future as it may result in skyrocketing smoking rates," suggests Joel.

Why delay and extend withdrawal and neuronal re-sensitization for weeks or months? Keep in mind that a 7mg. nicotine patch delivers the nicotine equivalent of smoking seven cigarettes a day.

In the end, all drug addicts who successfully recover must give-up their drug. In fact, all who successfully arrest their dependency eventually go cold turkey.

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71 Spitzer, J, Pharmacological Crutches, Joel's Library, 1984.

72 Spitzer, J, Quitting Methods - Who to Believe? Joel's Library, 2003.

73 Spitzer, J, 40 Years of Progress? Joel's Library, 2004.

It is then and there that the rule for staying free becomes the same for all ... no nicotine just one day at a time.

## Negative Support

***"You're such a basket case, you should just give up!"***

***"If this is what you are like not smoking,  
for Gods sake, go back!"***

***"I'm trying but my smoking friends laugh,  
tell me I'll fail and offer me smokes."***

No person's comment, look, laugh, stare or offer can destroy our freedom. Only we can do that. According to Joel, most of the time the person making comments or offers such as these has not considered their implications.<sup>74</sup>

It's comparable to telling someone on chemotherapy and in a really bad mood due to hair loss, nausea, and other horrible side effects, that they should get off that stuff because they are so irritable that they are ruining your day, suggests Joel.

"Of course, if analyzed by any real thinking person, the comment won't be made, because most people recognize that chemotherapy is a possible last ditch effort to save the other person's life."

"The decision to stop the treatment is a decision to die. So we put up



74 Spitzer, J, Negative Support from Others, February 15, 2001, <http://ffn.yuku.com/topic/23019>



with the bad times to help support the patients effort to save his or her life."

What's often overlooked, reminds Joel, is that stopping smoking too is an effort to save their life. "While others may not immediately appreciate that fact, the person stopping has to know it for him or herself. Others may never really appreciate the concept, but the person stopping has to."

As Joel notes, such comments are "usually from a spouse, a child of the smoker, a friend, a co-worker or just an acquaintance. It is much more uncommon that the person expressing it is a parent or even a grandparent. I think that says something."

"Parents are often used to their kids outbursts and moods, they have experienced them since they were infants. The natural parental instinct is not to hurt them when they are in distress and lash out, but to try to protect them. I think it often carries into adulthood, a pretty positive statement about parenthood."

But Joel has seen where people have encouraged friends or loved ones to relapse and then months or years later the smoker died from a smoking related disease.

"Sometimes the family member then feels great guilt and remorse for putting the person back to smoking," he says.

"But you know what? He or she didn't do it. The smoker did it him or herself. Because in reality, no matter what any person said, the smoker had to stop for him or herself and stay off for him or herself."

"How many times did a family member ask you to stop smoking and you never listened? Well if you don't stop for them, you don't relapse for them either. You stop for yourself and you stay off for yourself."

***"I can't stop. My husband still smokes and leaves his cigarettes lying around."***

***"I'm a bartender. How can I stop surrounded by smoke and smokers at every turn?"***

I recall attempts where I hoped smoking friends would be supportive in not smoking around me, and not leave their packs lying around to tempt me. While most tried, it usually wasn't long before they forgot.

I recall thinking them insensitive and uncaring. I recall grinding disappointment and intense brain chatter, that more than once seized upon frustrated support expectations as this addict's excuse for relapse.

Instead of expecting them to change their world for me, the smart move would have been for me to want to extinguish my brain's subconscious feeding cues related to being around them and their addiction.

The smart move would have been to take back my world, or as much of it as I wanted.

As I sit here typing in this room, around me are a number of packs of cigarettes: Camel, Salem, Marlboro Lights and Virginia Slims. I use them during presentations and have had cigarettes within arms reach for years.



Don't misconstrue this. It is not a smart move for someone struggling in early recovery to keep cigarettes on hand. But if a family member or best friend smokes or uses tobacco, or our place of employment sells tobacco or allows smoking around us, we have no choice but to work toward extinguishing tobacco product, smoke and smoker cues almost immediately. And we can do it!

Millions of comfortable ex-users handle and sell tobacco products as part of their job. You may find this difficult to believe, but I've never craved or wanted to smoke any of the cigarettes that surround me, even when holding packs or handling individual cigarettes during presentations.

Worldwide, millions of ex-smokers successfully navigated recovery while working in smoke filled nightclubs, restaurants, bowling alleys, casinos, convenience stores and other businesses historically linked to smoking.

And millions broke free while their spouse, partner or best friend smoked like a chimney.

Instead of fighting or hiding from the world, take it back. Why allow our circumstances to wear us down? Small steps, just one moment at a time, embrace challenge. Extinguish use cues and claim your prize once you do, another slice of a nicotine-free life.

Recovery is about taking back life. Why fear it? Instead, savor and relish reclaiming it.

Maybe I'll have a crave tomorrow. But it's been so many years (since 2001) that I'm not sure I'd recognize it.

Why fear our circumstances when we can embrace them? They cannot destroy our glory. Only we can do that.

## **Breathing Secondhand Smoke**



*Photo by National Cancer Institute*

***"I have to breathe smoke anyway  
so why not just go back to smoking."***

"Contrary to popular opinion or misconceptions, the risks of secondhand smoke exposure are nothing compared to actually smoking yourself," writes

Joel.

"As far as causing a relapse to needing nicotine, it can't do that. The trace amount of nicotine that can be absorbed from second hand smoke exposure is usually under 1% of what a smoker gets from smoking."

The primary metabolite that nicotine breaks down into is called cotinine. The benefit of researchers looking at cotinine levels in saliva, blood and urine, instead of nicotine, is that nicotine has a relatively short elimination half-life of about 2 hours. Cotinine's 17-hour half-life makes it a more stable indicator that nicotine was present.

The average of three studies reporting cotinine levels in the saliva of smokers was 260 ng/ml in women and 337 ng/ml in men.<sup>75</sup> Ng/ml stands for nanograms per milliliter. A nanogram is one billionth of a gram and a milliliter is one thousandth of a liter.

A 2006 study used spectrometry (a scope that measures wave lengths or frequency) to analyze cotinine levels of non-smokers after spending 3 hours in a smoke filled bar. Although they experienced an 8-fold increase in cotinine levels, their total average increase was still only 0.66 ng/ml or a little more than half of a nanogram.<sup>76</sup>

Let me quote from a 1979 Surgeon General report:

"Several researchers have attempted to measure the amount of nicotine absorbed by nonsmokers in involuntary smoking situations. Cano, et al. studied urinary excretion of nicotine by persons on a submarine. Despite very low levels measured in the air (15 to 32ug/ma), nonsmokers showed a small rise in nicotine excretion; however, the amount excreted was still less than 1 percent of the amount excreted by smokers."

"Harke measured nicotine and its main metabolite, cotinine, in the urine of smokers and nonsmokers exposed to a smoke filled environment and reported that nonsmokers excreted less than 1

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75 Wells AJ, et al, Misclassification rates for current smokers misclassified as nonsmokers. American Journal of Public Health, October 1998, Volume 88(10), Pages 1503-1509.

76 Fowles J, et al, Secondhand tobacco smoke exposure in New Zealand bars: results prior to implementation of the bar smoking ban, The New Zealand Medical Journal, April 21, 2006, Volume 119, Page U1931.

percent of the amount of nicotine and cotinine excreted by smokers. He concluded that at this low level of absorption nicotine is unlikely to be a hazard to the nonsmoker."<sup>77</sup>

It's the same analysis yet even less concern when considering the trace amounts of nicotine found in nightshade vegetables (tomatoes, potatoes, eggplant and peppers).

A 1999 nightshade vegetable nicotine study found that, "on the basis of the observed concentrations and the respective food consumption data for different countries, a distributive analysis of the results suggests that the mean daily dietary nicotine intake for the population of the countries for which consumption data were available is approximately 1.4 micro-grams per day."<sup>78</sup>

Contrast this study's 1.4 micro-gram figure (.0000014) for total daily dietary nicotine intake from nightshade veggies, to the 1 milligram of nicotine (.001) that enters the smoker's bloodstream after smoking a single cigarette. That one cigarette alone introduces 714 times more nicotine than a diet that includes nightshade veggies.

