

Chapter 6

Preparing for Common Hazards and Pitfalls

Just One, Just Once

It's a basic tenant of drug addiction that "one is too many, a thousand never enough." Yet fixating upon the thought of "just one, just once" is a relapse tease often entertained by the uneducated mind.

It isn't fair either to say that we don't really want one, because we do. What we don't want and don't recognize are the thousands upon thousands of others that come with it. It's fantasy versus reality, fiction versus truth.

As Joel says, "Don't say that we don't want one when we do. Rather, acknowledge the desire but then ask yourself, do I want all the others that go with it?"



According to the "Law of Addiction" we can't have just one. So why torment yourself with such an extremely destructive rationalization? When "just one" or "just once" enters your mind try to picture all of them, the thousands upon thousands that would follow.

Early Alcohol Use

A 1990 study found that nearly half who relapsed to smoking (47%) consumed alcohol prior to doing so. It also found that another 5% had been under the influence of "recreational" drugs.¹⁴⁵ Using an inhibition diminishing substance while in the midst of physical withdrawal is far too often a catalyst for relapse.

Early alcohol use is clearly the most avoidable relapse risk of all. Chapter 11 provides insights in



145 Brandon, TH, et al, [Postcessation cigarette use: the process of relapse](#), Addictive Behaviors, 1990, Volume

how to confront and extinguish alcohol related nicotine use cues once peak withdrawal has passed. We're far too vulnerable during withdrawal to chance using a substance that relaxes resolve or inhibits judgment.

Why ex-users may feel alcohol effects sooner - There are a number of nicotine/alcohol interactions including the combined effects (or synergy) of both alcohol and nicotine stimulating our brain dopamine pathways.¹⁴⁶ Additionally, as reviewed in Chapter 2, alcohol use causes our urine to turn more acidic, thus more rapidly drawing out and depleting reserves of the alkaloid nicotine. A third interaction may leave us feeling intoxicated sooner.

Nicotine stimulates the body's central nervous system while alcohol depresses it. Alcohol stimulates GABA production (gamma-aminobutyric acid), which produces a sedating effect¹⁴⁷ while impairing muscle (motor) control.¹⁴⁸ Nicotine stimulates fight or flight pathways, stimulating adrenaline and noradrenaline release.¹⁴⁹ This is why alcohol induced feelings of becoming sedated or even sleepy can be diminished by stimulating the body with nicotine.¹⁵⁰

When drinking alcohol, GABA production is stimulated and we soon begin noticing gradual sedation and anesthesia type effects. The more we drink, the more sedated our nervous system becomes. The more we drink, the more acidic our urine becomes and the quicker our kidneys eliminate the alkaloid nicotine from our bloodstream. Not only are we starting to feel tipsy, our nicotine reserves are now declining faster than normal.

Just one powerful hit of nicotine and in addition to an exaggerated dopamine "aaah" our automatic, in-born "fight or flight" neuro-chemical response is fooled into believing that danger is present and begins to stimulate an alcohol sedated body. Adrenaline, noradrenaline and cortisol are released into the bloodstream. Our heart pounds faster and our breathing rate increases. Digestion is shut down so that extra blood can be diverted to our muscles. Our pupils dilate, focus improves, hearing perks up and stored fats and sugars are pumped into our 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, our newfound sense of alertness instead emboldens us ask for another round. "Bartender, I'm ready for another drink!"

15(2), Pages 105-114.

146 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.

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

148 Hanchar 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.

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

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

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. Look on the sunny side. Because we don't need to drink as much to feel the same effects it's less expensive being an ex-user. 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.¹⁵¹ 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 too much? Even social drinkers need to take extreme care when attempting to extinguish alcohol related nicotine use cues. What should 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 then they 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."¹⁵²

If alcohol use seems to be your recovery roadblock then you need to know that smoking cessation may actually enhance the likelihood of long-term alcohol sobriety.¹⁵³ 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 appear to make fewer smoking cessation attempts, they are "as able to quit on a given attempt as smokers with no problems."¹⁵⁴

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. 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," says Joel.

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

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

153 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.

154 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.

“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 quit 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 quit 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 quit drinking, you should probably take heroin for a while until you get alcohol out of your system.”¹⁵⁵

Many of the lessons in this book 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.

Weight Gain

Before going further, it is important to understand that as a smoker you would need to gain at least 75 additional pounds to equal the health risks associated with smoking one pack of cigarettes a day. 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.”¹⁵⁶

For many, weight gain associated with nicotine cessation is of critical concern. It isn't unusual to see up to 5 pounds of water retention weight gain during the first week,¹⁵⁷ pounds that can be shed as quickly as they arrived. It is normal to notice food starting to taste better as early as day three. It is also normal to think about or attempt to use food as a replacement crutch; to try and replace missing nicotine generated dopamine “aaah” sensations with “aaah”'s from extra food.

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

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

156 Spitzer, J, [Patience in weight control issues](http://www.ffn.yuku.com/topic/11636), <http://www.ffn.yuku.com/topic/11636> April 24, 2003.