A critical fact that bears repeating is that just one puff of mainstream nicotine is sufficient to stimulate up to 50 percent of the brain receptors that sustain nicotine addiction.<sup>79</sup> Once we ring that bell it cannot be un-rung.

Breathing secondhand smoke introduces vastly more nicotine than nightshade veggies yet vastly less than taking a puff from a lit cigarette. One puff is sufficient to foster relapse, while secondhand smoke cannot.<sup>80</sup>

According to Joel, "as far as secondhand smoke and nicotine goes, you would have to be in a smoke filled room, non-stop for 100 hours, yes I am saying over 4 days to get the equivalent dose of nicotine delivered to a

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77 U.S. Surgeon General, Smoking and Health: A Report of the Surgeon General, 1979, Chapter 11, Page 24.

78 Siegmund B, et al, Determination of the nicotine content of various edible nightshades (Solanaceae) and their products and estimation of the associated dietary nicotine intake, Journal of Agriculture and Food Chemistry, August 1999, Volume 47(8), Pages 3113-3120.

79 Brody AL et al, Cigarette smoking saturates brain alpha 4 beta 2 nicotinic acetylcholine receptors, Archives of General Psychiatry, August 2006, Volume 63(8), Pages 907-915.

80 Spitzer, J, Withdrawal again? Quoting from Second Hand Smoke, November 21, 2001, <http://www.fff.yuku.com/reply/255814#reply-255814>

smoker from one cigarette."

"Other chemicals in secondhand smoke can reach some pretty toxic levels much quicker than that, in minutes not days. The side effects felt from being exposed to secondhand smoke are from carbon monoxide, hydrogen cyanide and some other noxious chemicals that can reach levels that are well above OSHA standards for safety," explains Joel.

But as many newbies discover, being forced to breathe secondhand smoke during recovery can be demoralizing. Breathing it can become a source of junkie thinking during times of challenge. "I have to breathe it anyway so why not just go back to smoking."

What this addict is really saying is, "I'm so concerned about the lesser harms of secondhand smoke and the damage it inflicts that "I'm going to suck main-stream smoke into my lungs and bloodstream, smoke that I know will cause far greater harm."

What they're saying is, "I'm so concerned about a risk that is many times less than I used to face, that I'm going to relapse back to the greater risk and take a 50% chance that I'll smoke myself to death 13 to 14 years early."<sup>81</sup>

Such thinking makes you wonder why it never, ever occurs to non-smokers to take up smoking for the same reason. Such logic only makes sense to a drug addict.

What such junkie thinking is saying is that, "I'm going to again become part of the problem and at times expose others to the smoke, smells and chemicals that my once again badly damaged senses will by then no longer find offensive."

Why allow such smoke screen junkie thinking to obscure the path home? Just one challenge at a time "endeavor to persevere," strive to see through it!

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81 Wald NJ and Hackshaw AK, Cigarette smoking: an epidemiological overview, British Medical Bulletin, January 1996, Volume 52(1), Pages 3-11.

## Extremely Vivid Use Dreams

Stay prepared for highly disturbing dreams of smoking, vaping or using oral nicotine products. They may be so vivid and so life-like that you'll awaken totally convinced that you've relapsed to using.

Such dreams are normal and expected. Physical healing makes early dreams the most vivid of all.

Picture a horizontal body of a new ex-user as they sleep during the early days of recovery. Mouth and throat tissues suddenly begin healing and re-sensitizing after years of being deeply marinated in nicotine, flavorings or toxin rich tobacco tars. If a recovering smoker, picture the sweeper brooms lining lung bronchial tubes (your cilia) quickly regenerating and beginning to sweep mucus and tars up to the back of your throat. Add to that, rapidly healing and substantially more sensitive senses of smell and taste.



*"Sleep" 1897 Eugene Carrière - National Gallery of Art*

Now, throw a dream into the mind of this horizontal healing body and presto, the odors, juices, smells and tastes experienced come to life. They are remnants of use and real. What better proof could we possibly feel and sense of the amazing healing happening within? And it isn't unusual to experience more than one use dream.

The dreams that seem to cause the most concern are those that occur later in recovery, weeks or even months after full acceptance that this time is for keeps. Although nearly always described as a "nightmare," they are sometimes mistaken by the ex-user as a sign that they want to start using again.

It's here that we point out the obvious conflict. If a nightmare and not real, then why would any rational person want to invite their nightmare to

become a real and destructive part of daily life? As Joel notes, seeing smoking as a nightmare is a healthy sign.

When we need to begin worrying is when we start liking such dreams. Should that occur, it's likely a sign that complacency has arrived, that your recovery is in need of remembering and accurately recalling what it was like to devote a portion of every waking hour of every day to feeding a mandatory chemical need.

And as for having smoking dreams long after ending use, such dreams are normal, yet not nearly as vivid as during the first week or so. We can no more erase from our mind our thousands of old nicotine use memories than we can our name. They reflect who we once were. What's amazing is that they happen so infrequently.

## Bad Days

Ex-users should expect to experience bad days. Why? Because everyone has them, including never-users. But when a bad day occurs early in recovery it can become ammunition inside the challenged addict's mind as it searches for any excuse to use.

Blaming a bad day on recovery would never have crossed our mind if it had occurred the week before ending nicotine use. But now, nicotine's absence becomes a magnet for blame.



*Photo by National Cancer Institute*

Would it ever occur to a never-user to reach for nicotine if having a bad day? It's a thought process peculiar to us nicotine addicts.

As Joel teaches, if the bad day happens during the first week after ending



nicotine use then feel free to blame recovery as "it is probably the reason." "But as time marches on you need to be a little more discriminating."

Acknowledge bad days but allow your healing to live. "Sure there are some tough times," writes Joel, "but they pass and at the end of the day, you can still be free." Staying free means that, "in the greater scheme of things, it was a good day."

If you want to hear about a horrible day, talk to someone who relapsed after having remained clean for a considerable length of time. "They are having bad weeks, months and years," writes Joel. If a smoker, unless they again break free, they will likely face a day when their doctor tells them they now have a serious smoking related disease.

And imagine all the bad days they'll force loved ones to endure if among the 50% of U.S. adult smokers losing an average of roughly 5,000 days of life.<sup>82</sup>

Regardless of how we feel, every hour these minds and bodies are allowed to heal is good. Acknowledge the bad while savoring the good.

And the good only gets better. Ahead are entire days where you'll never once think about wanting to use. Just here and now, let the healing continue.

## **Weight Gain & Control**

Escalating weight gain can gradually erode recovery motivation to the point of making the smoker's 50% odds of losing 13-14 years of life look more appealing than another pound. And let's be frank, many of us need to be concerned about weight gain.



*Photo by National Cancer Institute*

<sup>82</sup> Centers for Disease Control, Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Economic Costs - United States, 1995-1999, Morbidity and Mortality Weekly Report, April 12, 2002, Volume 51, Number 14, Pages 300-303, at Page 301.

But before going further, it's critical to note that a female smoker who is 64 inches tall (163cms) would need to gain 93 pounds (42kg) before experiencing the elevated risk of chronic heart disease generated by smoking.<sup>83</sup>

As Joel teaches, recovery's battle line is extremely easy to see. As a nicotine addict, "you can't administer any nicotine. There is no gray area here. Eating is more complicated. You will have to eat for the rest of your life."<sup>84</sup>

For many, initial weight gain associated with nicotine cessation can be frightening. It isn't unusual to see up to 5 pounds of water retention weight gain during the first week.<sup>85</sup> It's normally associated with physiological changes and the pounds are easily and quickly shed.<sup>86</sup>

Nicotine increases release of anti-diuretic hormone (ADH or vasopressin). ADH prevents us from dehydrating by increasing water retention.

According to Joel, during withdrawal some people experience a rebound type effect, where the normal effect of the drug is actually exacerbated when the drug is stopped.

"That temporary increase is likely what is causing the water retention (bloating) effect that many people notice when they first stop smoking, writes Joel. "The effect can go a few days and at times, even into the second week."

Still, most experience weight gain lasting beyond the second week. But why?

It's normal to notice food starting to taste better as early as day three. And normal to reach for food as a substitute hand to mouth psychological replacement crutch. And normal to attempt to replace missing nicotine generated dopamine "aaah" sensations with "aaah"s from extra food. And

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83 Diverse Populations Collaboration, Smoking, body weight, and CHD mortality in diverse populations, Preventive Medicine June 2004, Volume 38(6), Pages 834-840.

84 Spitzer, J, Patience in weight control issues, <http://www.ffn.yuku.com/topic/11636> April 24, 2003.

85 Weight Control Information Network, NIDDK, National Institute of Health, August 2006.

86 National Institutes of Health, You Can Control Your Weight as You Quit Smoking, NIDDK, Federal Citizen Information Center of the U.S. General Services Administration, web page visited August 26, 2008 - [http://www.pueblo.gsa.gov/cic\\_text/health/w8quit-smoke/#1](http://www.pueblo.gsa.gov/cic_text/health/w8quit-smoke/#1)

normal to need time to discover how to void the onset of hunger by fueling your body early and often, now that nicotine is no longer providing instant energy via your body's fight or flight response.

It is also entirely normal to experience a minor metabolism change associated with our body no longer needing to expend energy in attempting to expel scores of tobacco toxins, and no longer feeling nicotine's stimulant effects in making our body's organs work harder (primarily our heart).

Metabolism is all the chemical processes that occur within a living cell that are necessary to keep it alive. Some substances are broken down to create food energy while other substances necessary for life are synthesized or created.<sup>87</sup>

These processes themselves consume energy. "Basal Metabolic Rate" or BMR is the rate at which the body expends energy while at complete rest. It is expressed as "the calories released per kilogram of body weight [1 kilogram equals 1,000 grams or 2.2 pounds] or per square meter of body surface per hour."<sup>88</sup>

Were we ever really at complete rest while addicted to a stimulant? Does addiction's impact upon BMR account for nicotine cessation weight gain? Most studies examine short-term weight gain with little or no attempt to determine if the gain is due to diminished BMR, extra food or less exercise.

One long-term study followed weight change and body mass index (BMI) for 36 months. It found that the "contribution of smoking cessation to the BMI increase was practically negligible with "no considerable long-term weight gain."<sup>89</sup>

Most shorter studies report weight change results similar to those shared by the U.S. Surgeon General in his 1990 report on "The Health Benefits of Smoking Cessation."<sup>90</sup>

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87 metabolism. (n.d.). The American Heritage Dictionary of the English Language, Fourth Edition. Retrieved from Dictionary.com on August 6, 2008.

88 basal metabolic rate. (n.d.). The American Heritage Dictionary of the English Language, Fourth Edition. Retrieved from Dictionary.com on August 6, 2008.

89 John U, et al, No considerable long-term weight gain after smoking cessation: evidence from a prospective study, European Journal of Cancer Prevention, June 2005, Volume 14(3), Pages 289-295.

90 U.S. Surgeon General, The Health Benefits of Smoking Cessation, a report of the Surgeon General, 1990.

That report examined 15 studies involving 20,000 people and although "four-fifths of smokers gained weight during recovery, the average weight gain was only 5 pounds (2.3 kg)." "The average weight gain among subjects who continued to smoke was 1 pound.

Thus, smoking cessation produced a four pound greater weight gain than that associated with continued smoking." The Surgeon General also found that less than 4% gained more than 20 pounds.

A 1991 study found slightly greater weight increases than reported by the Surgeon General (2.8 kg or 6.2 lbs in men and 3.8 kg or 8.3 lbs in women). But it also found that while smokers weighed less than never-smokers before commencing recovery, "they weighed nearly the same" at one-year follow-up.<sup>91</sup>

Also noteworthy is a 2009 study which found average cessation weight gain of 3 kg for women and 5 kg for men. What's really interesting is its long-term finding of "no significant differences in weight gain over the 11-year period existed between never smokers and former smokers who had stopped at least five years ago."<sup>92</sup>

Theories as to potential causes are many<sup>93</sup> including genetics,<sup>94</sup> hand to mouth oral gratification replacement, improved senses of smell and taste (most notably sweets and salts), diminished exercise (isolation), changes in diet, and binge eating.

It isn't easy pinpointing the cause for consuming or burning even one extra calorie, especially when our metabolism slows as we age.

Also keep in mind that study weight findings reflect averages. As seen above, up to 4% clearly go hog wild with food during recovery. Also not

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91 Williamson DF, et al, Smoking cessation and severity of weight gain in a national cohort, New England Journal of Medicine, March 14, 1991, Volume 324(11), Pages 739-745.

92 Reas DL, et al, Do quitters have anything to lose? Changes in body mass index for daily, never, and former smokers over an 11-year period (1990--2001), Scandinavian Journal of Public Health, September 2009, Volume 37(7), Pages 774-7777. Epub 2009 Aug 7.

93 Wack JT, et al, Smoking and its effects on body weight and the systems of caloric regulation, The American Journal of Clinical Nutrition, February 1982, Volume 35(2), Pages 366-380.

94 Pietilainen KH, et al, Physical inactivity and obesity: a vicious circle, Obesity (Silver Spring), February 2008, Volume 16(2), Pages 409-414; also see, Waller K, et al, Associations between long-term physical activity, waist circumference and weight gain: a 30-year longitudinal twin study, International Journal of Obesity, February 2008, Volume 32(2), Pages 353-361.

reflected by averages is the fact that body weight remains unchanged for many, while actually declining for some.

While natural for the rationalizing "junkie mind" in its quest for relapse justifications to want to blame cessation weight gain entirely on metabolic changes or genetics, factors totally beyond our ability to control (not increased eating or lack of activity), the math simply doesn't add up.

As a general rule, it takes 3,500 extra calories to add one pound of body weight, and burning 3,500 to shed one pound. A study of 6,569 middle-aged men who stopped smoking found that at one year they had consumed an average of 103 fewer calories per day, which the study attributed to metabolic change.<sup>95</sup>



*Photo by National Cancer Institute*

Let's use that finding as our metabolic baseline. Let's assume that the average nicotine addict burns an extra 103 calories a day due to an increase in metabolism. If there is zero change in diet or activity after ending nicotine use, it would take 34 days without nicotine before a decrease in metabolism could be blamed for one pound of weight gain ( $34 \times 103 = 3,502$ ).

While true that minor metabolism changes mean fewer calories burned each day, if a former smoker, that change can be easily offset by taking advantage of the enhanced blood flow, greater oxygen levels and improved lung function you'll experience.

According to the Surgeon General, about half of smokers believe that smoking nicotine aids in controlling weight. The obvious question becomes, do "weight-concerned smokers endorse exaggerated beliefs in the ability of smoking to suppress body weight?"

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<sup>95</sup> Hall KD, [What is the required energy deficit per unit weight loss?](#) International Journal of Obesity, March 2008, Volume 32(3), Pages 573-576.

Research suggests they do.<sup>96</sup> It also suggests that education may help correct exaggerated weight control beliefs, making recovery more inviting.

**How to gain lots of extra weight** - Recovery heralds an end to both nicotine's arrival and to the "aaah" wanting relief sensations replenishment generated. Some find themselves camping out inside the refrigerator or potato chip bags where they "aaah" themselves sick with food.

Others intentionally invite weight gain in order to justify relapse. It's a costly ploy. Having outgrown their entire wardrobe and now wearing bed sheets, visible extra pounds is a relapse excuse that's easy to see and sell to ourselves and loved ones.

Why do up the 4 percent who go hog wild continue such destructive behavior to the point of outgrowing their entire wardrobe? Few had any understanding of the dopamine pathway relationship between food and nicotine.



*Photo by National Cancer Institute*

While normal healthy eating stimulates dopamine, during the first few days of recovery stimulation from normal eating obviously won't be sufficient to satisfy all wanting being felt.

Most of us used nicotine to satisfy subtle urges and wanting every waking hour of every single day. Over-eating cannot replace the stimulation effects of missing nicotine, at least not without leaving us as big as a house.