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

substances necessary for life are synthesized or created.¹⁵⁸ 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.”¹⁵⁹

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.”¹⁶⁰

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.”¹⁶¹ The 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 which 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) also found that while smokers weighed less than never-smokers prior to quitting, “they weighed nearly the same” at one-year follow-up.¹⁶²

If true, and the end result is nearly the same body weight as a comparable never-smoker, is weight gain inevitable? Are we simply returning to our “natural” body weight? Theories as to potential causes are many¹⁶³ including genetics,¹⁶⁴ hand to mouth oral gratification replacement, improved senses of smell and taste (most notably sweets and salts),

158 metabolism. (n.d.). The American Heritage® Dictionary of the English Language, Fourth Edition. Retrieved August 06, 2008, from Dictionary.com

159 basal metabolic rate. (n.d.). The American Heritage® Dictionary of the English Language, Fourth Edition. Retrieved August 06, 2008, from Dictionary.com

160 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.

161 U.S. Surgeon General, [The Health Benefits of Smoking Cessation, a report of the Surgeon General](#), 1990.

162 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.

163 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.

164 Pietiläinen 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; 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.

diminished exercise (isolation), changes in diet, and binge eating. It isn't easy pinpointing the cause for consuming or burning an 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 went overboard with food during recovery. Also not reflected by averages is the fact that body weight remained unchanged for many, while actually declining for some.

While it is 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, something we can pretend is totally beyond our ability to control (not increased eating or lack of activity), the cessation weight gain math usually doesn't add up.

As a general rule it takes 3,500 extra calories to add one pound of body weight and it takes burning 3,500 calories 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.¹⁶⁵ Using these figures, with zero change in diet or activity, it would take 34 days without nicotine before metabolic changes resulted in one pound of weight gain.

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?” Research suggests they do.¹⁶⁶ It also suggests that education may help correct exaggerated weight control beliefs, making recovery more inviting.

How to gain lots of extra weight - Once recovery heralds an end to nicotine's arrival and to the dopamine “aaah” sensations it produced, some find themselves camping out inside the refrigerator or in a bag of potato chips while “aaah”ing themselves sick with food. Turning to and adopting food as a dopamine replacement crutch is a sure fire means of adding weight gain.

Why do up to 4% of us continue such destructive behavior to the point of outgrowing our wardrobe? We do so because that's what drug addiction is all about; it's about stealing the brain's pleasure chemicals. While normal healthy eating stimulates dopamine, during the first few days of recovery, stimulation from normal eating may no longer feel sufficient. Over-eating cannot replace the stimulation effects of missing nicotine without leaving us as big as a house, as most of us used nicotine to steal unearned dopamine every waking hour of every single day.

Still, some try. Instead of allowing the brain time to restore natural pleasure pathway

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

166 White MA, et al, [Smoke and mirrors: magnified beliefs that cigarette smoking suppresses weight](#), Addictive Behaviors, October 2007, Volume 32(10), Pages 2200-2210.

receptor counts and sensitivities,¹⁶⁷ it's as if the up to 4% gaining more than 20 pounds attempt to make their brain's dependency wiring operate on taste's "aaah" influence instead of nicotine's.¹⁶⁸

Clearly there is significant overlap in how food and nicotine affect brain reward and craving pathways. But there's also one massive distinction, the brain doesn't die without nicotine, it thrives!

The sad part about attempting "aaah" replacement using large quantities of food is that once the demoralizing weight increases are adopted as the addict's relapse justification, the extra pounds usually remain following relapse. That 20+ pound bag of rocks they are carrying makes daily exercise more difficult, 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, again engaged in the gradual self-destruction of their body's ability to receive and transport oxygen, and likely more depressed.

Binge eating - Binge eating reflects a loss of control, that is, being unable to stop eating or control what or how much is consumed.¹⁶⁹ The primary psychological binge-eating cue is waiting too long before eating and sensing the onset of hunger.¹⁷⁰ 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.

Binge eating can feel like attempting to satisfy hunger with a shovel. As nicotine addicts we use nicotine as a spoon. It pumps stored fats and sugars into the bloodstream via the body's fight or flight pathways. It allowed us to eat one or two larger meals each day and then use nicotine to release stored reserves. 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.¹⁷¹

167 Picciotto MR, et al, [It is not "either/or": activation and desensitization of nicotinic acetylcholine receptors both contribute to behaviors related to nicotine addiction and mood](#), Progress in Neurobiology, April 2008, Volume 84(4), Pages 329-342.

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

169 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.

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

171 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.

The problem is that an active nicotine addict is able to quickly 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, whether we eat with a toothpick or a shovel we will need to wait for digestion to satisfy our hunger.

It is critical that we quickly re-learn how to properly fuel our body. We should fully expect to confront hunger if we insist on skipping meals. When eating we need to chew our food well, into small pieces. Doing so allows a mouth enzyme (salivary amylase) to begin the breakdown of carbohydrates. This will speed digestion and help satisfy hunger sooner. Remember, eat slowly as it's not so much a matter of how much we consume or how quickly we consume it but about being patient in allowing time for digestion to satisfy hunger.

Fear's unburned calories - Imagine being so consumed by fear of failure that you withdraw from life. How many calories are burned while lying in bed watching television or setting at a computer and clicking a mouse? Yes, some nicotine addicts take the term "quitting" literally and withdraw from life entirely.

Body weight is likely to climb if the amount of daily energy expended substantially declines, while the number of calories consumed remains the same or increases. Demoralizing weight gain is fertile ground for destroying freedom's dreams. The only activity we need end during recovery is the use of nicotine. Don't allow fear to transform recovery, our gateway to freedom, into a prison.

Controllable withdrawal symptom – Some researchers assert that increased eating can be a symptom of nicotine withdrawal.¹⁷² If true, it is clearly one within our ability to minimize. The most important factor in controlling recovery weight gain is understanding the potential causes. Knowledge is power.

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

Dopamine "aaah" sensations are the mind's way of motivating behavior (anticipatory "aaah"s) and rewarding it. It is our survival instinct's teacher and we each have a hefty collection of durable "aaah" memories. Reach for zero calorie "aaah"s like those described above if you want to sense dopamine pathway stimulation without weight gain.

Picking mealtime - Understanding our food focus cycles can make excess temptation manageable. We are only talking about the "excess" food, for without adequate nutrition we die.

172 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.

Instead of eating large meals, eating little and often can enhance appetite control. Eating more frequently could result in consuming up to 27% fewer calories.¹⁷³

During the first two weeks of your recovery, try fueling your body with small healthy food portions at least five times a day. By doing so you'll likely diminish any blood-sugar swing type symptoms and avoid hunger pains, thus reducing risk of "aaah" eating binges.

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

Using food as an oral hand-to-mouth substitute for tobacco is reaching for a crutch, a crutch that delays psychological healing and can threaten recovery. There are a number of healthy options if you feel the need to teach your mind that mealtime is over.

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, or brushing our teeth.

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 lives.

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 may discourage us from being active again tomorrow. Instead, why not become dedicated to a small but deliberate addition to our normal level of physical activity. It can be an exercise session 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, doing extra house or yard work, taking a lap around the block, going on a bike ride or any other activity that expends energy.

Although making 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 to that a modest change in eating patterns? 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!

173 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.

Small adjustments can be made anytime. Consider eating more often but consuming less, taking a few less bites, using a tad less butter, choosing baked instead of fried, cooking a bit less food, one cookie versus two, learning to cut out after dinner snacks or trading empty carbohydrates for long lasting ones.¹⁷⁴

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 our next fix and withdrawal prevention kept hidden. Even if already disabled by smoking, our physician will likely be able to assist us in developing an increased activity or exercise plan that's appropriate, even if done while on oxygen, in a wheelchair or bed.

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 will slowly increase. 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, we lacked the ability to build cardiovascular endurance - not any more!

Aging gracefully does not require "dieting" but the determination to make minor adjustments, which when adhered to, over time, maintain the body size we desire.

Crutches

A crutch is any form of reliance we lean upon so heavily in order to support or motivate recovery that if suddenly removed would significantly elevate risk of relapse. Why lean heavily upon some person, place, thing or activity? Why risk its sudden removal? Why allow our freedom, healing and possibly our life to rest upon the significance given to 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 it's great when our expectations are fulfilled, what happens when they are not? Why tie our fate to the actions or inactions of others, to their sympathies 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're standing on your own, without crutches.

Waiting for another nicotine dependent person to join us in recovery is a delay tactic. We're waiting for a crutch. While it is wonderful when able to share our experience with a spouse, significant other, family member, friend or co-worker, drug recovery programs such as AA do not partner two new ex-drinkers together. Such programs understand that during early recovery the risk of relapse remains high. Partnering newly recovering

174 [The Glycemic Index](http://glycemicindex.com), glycemicindex.com, University of Sidney, 2002, website accessed August 9, 2008.

addicts creates a greater likelihood that should one relapse, the other will follow suit. Instead, serious recovery programs partner new ex-users with stable long-term ex-users.

Successful recovery isn't about coming together to commiserate or share addiction war stories. It's about taking an honest and informed look at where we were and the choices we made. It isn't dependent on being able to lean on a person who ended nicotine use with us but understanding what is required to succeed or fail.

Statistically, roughly 1 in 8.7 who attempt recovery will succeed in remaining nicotine-free for six months.¹⁷⁵ That does not mean that two new ex-users navigating recovery together can't both succeed. We see it all the time. In fact, as long as neither allows nicotine back into their body it is impossible for either to relapse.

Romeo and Juliet is the tragic tale of a man and women whose love for each other is so great that they would rather die than be separated. Some might make the same comparison to their relationship with nicotine. Each year millions surrender life itself rather than stop smoking it. But this isn't Romeo and Juliet being played out on some grand scale. It isn't love reaching for a deadly chemical. It's physical and psychological dependence upon a chemical that shatters lives.

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? Roughly half of adult smokers are smoking themselves to death. The death toll is staggering. Smoking is blamed for 20% of all deaths in developed nations.¹⁷⁶ 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 years.¹⁷⁷ Waiting on our partner to be our "recovery buddy" can prove deadly. One partner needs to go first and blaze a trail home that the other can eventually follow.

There were a number of times during my thirty-year struggle where I wanted others to pick me up and carry me home. I wanted rock solid support from two daughters who couldn't possibly understand my challenges, as they had never been addicted to any chemical in their life. 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'd relapsed, I relapsed too.

But the story had a healthy ending. He attended a 2002 recovery seminar I presented at

¹⁷⁵ Polito, JR, [Does the Over-the-counter Nicotine Patch Really Double Your Chances of Quitting?](#) WhyQuit.com, April 8, 2002.

¹⁷⁶ Wald NJ and Hackshaw AK, [Cigarette smoking: an epidemiological overview](#), British Medical Bulletin, January 1996, Volume 52(1), Pages 3-11.

¹⁷⁷ 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.

the high school from which my daughters graduated. Standing on the auditorium stage, I remember sharing this crutch and “quitting buddy” lesson and our mutual failure 18 years earlier. I recall hoping that as a seasoned ex-user that I could now show him the way home. After the seminar 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 quit 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.”¹⁷⁸

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,” one participant enthusiastically proclaimed, “But I did not smoke!” “She was so proud of her accomplishment,” Joel recalls. “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 quitting 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 elevates the risk of relapse due to diminished inhibitions while using them. It can also create 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 addiction 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.”¹⁷⁹

On the Internet a number of 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 quit smoking? If not, the comment of “do whatever it takes” loses any real concept of credibility.”