Still, some try. Instead of allowing the brain time to restore natural dopamine pathway receptor counts and sensitivities,<sup>97</sup> it's as if the up to 4

<sup>96</sup> White MA, et al, Smoke and mirrors: magnified beliefs that cigarette smoking suppresses weight, Addictive Behaviors, October 2007, Volume 32(10), Pages 2200-2210.

<sup>97</sup> Picciotto MR, et al, It is not "either/or": activation and desensitization of nicotinic acetylcholine receptors both

percent gaining more than 20 pounds attempt to make their brain's dependency wiring operate on taste's "aaah" influence instead of nicotine's.<sup>98</sup>

A 2012 study used brain-imaging studies to contrast eating food to smoking. It found that "food and smoking cues activate comparable brain networks" and "there is significant overlap in brain regions responding to conditioned cues."<sup>99</sup>

While compromised dopamine pathways have assigned the same use priority to nicotine as they have to eating food, there's one massive distinction. The brain does not die without nicotine, it thrives!

The sad part about attempting "aaah" relief replacement using large quantities of additional food is that, once the addict adopts and acts upon their demoralizing weight increase as their justification for relapse, the extra pounds are likely to remain.

That 20+ pound bag of rocks they are carrying makes daily exercise more difficult, and thus less likely.

Now, instead of the former smoker's bloodstream being filled with oxygen reserves sufficient to allow prolonged vigorous physical activity, the significantly heavier relapsed smoker feels the effects of an oxygen-starved bloodstream that is once again occupied by large quantities of toxic carbon monoxide.

Instead of extra pounds being counterbalanced by greater self-esteem and self-worth at having broken free, the relapsed addict is heavier, less healthy and likely more depressed.

Worst of all, the smoker is again engaged in slow suicide via the gradual self-destruction of their body's ability to receive and transport oxygen.

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contribute to behaviors related to nicotine addiction and mood, Progress in Neurobiology, April 2008, Volume 84(4), Pages 329-342.

98 de Araujo IE, et al, Food reward in the absence of taste receptor signaling, Neuron, March 27, 2008, Volume 57(6), Pages 930-941.

99 Tang DW, et al, Food and drug cues activate similar brain regions: A meta-analysis of functional MRI studies, Physiology and Behavior, June 6, 2012, Volume 106(3), Pages 317-324.

**Binge eating** - Binge eating reflects a loss of control, that is, being unable to stop eating or control what or how much is consumed.<sup>100</sup> The primary psychological binge-eating cue is waiting too long before eating and sensing the onset of hunger.<sup>101</sup>

Although it may feel like the only way to satisfy a hunger craving is to eat as much food as quickly as possible, repeatedly doing so could result in binge eating becoming hunger's conditioned response.

As mentioned, there is substantial overlap between eating and dependency pathways. Former smokers who relapse to smoking often report an increase in the amount smoked, over the amount smoked prior to their attempt. Akin to binge eating, it's as if their brain goes into starvation mode upon relapse and begins hoarding nicotine, resulting in a higher level of tolerance and need.

Binge eating is an attempt to satisfy hunger with a shovel. As nicotine addicts, we didn't need to eat regularly, as we used nicotine as a spoon. It pumped stored fats and sugars into our bloodstream via our body's fight or flight response. It allowed us to eat one or two larger meals each day and then use nicotine to release stored calories.

So, what happens when nicotine is no longer there? Can the addition of hunger cravings atop early nicotine withdrawal result in binge eating? Research suggests that it may be more of a concern for those having a high BMI.<sup>102</sup>

The root problem was that the active nicotine addict became conditioned to instantly satisfy the onset of hunger by using nicotine to release stored energy. Non-users who get hungry can't do that.

They have to eat food and then wait for digestion to turn off the body's hunger switch. Once we become non-users, when hunger strikes, whether we eat with a toothpick or shovel, we will need to wait for digestion to satisfy hunger.

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100 Colles SL, et al, Loss of control is central to psychological disturbance associated with binge eating disorder, Obesity, March 2008, Volume 16(3), Pages 608-614.

101 Vanderlinden J, Which factors do provoke binge-eating? An exploratory study in female students, Eating Behaviors, Spring 2001, Volume 2(1), Pages 79-83.

102 Saules KK, et al, Effects of disordered eating and obesity on weight, craving, and food intake during ad libitum smoking and abstinence, Eating Behaviors, November 2004, Volume 5(4), Pages 353-63.



It is critical that we quickly re-learn how to properly fuel our body. Yes, it takes a bit of practice to now that instant feedings from liver to bloodstream are history. And we should fully expect to confront hunger if we insist upon skipping meals.

While eating, it's beneficial to learn to chew our food longer and more slowly. Doing so allows a mouth enzyme (salivary amylase) to begin breaking down carbohydrates. This will speed digestion and aid in satisfying hunger sooner.

Research suggests that we eat slower when we turn off and tune out distractions. Maintain your focus on the act of eating and chewing and you'll actually eat less.

But what if you forget to eat and hunger arrives? If you should find yourself reaching for extra food, reach for healthy, low calorie foods such as fresh vegetables and fruits. It's best to have them washed, pre-cut and in the refrigerator in a bowl of cold water, available and ready to eat within seconds of feeling hungry.

**Fear's unburned calories** - Imagine being so consumed by fear of failure that you withdraw from life. How many calories are burned while hiding in a closet, lying in bed watching television or setting at a computer and clicking a mouse?



*Photo by National Cancer Institute*

Yes, some of us take the term "quitting" literally and withdraw from life entirely.

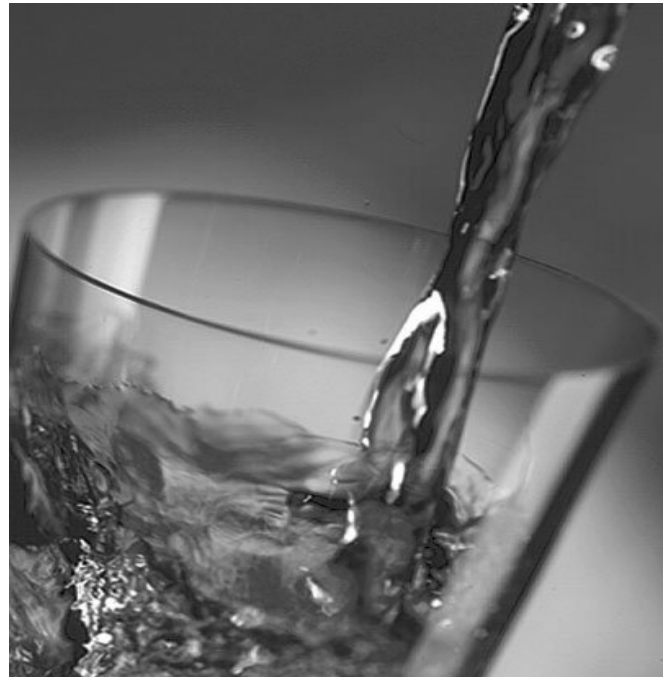
Body weight will climb if the amount of daily energy expended substantially declines, while the number of calories consumed remains the same or increases. Also consider that 12 of 15 studies since 2006 have found that exercise reduces smoking cessation cravings.<sup>103</sup>

Demoralizing weight gain is fertile ground for destroying freedom's dreams. The only activity we need end during recovery is nicotine use. Don't allow fear to transform recovery into a prison.

**Reaching for a zero calorie "aaah"** - The cornerstone of our dependency was nicotine's ability to release dopamine and briefly end wanting. And yes, an extra mouthful of food also provides a short-lived burst of dopamine. But reflect on how many times and how long each day that you devoted to nicotine use.

What if, day after day, you started reaching for and eating extra food, as often and long as you reached for and used nicotine? Yes, reaching for and adopting extra food as a nicotine replacement crutch could turn into a "huge" mistake.

Some researchers classify increased eating as a symptom of nicotine withdrawal.<sup>104</sup> If true, it's clearly one within our ability to minimize.



Consider reaching for a non-fat "aaah" sensation. Take a slow deep breath. Do you feel the "aaah" while exhaling? Drink a glass of cool and refreshing water when thirsty. Do you feel the "aaah" that arrives when satisfying thirst?

Give your favorite person a big, big hug. Are you feeling it now? Take your

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103 Roberts V, et al, The acute effects of exercise on cigarette cravings, withdrawal symptoms, affect, and smoking behaviour: systematic review update and meta-analysis, Psychopharmacology (Berlin), July 2012, Volume 222(1), Pages 1-15. Epub 2012 May 15.

104 Benowitz NL, Neurobiology of nicotine addiction: implications for smoking cessation treatment, The American Journal of Medicine, April 2008, Volume 121(4 Suppl 1), Pages S3-10.

normal walk, even if just around the yard but this time go a little further or a little quicker than normal. Do you feel accomplishment's "aaah"?

Dopamine "aaah" wanting relief sensations are the mind's way of motivating behavior. Lifetimes of living our priorities teacher's lessons, we each have a hefty collection of durable "aaah" wanting relief memories.

Reach for the healthy zero calorie "aaah" if seeking relief from wanting without weight gain.

**Picking mealtime** - Nicotine no longer our spoon, increasing the frequency of meals while decreasing the amount eaten may be all that's needed to avoid adding hunger atop withdrawal.

Instead of eating large meals, consider eating little and often as a means to enhance appetite control. One study found that eating more frequently resulted in 27% fewer calories being consumed.<sup>105</sup>



*Photo by National Cancer Institute*

Consider fueling your body with small, healthy food portions at least five times daily during the first two weeks. Doing so should diminish blood-sugar swings and hunger pains, thus reducing risk of binge eating.

**Ending Mealtime** - Many of us conditioned our mind to believe that eating was complete and mealtime was over by putting a cigarette between our lips or oral tobacco into our mouth. Now, without a new cue, there may be no clear signal to our brain that our meal is complete. It could result in reaching for additional food with zero leftovers.

Healthy meal completion cues may be as simple as pushing away or getting up from the table, standing and stretching, clearing the table, reaching for a toothpick, taking a slow deep breath, doing the dishes, giving a hug or kiss, stepping outside, brushing our teeth, a stick of sugarless gum or a

<sup>105</sup> Speechly DP, et al, Greater appetite control associated with an increased frequency of eating in lean males, *Appetite*, December 1999, Volume 33(3), Pages 285-297.

walk.

**Diminishing body weight** - A "diet" is a temporary program for losing weight, which by definition ends. The key to sustained weight control isn't dieting. It's in committing to minor changes in our daily calorie intake or activity level that become part of the fabric of our life.

If the removal of one pound of body weight requires the expenditure of 3,500 calories, attempting to burn all 3,500 during a single session of activity or exercise may leave us tired and sore. It might discourage us from being active again tomorrow.

Instead, consider a small yet deliberate increase in today's level of physical activity over yesterday's, or if today's level seemed sufficient, maintaining that level tomorrow.



*Photo by National Cancer Institute*

It can be exercise or a bit more of any physical activity that we love and enjoy. Consider gardening, walking your favorite path, visiting or caring for a neighbor, extra house or yard work, a lap around the block, a bike ride or any other activity that expends energy.

Although a minor daily activity adjustment may seem insignificant, burning just 58 extra calories per day will cause our body weight to decline by half a pound per month (1,740 fewer monthly calories). What if we add a minor change in eating patterns to a minor activity adjustment?

If we consume 58 fewer calories per day we would experience a total monthly decline of roughly 3,500 calories and the loss of one pound per month. Learning to sustain these minor lifestyle adjustments could mean 12 fewer pounds within a year!

How do we lose 12 pounds? Baby steps ... another moment of activity, a few less calories, just one ounce at a time!

Small adjustments can be made anytime. As mentioned, we can eat more often while consuming the same or less, focus upon, savor and chew each

bite longer, take just one less bite, get comfortable leaving something on our plate, use a tad less butter, choose baked over fried, portion control or cooking less food, one cookie versus two, eliminating evening snacks, or trading empty carbohydrates for longer lasting ones.<sup>106</sup>

Get excited about climbing from the deep ditch in which our addiction forced us to live. Savor the richness and flavor of life beyond. Be brave and explore the world that obedience to our dependency's wanting kept hidden from view.

If already impaired or disabled by smoking, your physician should be able to assist in developing an increased activity or exercise plan appropriate to your abilities, even if done while on oxygen, in a wheelchair or in bed.



*Photo by National Cancer Institute*

Should you find yourself gaining extra pounds during recovery, don't beat yourself up. Your breathing and circulation will improve with each passing day. Whether realized or not, your endurance potential is slowly on the rise.

In a way, we are turning back the clock to a time when we had greater ability to engage in prolonged vigorous physical activity. As smokers, most of us lacked the ability to build cardiovascular endurance. Not any more!

Aging gracefully does not require "dieting." Our slowing metabolism simply requires a minor calorie or activity adjustment now and then, which over time results in the desired body weight.

But what if your dopamine pathways refuse such simplicity when it comes to food? Frankly, I'd rather be slightly bigger and alive, than a tad smaller but dead. Today and tomorrow are worth vastly more than a few extra pounds.

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<sup>106</sup> [The Glycemic Index](http://TheGlycemicIndex.com), [glycemicindex.com](http://glycemicindex.com), University of Sidney, 2002, website accessed August 9, 2008.

## Menstrual Cycle Considerations

A complex interaction of hormones cause many women of childbearing years to experience physical, psychological, and emotional symptoms related to their menstrual cycle.

An estimated 80% experience premenstrual symptoms, which may include: irritability, tension, anxiety, depression, restlessness, headaches, fatigue and cramping. The severity of symptoms can range from mild to disabling.

So how does a woman experiencing significant menstrual symptoms successfully navigate nicotine dependency recovery?

The menstrual cycle can be broken down into two primary segments, the follicular and luteal phases. The follicular or pre-ovulation phase is when significant hormonal changes occur. It announces the first day of a woman's cycle, includes the period of menstrual bleeding and normally lasts in the neighborhood of two weeks.

The luteal phase commences at ovulation, normally lasts two weeks and ends the day before her next period.

A 2008 study tried to determine if the menstrual phase during which a woman attempts to stop smoking affects the risk of smoking relapse.<sup>107</sup>

A total of 202 women were assigned to either commence recovery during the luteal phase or the follicular phase. After 30 days, 34% of women who started during the luteal phase were still not smoking, versus only 14% who started during the follicular phase.

While normal to focus on the 34%, what I find encouraging is the 14%. As they demonstrate, success is achievable even if commencing recovery during the follicular phase, during significant premenstrual symptoms.

Hormone related stress and tension might actually accelerate nicotine elimination by turning urine more acidic, thus causing the kidneys to draw the alkaloid nicotine from the bloodstream quicker (see [Chapter 4](#) "Use

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107 Allen SS et al, Menstrual phase effects on smoking relapse, *Addiction*, May 2008, Volume 103(5), Pages 809-821.

relieves stress and anxiety").

The question now being asked is, is addiction to smoking nicotine a cause of premenstrual syndrome (PMS)? A ten year study published in 2008 followed 1,057 women who developed PMS and 1,968 reporting no diagnosis of PMS, with only minimal menstrual symptoms.<sup>108</sup>

After adjustment for oral contraceptives and other factors, the authors found that "current smokers were 2.1 times as likely as never-smokers to develop PMS over the next 2-4 years." The study concludes, "Smoking, especially in adolescence and young adulthood, may increase risk of moderate to severe PMS."

When is it best to face challenge? Early on or delay it? As Joel often states, commencing recovery during a period of significant anxiety increases the odds that anxiety will never again serve as an excuse for relapse.

Can hormonal related symptoms be so profound that it is best to navigate the most challenging portion of recovery -- the first 72 hours -- during the luteal phase? If concerned, discuss it with your physician.

Keep in mind that the smoking woman's unconscious mind has likely been conditioned to reach for a cigarette during specific menstrual cycle hormonal or symptom related events. The more nicotine use cues encountered and extinguished during the luteal phase, the fewer that will remain to trigger crave episodes during the follicular phase.