“As far as quitting smoking goes, the advice should not be ‘do whatever it takes to quit smoking,’ but rather, ‘do what it takes to quit smoking,’ ” says Joel. “What it takes to quit smoking is simply sticking to your commitment to Never Take Another Puff!”¹⁸⁰ To be a

178 Spitzer, J, [Buddy Systems](http://www.ffn.yuku.com/topic/12760), April 29, 2000, <http://www.ffn.yuku.com/topic/12760>

179 Spitzer, J, [Replacing Crutches](#), WhyQuit.com, Joel’s Library, 1987.

180 Spitzer, J, [“Do whatever it takes to quit smoking”](#) March 19, 2003,

bit more inclusive, Never Take Another Puff, Dip or Chew.

Exercise programs - Some crutches appear rather harmless. For instance, consider an exercise program that was started on our first day of recovery. Imagine our mind so tying the program to successful recovery that we were totally convinced that it was the only reason we had so far been able to succeed. What would happen if our exercise facility suddenly closed, the weather made attendance impossible or if we were to develop an illness or sustain an injury that made exercise impossible?

Exercise is always beneficial and I am in no way trying to discourage those in early recovery from beginning an exercise program. However, while surely beneficial it is not a requirement. View your program in terms of the benefits that 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 too can become a crutch. While online support groups such as WhyQuit's *Freedom from Nicotine* forum¹⁸¹ can be extremely supportive, take care not to lean too heavily upon them. What if our computer's motherboard goes bad and the repair bill exceeds the computer's value yet at the moment we can't afford a new computer? Imagine our Internet service provider's servers crashing for an entire week. Worse yet, what if the company hosting the online support site goes bankrupt or abruptly discontinues service? Picture your recovery and resolve remaining strong and firm through the loss of your computer, the Internet or even loss of electrical service.

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

Food - As discussed earlier, food can become an "aaah" 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 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!"

We need to build our 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 is

<http://www.ffn.yuku.com/topic/12855>

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

suddenly removed. You'll be fine. The next few minutes are all we can control and each is entirely do-able.

Quitting Aids

Open lies and hidden truths -

Over the years I've written much on this topic. There are three key points that need making. First, any quitting product manufacturer whose marketing suggests that few smokers succeed in quitting on their own has already lied to us. Second, that out here in the real world, once outside of placebo controlled clinical trials, cold turkey prevails and is king. Lastly, 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 nicotine, or to use a product which poses risk of death when our objective is longer life?



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. Probably the most damaging and deplorable lies of all are being told by those seeking to increase the market share of their product or procedure by falsely suggesting that few nicotine addicts successfully quit cold turkey, or that we have to be a super-hero to do so.

Billions in marketing have been spent during the past two decades on getting us to fear our natural recovery instincts. It is likely taking a toll in lives. Never in history have a greater array of approved quitting products promised to double cessation. An endless stream of new health studies on the negative effects of smoking, never has the pressure upon smokers to stop been greater. Those in bondage are increasingly feeling the effects of the smoke-free indoor air movement that's now sweeping the globe. Many have felt the economic pinch as government attempts to tax cigarettes to death. Yet, on October 27, 2006, the U.S. Department of Health was forced to report that the U.S. smoking rate decline had stalled at 21% during 2005.¹⁸²

Two additional years would pass before the pharmacology era could pretend that it was somehow responsible for a modest decline. On November 14, 2008 the CDC unveiled the latest U.S. adult cigarette smoking data. The CDC's report stated, "After 3 years during which prevalence in current cigarette smoking among adults remained virtually unchanged

182 Polito, JR, [Is the U.S. Government's Quitting Policy Killing Smokers?](#) WhyQuit.com, October 26, 2006.

(20.9% in 2004, 20.9% in 2005, and 20.8% in 2006), the prevalence in 2007 (19.8%) was significantly lower than in 2006.”¹⁸³ Significantly lower?

Here in the U.S. the cigarette industry successfully enslaves more than 2,000 new U.S. youth smokers daily. I hate to think how bad things would be if natural nicotine cessation wasn't still out there producing the vast majority of success stories. Even in the face of a sea of magic cures that include an array of nicotine replacement therapy (NRT) devices, risky designer drugs such as varenicline,¹⁸⁴ quit smoking shots invented by a quack who is now doing hard time for fraud, magic herbs, hypnosis, acupuncture, lasers, and every gimmick and ploy imaginable, 80-90% of all successful long-term ex-users are succeeding without resort to products or procedures.¹⁸⁵

A 2006 Australian study followed smoking patients of family practice physicians. It found that 88% of all successful ex-smokers did so 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).¹⁸⁶

We nicotine addicts make extremely easy prey. While normal to dream of painless cures, we must not close our eyes and minds to actual results in an arena where the most ridiculous or even fraudulent quitting scheme imaginable should statistically generate success testimonials from 10-11% of users at six months and 5% at one year.¹⁸⁷ Yes, these statistics are the odds of successful recovery that an uneducated “on-your-own” quitter. It's why so many of us are eventually claimed by our addiction. It's the reason for this book, to share the insights needed to turn darkness to light.

Pretend that together we concoct a new magic quitting product called Billy Bob's Lima Bean Butter. What's amazing is that the 10-11% who should be able to quit for 6 months while eating our magic product (unless it somehow undercuts their own natural odds of success) will each deeply believe that our butter was almost entirely responsible for their success. No one will be able to convince them otherwise. It's almost a waste of breath to even try.

But could we make the statistics for success while using our butter look vastly better than 10-11% by surrounding it with quality recovery tools known to double or even triple cessation rates? Tools such as ongoing group or telephone support, cessation education programs, coping skills development, quality self-help materials, behavioral therapy, and group or individual counseling all have their own proven effectiveness. Adding them to our Butter is a means to ensure more newsworthy results and is a practice which occurred in almost all early NRT, bupropion (Zyban) and varenicline (Chantix or Champix) clinical studies.

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

184 Polito, JR, [“Will Chantix really help me quit smoking?”](#) WhyQuit.com, August 25, 2006.

185 American Cancer Society, [Cancer Facts & Figures 2003](#), Table 3, Page 25.

186 Polito, JR, [Cold Turkey Twice as Effective as NRT or Zyban](#), WhyQuit.com, May 19, 2006.

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

Imagine regular AA meetings where alcoholics come together to educate and support mutual successful ongoing recovery. Imagine the group's support dynamics achieving some rather impressive recovery rates in the 20 to 40% range 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 by falsely representing that users would experience the exact same odds of recovery as those attending live AA meetings.

How long would it take for allegations of consumer fraud to start flying once it was noticed that 93% buying and trying the program were relapsing to alcohol within six months? Pfizer's five varenicline studies (Chantix and Champix) broke records for the number of counseling sessions, with up to twenty-five. Yet marketing awards all credit to varenicline.

While quitting pharmacology products clobber placebo users inside clinical trials rich in support and counseling, real-world performance has been dismal. California,¹⁸⁸ Minnesota,¹⁸⁹ Quebec,¹⁹⁰ London,¹⁹¹ Western Maryland,¹⁹² Nottingham,¹⁹³ Australia,¹⁹⁴ the United States,¹⁹⁵ and England,¹⁹⁶ it should bother all of us that after more than two decades of widespread use that real-world quitting method surveys continue to show that those buying and using cessation pharmacology products fail to perform better than those quitting entirely on-their-own. Such stop smoking method surveys are relatively inexpensive, quick and easy to generate, and those successful have absolutely no reason to lie about how they had finally achieved success.

But NRT stakeholders quickly dismiss such surveys as "unscientific." They content that we can't trust those who recently attempted recovery to correctly remember the method they used and whether or not it brought them success. What should be dismissed as unscientific is any clinical trial whose validity is grounded in use of placebos.

Placebo isn't a quitting method, it isn't cold turkey - Let me ask you this. If I hand you a piece of nicotine gum or a nicotine lozenge, how long will it take you to tell me whether

188 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.

189 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.

190 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.

191 SmokeFree London, [Tobacco In London, Facts and Issues](#), [see Figure 14], November 26, 2003.

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

193 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].

194 [Smoking status of Australian general practice patients and their attempts to quit](#), Addictive Behaviors, May 2006 May, Volume 31(5), Pages 758-766.

195 2006 [Unpublished U.S. National Cancer Institute Survey of 8,200 quitters](#), as reported in the Wall Street Journal, Page A1, February 8, 2007.

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

or not it really contains nicotine or is instead a nicotine-free placebo? Not all can do it but 3 to 4 times as many of us will be correct as will be wrong.¹⁹⁷

Pretend for a moment that we hear about a nicotine gum “quitting” study at the local hospital that is offering participants three months of free nicotine gum. There is only one catch; half signing up for the study will be randomly assigned to receive nicotine-free placebo gum instead. Will we stick around and allow ourselves to be toyed with for the next 12 weeks if convinced that we have been assigned to receive placebo gum instead of the real thing? Neither did they.

What if a significant percentage of other placebo group members have a history of prior recovery attempts, attempts that have taught them to recognize the onset of full-blown withdrawal? Frustrated by recognizing assignment to the placebo group, what if they simply give up too? What validity will there be in the study's ultimate 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 victories grounded in frustrated expectations as having been “science-based.”

It's why using placebo controls in drug addiction studies have acted 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 be the only known research area in which blinding is impossible.”¹⁹⁸ You cannot fool cessation savvy drug addicts as to whether or not their brain dopamine pathways are being stimulated or withdrawal anxieties are present.

A June 2004 study was entitled “The blind spot in the nicotine replacement therapy literature: Assessment of the double-blind in clinical trials.”¹⁹⁹ It teaches that anyone asserting that NRT studies were blind is not being honest, as far too many study participants correctly guessed their assignment. In fact, 71% of NRT studies attempting to assess the integrity of their study's blinding failed their own assessment.

Contrary to industry marketing hype, those wanting to stop smoking cold turkey were never invited to compete in clinical trials against self-selecting smokers seeking months of free replacement nicotine, bupropion or varenicline.²⁰⁰ Unlike those going cold turkey, those seeking free “medicine” joined in hopes of diminishing, not enduring, their

197 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 placebo assignment as were wrong.

198 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.

199 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.

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

withdrawal syndrome. I submit that if honest competition had occurred that there would be no need for these words and explanations.

Smoking cessation clinical trial research is increasingly void of scientific integrity. Most calling themselves researchers are little more than glorified salesmen. They have become dependent upon pharmaceutical industry financial interests. They know that if their comments or work should ever cause the industry financial harm that they can forget participating in any pharmaceutical industry funded study again.