The beauty of recovery is that next month's cycle will not be affected by the heightened stresses associated with rapidly declining reserves of the alkaloid nicotine. Also, next month's cycle may very well stand on its own, unaffected by either early withdrawal or cue related crave triggers.

Joel encourages doubters to stroll through the hundreds of thousands of indexed and archived member posts at [Freedom](#), the free message board support group, where each day he supports members in navigating recovery.<sup>109</sup>

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108 Bertone-Johnson ER, et al, [Cigarette Smoking and the Development of Premenstrual Syndrome](#), American Journal of Epidemiology, August 13, 2008.

109 Freedom from Nicotine - <http://www.fff.n.yuku.com>

"Go back one month and see how many of the woman at our site seem to have panicking posts complaining of intense smoking thoughts month after month after month on any kind of regular pattern."

"The fact is, there are no such posts on the board because after the first few months, not smoking becomes a habit even during times of menstruation."<sup>110</sup>

Joel closes by reminding women concerned about menstrual symptoms, that to keep their recovery on course and getting easier and easier over time, it's still simply a matter of staying totally committed, even during tough times, to their original commitment to Never Take Another Puff!

## Pregnancy

The awe and excitement of a new life growing inside, the fear and horror that your chemical dependency may harm or destroy it, news of pregnancy can be an emotional kaleidoscope.

Upon confirmation, often within minutes, the mother-to-be makes the biggest mistake of her entire pregnancy. She decides to "stop for the baby." How could something that sounds so right, be so wrong?



*Photo by National Cancer Institute*

Only about half of women claim to be successful in ending nicotine use after learning they are pregnant.<sup>111</sup> Sadly, the real figure is probably closer to one-third.

Researchers conducting third trimester blood tests on women claiming to have stopped smoking report that 25% are untruthful.<sup>112</sup> Why do so few succeed?

<sup>110</sup> Spitzer, J, PMS and Quitting September 14, 2004, <http://www.ffn.yuku.com/topic/12132>

<sup>111</sup> Tong VT, Smoking patterns and use of cessation interventions during pregnancy, American Journal of Preventive Medicine, October 2008, Volume 35(4), Pages 327-333; also see, Pauly JR, et al, Maternal tobacco smoking, nicotine replacement and neurobehavioural development, Acta Paediatrica, June 12, 2008.

<sup>112</sup> George L, et al, Self-reported nicotine exposure and plasma levels of cotinine in early and late pregnancy, Acta Obstetrica Gynecologica Scandinavica, 2006, Volume 85(11), Pages 1331-1337.



Stopping for others, including the unborn, is a formula and recipe for relapse.<sup>113</sup> It can mean an entire pregnancy spent either feeling deprived of nicotine or gradually growing numb to the fears of harm that use would inflict, and eventually surrendering.

What logic is there in making this "the baby's" recovery instead of its mother's? Stop for the baby? Is it the baby who needs help or its mom-to-be?

No longer in harm's way, the precious seconds during and after childbirth are often soured by fixation upon relapse. Instead of savoring life's richest moment, she's plotting the act she knows may bring an early end to both motherhood and life. Each contraction is followed by thoughts that she has sacrificed long enough, that danger of harming the baby is about to pass.

Stopping "for the baby" makes pregnancy cessation vastly harder than need be. Doing it "for the baby" may as well be an open declaration that this baby will have an actively feeding drug addict for a mom. Here are a few quotes from e-mails I've received:

- "I am 33 years old. I started smoking at age 13 and of course never thought I would still be a smoker 20 years later, and a pack to a pack and a half each day. I stopped for nine months while I was pregnant and could not wait the entire pregnancy for just one cigarette. The minute I was home from the hospital I started again."
- "I stopped smoking each time I found out I was pregnant, but right after they were born I was back to a pack a day."
- "I'm 38 years old with three children and have smoked since I was 17, stopping when pregnant only to re-light within hours of giving birth."
- "I started smoking at 13 (well I couldn't draw back like all the other girls) but by the time I was 14, I was smoking at every opportunity. The only time I stopped smoking is whilst I was pregnant and breastfeeding. Then, as soon as my babies weaned, I started again!"
- "When I was pregnant with my first child I gave up smoking as soon as I found out, the same for the second pregnancy. My mistake is I started back up. I'm stopping smoking today even though I'm about

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113 Spitzer, J, Quitting for Others, WhyQuit.com, Joel's Library, 1984.

to wean my daughter."

- "My daughter is 5 months pregnant and still smokes occasionally. Actually I don't know how much she smokes. For someone who is trying to be so protective of her unborn child she isn't. She is an intelligent person but putting her baby at risk."
- "I am concerned about my neighbor's smoking. She is pregnant again but still smokes. She was smoking while pregnant with her 1st son who is 4 years-old now and deaf."

Approximately half of women who stop smoking during pregnancy relapse within six months of giving birth.<sup>114</sup> Adding it all up, it means that, unbelievably, only about 1 in 5 women who smoked at conception will experience the joys of smoke-free motherhood.

The reasons given in trying to justify relapse following childbirth vary greatly:

- "I am an attractive, 39 year old professional yuppie turned new mom who has been hiding it and in the closet for many years. I stopped successfully when I found out I was 2 weeks pregnant and then started during a brief bout of postpartum depression when my baby was 6 weeks old and I had stopped nursing. I was back to smoking a half a pack to a pack a day."
- "I am addicted to nicotine gum. I stopped smoking and started chewing the gum. Then I got pregnant with my daughter and stopped chewing the gum. My mother died right after my daughter was born, so I started smoking again. Three months later, I stopped using cigarettes and started with the gum again. I finally ended gum use in January of 2003. I was totally nicotine-free for about 18 months when my sister-in-law gave me a cigarette. I figured I could handle just one" "I bought a pack the next day. Now, I'm stuck on the gum again...no pun intended."

Driven by significant and very real risks, these women were able to temporarily suspend nicotine use. Then, postpartum depression and a mother's death were used as reasons for relapse. Although not mentioned, it's highly unlikely that relapse and active drug addiction improved either

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114 Colman GJ, et al, [Trends in smoking before, during, and after pregnancy in ten states](#), American Journal of Preventive Medicine, January 2003, Volume 24(1), Pages 29-35; Kaneko A, et al, [Smoking trends before, during, and after pregnancy among women and their spouses](#), Pediatrics International, June 2008, Volume 50(3), Pages 367-375.

situation.

Pregnancy is a golden opportunity. It's a period during which a mind, body and life can be clean, healed and reclaimed in order to prepare for the blessings of nicotine-free motherhood.

Instead, roughly 4 of 5 pregnant smokers spend their pregnancy somewhere between the grips of penetrating guilt over the harms use continues to inflict, and a growing sense of self-deprivation, which they'll satisfy shortly after giving birth.



*National Cancer Institute*

Let's be clear, it's normal and natural to want to stop for the baby. The risks of harm are tremendous. It isn't a matter of whether or not nicotine will damage the fetus but how bad and noticeable the damage will be.

The risks are so huge that the fears flowing from them consume reason, logic and common sense.

Before learning they were pregnant, most women had their own dream of someday stopping smoking, at a time, place and manner chosen by them. But now gripped by worry of harm to the developing life inside, it's a dream quickly forgotten.

Instead of seeing here and now as the perfect time to live that dream, it's abandoned it in favor of self-sacrifice for the innocent preciousness inside.

Their dream forgotten, some are able to temporarily suspend use for the benefit of the fetus while others do not. Those that don't are forced to invent new nicotine use rationalizations in order to suppress the harms being inflicted. Here are more quotes from e-mails.

- "My daughter just found out that she is pregnant and she smokes. She was going to just stop but then a midwife told her that if she did, her fetus would go into shock and that she should just taper off."

- "I did attempt to stop when I found out I was pregnant the first time, but after thinking about all the people I knew who smoked while pregnant and had normal kids, I kept right on smoking." "I kept my mouth shut, as I had lied to the doctor and the hospital about smoking."

There's also the rationalization that "stopping for the baby is just too hard." She's absolutely correct. The challenge truly is far greater when attempting cessation for others.