We have now seen more than 200 placebo-controlled smoking cessation pharmacology studies, when 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.²⁰¹ Why not use the most effective proven treatment as our control and see how the newest method compares? How many study participants assigned to placebo groups are looking at their final cessation opportunity before experiencing a smoking induced heart attack or stroke, or being diagnosed with terminal cancer or advanced emphysema?

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.²⁰² How many study participants have smoking cessation researchers needlessly killed? Do any of them care?

One of the reasons researchers use placebo controls instead of the "best current proven intervention" is that placebo promises the biggest margin of victory possible and the largest news headlines. Also, pitting cessation products against each other means that one product must win while another loses. Pharmaceutical companies avoid risk of defeat in meaningful head-to-head product competition by use of a control that isn't a real quitting method. This way, no company's economic interests are hurt. Are the lives of clinical trial participants being intentionally sacrificed by an ethic-less smoking cessation research industry? It certainly looks that way.

What "Big Pharm" doesn't want us to know - I believe that clinical cessation pharmacology studies reflect the worst junk-science ever perpetrated upon humans. Regretfully, true science turned its collective head as stakeholders redefined "quitting" as quitting smoking while continuing to use nicotine. They remained silent as the pharmaceutical industry re-labeled a natural poison "medicine" and termed its use "therapy." And why silence when seeing apples compared to oranges? Does it make sense to compare the accomplishment of those who have re-adjusted to natural brain dopamine stimulation to those using external chemicals that continue artificial

201 National Institute of Health, www.ClinicalTrials.gov, visited December 2008, search: placebo + smoking

202 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.

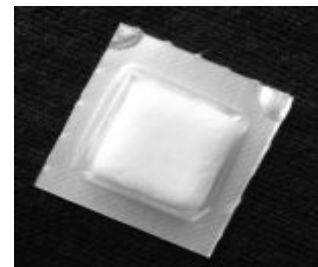
stimulation?

But who has greater fault, those who have knowingly engaged in nicotine shell games, or government agencies and health organizations which continue to hide critical cessation pharmacology study findings that would allow nicotine addicts to make informed, intelligent and reasoned decisions?

What percentage of over-the-counter (OTC) NRT users is still not smoking at six months? Would this be important to know? I challenge you to try to locate an answer to this question at 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.²⁰³ OTC studies are important because their design is as close as possible to the way these products are used in the real world. We walked into the store, purchased the product, and used it without any formal counseling, education or support.

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 conducting this study also published a November 2003 study that found that as many as 7% of successful gum users and 2% of patch users were still hooked on the gum or the patch at six months.²⁰⁴ Obviously these were two entirely different studies but 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? As with the 7% OTC NRT six-month rate, I challenge you to locate any government or health organization sharing an answer to this question.

The pharmaceutical industry, government health agencies and health non-profits have known since as early as 1993 that if we have already tried quitting once with the nicotine patch that our odds during a second patch attempt drop to near 0%.²⁰⁵ Unlike cold turkey, where each failed quit attempt actually increase the odds of eventually self-discovering the Law of Addiction and power of one hit of nicotine to foster relapse, the odds of success for the repeat NRT user dramatically decline with subsequent use. Why would we hide this data?

203 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.

204 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.

205 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.

Nicotine addicts are also not being told that at least 36.6% of all current nicotine gum users are chronic long-term users of greater than 6 months.²⁰⁶ Unlike the gum, which traps some nicotine, the nicotine lozenge fully dissolves, delivering up to 25% more nicotine. We have no reason to believe that the number of NRT users getting hooked on the cure isn't at this moment climbing higher.

Let me share the first paragraph of an email I received yesterday. “I'm a 24 year old male who smoked cigarettes for about 6 years until quitting 2 years ago. Unfortunately, I decided to quit back then by switching to Nicorette. In a horror story I'm sure you've heard dozens of times, I'm now horribly addicted to the gum.”



If we are able to get our brain's dopamine, adrenaline and serotonin pathways adjusted to fully function without nicotine at the exact same time that we are feeding them nicotine, we should be extremely proud of ourselves 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, we should not grow discouraged as we are in some wonderful, wonderful company.

We are not breaking free because of weeks or months spent toying with pharmacology products but in spite of having done so. It's testimony to our drive and determination.

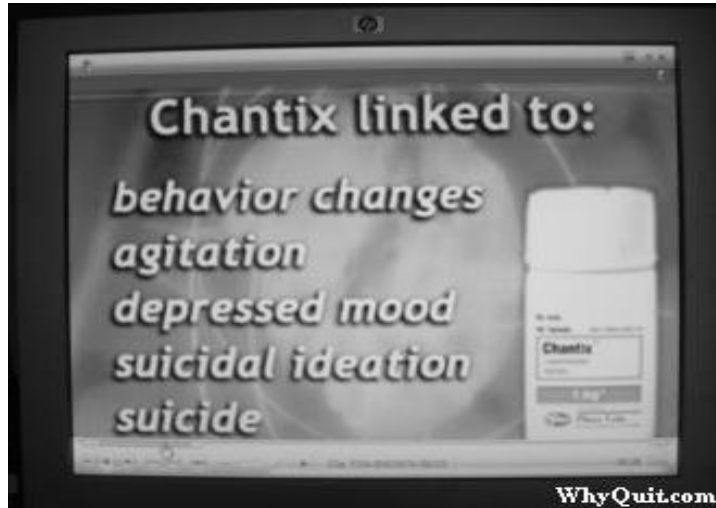
Core dreams and desires for freedom are not altered by standing in front of any weaning product or even Billy Bob's Lima Bean Butter. It is "us" doing the work.