Think about the day to day agony and anxiety endured by these women. Imagine the disapproving stares and verbal abuse by those who notice them smoking. Society's disdain only increases her focus upon "stopping for the baby."

- "I am 8 weeks pregnant and have been struggling with stopping for some time. Even before my pregnancy I was trying to stop. The scariest part for me is the anxiety it creates. Is it dangerous to go through withdrawal cold turkey?"
- "I am 26 years old. I'm 9 weeks pregnant. I've smoked a pack a day for 11 years. I've tried to stop 3 times now in 4 weeks and blown it every time. I am down to about 3-5 cigarettes a day. I am worried about my baby and I have smoked through the whole thing. I am trying to stop again. It has been about 12 hours without a smoke."
- "I am a 22 year-old female who is currently 32 weeks along in my pregnancy. I feel that the reason why I haven't stopped is just that! I am deathly afraid of the feeling of withdrawal."

We can only live in fear for so long before growing numb to it. If this isn't "your" recovery but instead a temporary pause for the baby, how long before that deprived feeling overwhelms diminishing fears? And how much anxiety and guilt would relapse bring?

If the expectant mother has gone two weeks without nicotine, her brain has already substantially completed restoring neurotransmitter sensitivities and counts. Although she will continue to feel the tease of thousands of old nicotine replenishment memories, they belonged to an actively feeding drug addict whose blood-serum nicotine reserves were always on the decline. After two weeks it's nearly all psychological, as there is nothing

missing and nothing in need of replacement.

For her, relapse will not match expectations. There will not be an underlying "aaah" wanting relief sensation as nothing was missing. But lapse will immediately re-fire dependency's engines, as nicotine drenched receptors cause her dopamine pathways to re-assign using again, the same priority as eating food.

And the circumstances of lapse will be documented in high definition memory, breathing life into thousands of old use memories that will, in the short term, make lapse nearly impossible to forget.

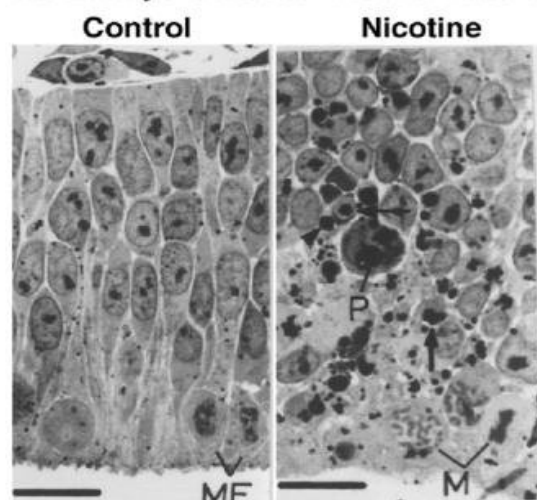
Her "aaah" missing following lapse, her focus will instead turn to the sensations felt when scores of cigarette toxins strike healing tissues, and carbon monoxide invades an oxygen rich mind.

The toxic assault will likely compel her dizzy and disrupted mind to turn its focus to her now failed objective, "stopping for the baby." She'll wonder whether the burning sensations generated by carbon monoxide, hydrogen cyanide, arsenic, sulfur, ammonia, and formaldehyde are also burning her unborn baby.

But it's too late. Once nicotine is inside, relapse is all but assured, with more assaults and guilt to follow.

- "Unfortunately, I have given in and I had my first cigarette in 10 months yesterday. I had another today and now I'm feeling absolutely horrible about it. I am breastfeeding and I would like to continue breastfeeding without harming my child."
- "I am 41 years-old and smoked a pack a day since I was 15 years old, with the exception of 9 months when I pregnant (started right up again the day after she was

**A. Rat Embryo Cultures - Neural Tube Stage**



born). I hated myself for failing. I hated the way I smelled. I hated "sneaking" a smoke to get through the day. I hated the disgusted looks of people walking by me as I huddled outside my office building sucking on that disgusting thing, rain or shine, cold or hot. I hated myself for hurting my daughter - thinking for sure, unless I could find the strength and courage to stop that my daughter would lose her mother."

As mentioned, it isn't a matter of whether or not nicotine will damage the fetus but how noticeable the damage will be. Not convinced? Let me share some of the work and findings of those who have devoted their lives to the study of nicotine toxicology and pharmacology.

But before doing so, realize that the primary reason these harms occur is because the woman convinced herself that she had to "give-up" her drug for the "sake of the baby."

Instead, reflect upon the truth that the only way the baby's time with its mother will not be constantly interrupted by the need to replenish missing nicotine is if she embraces recovery for the "sake of the mother." Allow your own dreams and desires to transport you home to the freedom, calmness and beauty that's "you!"

Dr. Heinz Ginzel is a medical doctor and retired University of Arkansas pharmacology and toxicology professor who has devoted decades to the study of nicotine. Dr. Ginzel's medical journal articles use language that tends to speak over-the-heads of most expectant women.

They share concerns over "fetotoxicity and neuroteratogenicity that can cause cognitive, affective and behavioral disorders in children born to mothers exposed to nicotine during pregnancy."<sup>115</sup> But he has also written taking direct aim at pregnant women. Listen carefully to his message:

"To set the stage, one has to recognize that nicotine interacts with the very basic functions of the peripheral and central nervous system, i.e., the nerves supplying organs and tissues of the body and the vital command stations in the brain. When these systems are formed during fetal life, the nicotine the mother is exposed to from smoking,

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115 Ginzel KH, et al, Critical review: nicotine for the fetus, the infant and the adolescent? Journal of Health Psychology, March 2007, Volume 12(2), Pages 215-224.

secondhand smoke or NRT will impair their normal development."

"Such impairment can manifest itself in a variety of symptoms depending on the site, time and intensity of nicotine action. Here are a few examples: The notorious "Sudden Infant Death Syndrome" or SIDS has been traced to prenatal and/or postnatal nicotine exposure. Nicotine exposure is responsible for cognitive and learning deficits in children as well as affective and behavioral problems such as 'Attention Deficit Hyperactivity Disorder' (ADHD), with displays of unruliness and aggression."

"Neonatal nicotine exposure impairs so-called auditory learning, a very specific lifelong handicap. Prenatal nicotine also primes the developing brain for depression and for nicotine addiction in adolescence. Wrongly believing or being told that NRT is risk-free, pregnant smokers who would have stopped during pregnancy may begin using NRT throughout pregnancy."



"As a consequence, intelligence expressed by I.Q. standards may decline in their offspring, but as larger segments of the population are affected, this decline may not be readily discernible."<sup>116</sup>

Warnings such as Dr. Ginzel's make the expectant woman's failure to place her own drug addiction recovery above "stopping for the baby" almost understandable.

Duke Medical University Professor Theodore Slotkin is probably the world's leading nicotine toxicology researcher. He is deeply concerned that nicotine, including replacement nicotine, may cause as much or more harm to the developing fetus than crack cocaine.<sup>117</sup>

<sup>116</sup> Ginzel, KH, [Why do you smoke?](#) WhyQuit.com, February 6, 2007.

<sup>117</sup> Slotkin TA, [Fetal nicotine or cocaine exposure: which one is worse?](#) The Journal of Pharmacology and Experimental

According to Professor Slotkin, "NRT, especially by transdermal patch, delivers more nicotine to the fetus than smoking does." "Studies have found that the brains of fetal mice wound up with 2.5 times higher nicotine concentrations than found in the mother's blood when on a slow continuous nicotine feed, as would be the case with the nicotine patch."<sup>118</sup>

The patch's continuous delivery of nicotine is believed to somehow overwhelm and saturate the ability of the placenta to perform limited nicotine filtering.

In 2008 Professor Slotkin wrote that, "nicotine by itself is able to reproduce the net outcome from tobacco smoke exposure; that is not to say that the other components are not injurious, but rather, the replacement of tobacco with NRT is likely to produce less improvement than might otherwise be thought, and as shown above, may actually worsen some of the critical outcomes."<sup>119</sup>

Ponder the collective regret of the millions of mothers whose intense focus on protecting the baby actually resulted in harming them.

- "I learned first hand the results of smoking during pregnancy. I had taken lightly my responsibility to him and I will always regret it."
- "My son was born at a comparatively low birth rate, and notably, his umbilical cord, instead of a healthy red color, was a sickly, puss-like shade of yellow. It was not thick and healthy, but tapered and became thinner toward where it was attached to him."
- "So, now my second son is two and a half with developmental delays, and my four year old has Attention Hyperactivity Disorder, with extreme emphasis on the hyperactivity part. I know in my heart that I probably caused these problems but I keep finding other excuses."
- "I smoked very little during my first pregnancy. My child has allergies and catches bronchitis very easily. With my



Therapeutics, June 1998, Volume 285(3), Pages 931-945.

118 Slotkin, TA, e-mail from Professor Slotkin to John R. Polito, January 8, 2006.

119 Slotkin, TA, Slotkin, [If nicotine iGinzel KH, et al, Critical review: nicotine for the fetus, the infant and the adolescent? Journal of Health Psychology, March 2007, Volume 12\(2\), Pages 215-224.s a developmental neurotoxicant in animal studies, dare we recommend nicotine replacement therapy in pregnant women and adolescents? Neurotoxicology and Teratology, Jan-Feb 2008, Volume 30\(1\), Pages 1-19.](#)



second child I stopped smoking during pregnancy. My husband began smoking again and so did I. When I began breastfeeding after the birth it became another concern for me. I tell myself that it's not hurting the baby, but in my mind it bothers me."

And what will the child say?

- "I hate, hate, hate cigarette smoking, second hand smoke and smokeless tobacco! My mother smoked while she was pregnant (both times) and smoked until I was 17 years old. I was born with a head tumor which continues to give me trouble after two surgeries and more than 35 years of life."
- "My mother smoked, even when pregnant with me. So I guess, being born that way, I've always been addicted to nicotine." "At age 22, my mother died of a sudden and massive stroke caused by hypertension, elevated by smoking. That's exactly what was put on the coroner's report. Even then, I kept smoking."

Imagine never being able to fully bond with your baby because nicotine keeps coming between you. Alternatively, envision the rich calmness of nicotine-free motherhood.

Why not reach back and seize upon your own pre-pregnancy dream of freedom and make recovery your loving gift of "you" to "you"?

Why not exchange all fears of fetal harm for the celebration of using pregnancy as a golden opportunity to come home to "you"? Picture your new baby basking in liberty's blessings.

- "I am very happy to say that I have been nicotine free for six months now! My kids have not missed any days of school this year. I have started to workout three times a week. I feel better. Most people tell me I look a lot better. My house and car are cleaner. I am so glad I stopped."
- "Now, although I still know I am an addict, I concentrate on keeping my



*Photo by CDC*

recovery alive by celebrating my freedom. One thought I find very heartening is that I am doing "easy time." Compared with the first days, it is so easy for me not to smoke today. Most of the costs have gone, but I still get the benefits. Smoking is expensive in the UK, and so far I have saved £14,000 (that's U.S. \$27,500)! I save so much I can easily justify a weekend away on my annual stopping anniversary. Best of all, I have a 10 week-old son who has a smoke-free mom."

- "I had stopped with my previous pregnancies (three older daughters), but I picked it right back up again with ferocity. After each failure I increased my nicotine intake more and more. At 2 to 2 1/2 packs a day, I saw not much hope for an end. But this pregnancy scared me. Now, I was much older and this baby was counting on me to not just stop during my pregnancy, like with the sisters, but for the rest of my life. I visited WhyQuit and read, and read, and read. I finally learned WHY every time I had picked them back up again in my postpartum periods. I was still in post acute withdrawal. Riddled with anxiety, I did not approach stopping with a recovery mind-set but with a 'suspended sentence' on smoking. For our fifteenth anniversary, I gave my husband another daughter ... and a nicotine-free wife."

Regarding postpartum depression, ready yourself for the possibility. Studies analyzing how often it occurs vary significantly depending on where the women studied lived, the study's definition of depression, and whether or not the results included women who were experiencing depression before giving birth.

Among studies reporting new cases of depression arising after childbirth, 6.9% of 280 new moms in Israel reported postpartum depression at 6 weeks (Glasser 1998), 12.5% among 1,584 Swedish women at 8 weeks, which declined to 8.3% by 12 weeks (Wickberg 1997), 5.8% among 465 Wisconsin women between months 1 and 4 (Chaudron 2001), and 3.7% of 403 Minnesota woman during the first year following childbirth (Bryan 1999).

If depressed following childbirth be sure and let your doctor know. Postpartum depression is not some character flaw or weakness but as real as the nose on our face.

It's believed to be associated with a large increase in progesterone-derived

neuro-steroids during pregnancy, and its sharp decline following childbirth, which may have significant effects on GABA receptors.<sup>120</sup>

Emerging research suggests that these receptors could be a path to effective treatment.<sup>121</sup> Clearly, what no physician on earth will suggest as a treatment course is relapse to the highly addictive, fetal teratogen nicotine.

As for replacement nicotine, even its most vocal advocates are forced to admit that, "there is no evidence that NRT is actually effective for smoking cessation in pregnancy."<sup>122</sup>

Keep your eye on the placebos and nicotine should some future "placebo" controlled pregnancy study proclaim NRT "effective." Remember, placebo is not a real-world recovery method.<sup>123</sup> There's no such thing. But it certainly has proven effective in allowing the pharmaceutical industry to make mountains of money.<sup>124</sup>

Also, with any new study, look closely to see if the pregnancy pharma product cessation study examined cotinine levels (the primary chemical nicotine breaks down into), to see if women were truly able to get off nicotine.

If nicotine and cotinine levels were ignored, it immediately tells us that those conducting the study were vastly more interested in selling their product than preventing fetal harm.

Pregnant women would be wise to accept that knowledge and understanding are extremely effective recovery tools. The highest known pregnancy cessation rates continue to be associated with "counseling and behavioral interventions."<sup>125</sup>

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120 Maguire J, et al, GABA(A)R plasticity during pregnancy: relevance to postpartum depression, Neuron, July 31, 2008, Volume 59(2), Pages 207-713.

121 Nemeroff CB, Understanding the pathophysiology of postpartum depression: implications for the development of novel treatments, Neuron, July 31, 2008, Volume 59(2), Pages 185-186.

122 Coleman T, Recommendations for the use of pharmacological smoking cessation strategies in pregnant women, CNS Drugs, 2007, Volume 21(12), Pages 983-993.

123 Brewster, JM, Pharmacotherapy for Smoking Cessation, electronic letter, Canadian Medical Association Journal, July 29, 2008, <http://cmaj.ca/cgi/eletters/179/2/135#19879>

124 Polito, JR, Meta-analysis rooted in expectations not science, electronic letter, Canadian Medical Association Journal, July 29, 2008, <http://cmaj.ca/cgi/eletters/179/2/135#19781>

125 Crawford JT, et al, Smoking cessation in pregnancy: why, how, and what next..., Clinical Obstetrics and Gynecology, June 2008, Volume 51(2), Pages 419-435.

It's what we're doing now, reviewing the knowledge, insights and skills needed to embrace and celebrate nicotine-free motherhood. Let this be your loving gift of "you" to "you." Watch the magic unfold as your nicotine-free body heals, mends and repairs while at the same time making a new life.

Why deprive your baby of knowing you? Why sense it feel extreme contentment while in the arms of smokers, especially those who smoke your brand?

Instead, picture your new baby bonding to its mother's natural skin fragrance instead of the more than four thousand chemicals that cigarette smoke would have deposited upon your hair, skin and clothing.



*Photo by National Cancer Institute*

I encourage you to continue reading, learning and growing. Allow yourself to become vastly more dependency recovery savvy than your addiction is strong.

Baby steps, yes you can! There's only one rule ... no nicotine just one hour, challenge and day at a time!

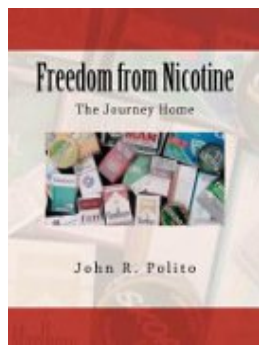
Breathe deep, hug hard, live long,

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