As long as we keep our day #1 dreams vibrant and alive long enough to allow ourselves to again 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 this book serve as a tool that aids you in your recovery, it is “you” who put the lessons to work. The glory is 100% 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.

206 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.

A 2008 study was the first to pit the nicotine patch against varenicline. Participants were asked at both six months and one year whether or not they had smoked any cigarettes in the past seven days. The authors report that there "were no significant differences" between Chantix and nicotine patch users at either 6 months (varenicline 38.6% vs. patch 34.1%) or one year (varenicline 34.8% vs. patch 31.4%).²⁰⁷



The study notes that two varenicline users experienced severe depression, with suicidal ideation causing one to be hospitalized 11 days after ending Chantix use. It found that among 376 Chantix users and 370 patch users that the likelihood of a Chantix user experiencing vomiting was 5.5 times greater than among nicotine patch users, that decreased sense of taste was 5.3 times greater, abdominal pain was 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 benefits?

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. A 2008 study analyzing program performance found that at four weeks after starting varenicline treatment that 63% of varenicline users were still not smoking as compared to 48% using nicotine replacement products (NRT) such as the nicotine patch, gum or lozenge, and 51% who stopped smoking without use of any quitting product.²⁰⁸

While at first blush it might appear that varenicline has the lead, keep in mind that these are four-week results and that both varenicline and NRT users still face another 4-8 weeks of treatment before trying to adjust to living and functioning with natural brain dopamine stimulation.

The only long-term English evidence is from an April 2005 study that examined one-year success rates.²⁰⁹ The study did not include varenicline as it wasn't yet on the market. It

207 Aubin HJ, et al, [Varenicline versus transdermal nicotine patch for smoking cessation: results from a randomised open-label trial](#), Thorax, August 2008, Volume 63(8), Pages 717-724.

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

209 Ferguson J, et al, [The English smoking treatment services: one-year outcomes](#), Addiction, April 2005, Volume

found that while 25.5% of those who attempted recovery without using any pharmacology product at all 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 after one year varenicline will most likely finish slightly ahead of NRT but behind cold turkey.

Don't expect any researcher to ever provide a copy of this book or Joel's as part of any fair, open-label study pitting varenicline against those wanting to quit cold turkey. Doing so would produce a cold turkey victory that would seriously damage a massive golden goose. The researcher bold enough to conduct the study would never receive pharmaceutical industry funding of any study ever again.

Joel's basic pharmacology lessons - Joel has also written extensively on pharmacology cessation products. As early as 1984 he was warning about nicotine gum's ability to foster relapse or become a crutch.²¹⁰ He encourages those contemplating using pharmacology products to take their own poll of all successful long-term ex-users who have remained nicotine-free for at least a year.²¹¹ 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 pharmacology products 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--the gum and two of the four patches went over-the-counter and Zyban (bupropion) was just coming into the fray,” writes Joel.²¹² “Let's hope not too many miracle products for smoking cessation get introduced in the future as it may result in skyrocketing smoking rates.”

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

100 Suppl 2, Pages 59-69 [see Table 6].

210 Spitzer, J, [Pharmacological Crutches](#), Joel's Library, 1984.

211 Spitzer, J, [Quitting Methods - Who to Believe?](#) Joel's Library, 2003.

212 Spitzer, J, [40 Years of Progress?](#) Joel's Library, 2004.

Negative Support

“You’re such a basket case, you should just give up!”

“I’m trying but my smoking friends laugh, tell me I’ll fail and offer me smokes.”

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

No person’s comment, look, laugh or stare can destroy our freedom. Only we can do that.²¹³ According to Joel, most of the time the person making comments such as those above have not considered the implications of the statement. “It is comparable to you telling someone on chemotherapy, and who is in a really bad mood due to hair loss, nausea, and other possible horrible side effects, and hence, in a less than happy mood, that he or she should get off that stuff because he or she is so irritable that he or she is ruining your day,” writes 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 with the bad times to help support the patients effort to save his or her life,” he explains.

“What family members and friends often overlook,” says Joel, “is that quitting smoking too is an effort to save the quitters life. While others may not immediately appreciate that fact, the person quitting has to know it for him or herself. Others may never really appreciate the concept, but the person quitting has to.”

“One thing I did notice over the years though, while the comment is made often, it is usually from a spouse, a child of the smokers, a friend, a coworker 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,” he explains. “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 quit for him or herself and stay off for him or herself. How many times did a family member ask you to quit as a smoker and you never listened. Well if you don't quit for them, you don't relapse for them either. You quit for yourself and you stay off for yourself.”

“I can’t quit. My husband still smokes and leaves his cigarettes lying around.”

I recall attempts where I hoped smoking friends would be supportive in not smoking around me, and not leaving 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 loud brain addiction chatter that seized upon frustrated support expectations as fuel during some rather intense internal relapse debates.

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.

During my final attempt, I did, but not before initially spending some time away from them, in order to get my recovery legs under me first.

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 may have no choice but to work toward extinguishing tobacco product, smoke and smoker cues almost immediately. And we can do it!

Thousands of comfortable ex-users handle and sell tobacco products as part of their job. What is it like to hold these packs sitting before me yet feel no crave or urge? Maybe I’ll have one tomorrow but it’s been so many years, 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.

“I’m a bartender. How can I quit surrounded by smoke and smokers at every turn?”

Imagine the total number of ex-smokers who successfully navigated recovery while working in n bars, bowling alleys, casinos, convenience stores and other businesses historically linked to smoking. Imagine the total number who broke free while their spouse or significant other smoked like a chimney.

Instead of fighting or hiding from our world, take it back. Why allow our circumstances to wear us down? Small steps, just one moment at a time. Embrace challenge. Extinguish cues. Use honesty to filter conscious thoughts of wanting. Recovery is about reclaiming. This is our time, don’t fear it. Although it may sound strange, try to enjoy and savor reclaiming your mind and life.

Breathing Second-Hand Smoke

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

“Contrary to popular opinion or misconceptions, the risks of second-hand 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. The half-life of cotinine is 17 hours, making it a more stable indicator that nicotine was present.

The average of three studies reporting cotinine levels in saliva was 260 ng/ml in women and 337 ng/ml in men.²¹⁴ 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 to analyze cotinine levels of non-smokers spending 3 hours in smoke filled bars. 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.²¹⁵

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 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.”²¹⁶

But this is much different from inhaling a puff of smoke from a lit cigarette or even taking a puff into one's mouth without inhaling. A sufficient quantity of nicotine would be absorbed through the lungs, or through the oral mucosa if not inhaled, to cause a full-blown relapse.²¹⁷ There is a significant difference in the amount of nicotine absorbed when puffing on a cigarette and breathing second hand smoke.

214 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.

215 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.

216 US Surgeon General, [Smoking and Health: A Report of the Surgeon General](#), 1979, Chapter 11, Page 24.

217 Spitzer, J, [Withdrawal again?](#) Quotting from Second Hand Smoke, November 21, 2001, <http://www.ffn.yuku.com/reply/255814#reply-255814>

A critical fact that bears repeating is that just one puff of mainstream nicotine is sufficient to stimulate up to 50% of brain receptors believed associated with nicotine addiction.²¹⁸ Once we ring that bell it cannot be un-rung. Our brain will soon be begging us to steal more.

According to Joel, “as far as second-hand 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 smoker from one cigarette.”

“Other chemicals in second-hand smoke can reach some pretty toxic levels much quicker than that, in minutes not days. The side effects felt from being exposed to second-hand 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 we may soon discover, being forced to breathe second-hand smoke during recovery can be demoralizing and actually provide a source of junkie thinking during times of challenge. "I have to breathe it anyway so why not just go back to smoking." Such non-sense rationalizations are the relapsing addict's refuge.

What this addict is really saying is, "I'm so concerned about the lesser harms of second-hand 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." "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% chance²¹⁹ that I'll smoke myself to death 13 to 14 years early."

Such thinking makes you wonder why it never occurs to non-smokers to take up smoking for such reasons. Such relapse logic could only make sense to an 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 negative support or smoke screens to obscure our view of the path home? See through it just one challenge at a time.

Bad Days

Ex-users should expect to experience bad days but should keep in mind that never-users have bad days too. When a bad day occurs early in recovery it can become ammunition inside a mind toying with relapse excuses. The association would never have crossed our mind if we'd had a bad day during the week prior to ending nicotine use. But now the absence of nicotine becomes a magnet for blame.

218 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.

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

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

As Joel teaches, if the bad day happens during the first week after ending nicotine use then blame recovery as "it is probably the reason." "But as time marches on," Joel cautions, "you need to be a little more discriminating." As you gradually navigate recovery, having ended nicotine use will play a diminishing role in bad days. Before you know it, you'll be going entire days without once thinking about wanting to use nicotine.

Acknowledge bad days but allow this gift of freedom and healing we've given ourselves to live on. "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 we want to hear about a horrible day we need to 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. Imagine all the bad days they'll force loved ones to endure if they are among the 50% of U.S. adult male smokers claimed an average of 13 years early or 14 years early for women.²²⁰

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

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.

220 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.

A 2008 study tried to determine if the menstrual phase during which a woman attempts to stop smoking affects the risk of smoking relapse.²²¹ 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% of women who started during the follicular phase.

As these 14% 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 faster (see Chapter 8). While quicker elimination is desirable while engaged in recovery, adding the onset of early withdrawal to premenstrual symptoms clearly makes navigating each month's menstrual cycle more intense.

In fact, 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.²²² 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 excess anxiety will never again serve as our relapse excuse. It may be that hormonal related symptoms are so profound for some women that it is best to navigate the most challenging portion of recovery -- the first 72 hours -- during the luteal phase. Subconscious recovery can also be aggressively pursued.

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 remaining 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 from Nicotine, the free message board support group where he serves as education director.²²³ "Go back one month and see how many of the

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

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

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

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.”²²⁴

Joel closes by reminding women concerned about menstrual symptoms, that to keep their recovery on the course of getting easier and easier over time is still just as simple as 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 our chemical dependency may damage or kill it, news of pregnancy can be an emotional waterfall. Upon confirmation, often within minutes, the mother-to-be makes the biggest mistake of her entire pregnancy. She decides to “quit for the baby.” How could something that sounds so right be so wrong?

Only about half of women claim to be successful in ending nicotine use after learning they are pregnant.²²⁵ Sadly, the real figure is probably closer to one-third. Researchers conducting third trimester blood tests on women claiming to have succeeded found that 25% had been untruthful.²²⁶ Why do so few succeed?

Quitting for others, including the unborn, is a formula and recipe for relapse.²²⁷ It can mean an entire pregnancy spent either feeling deprived of nicotine or gradually growing numb to the fears of harm it would inflict, and eventually surrendering to it. What logic is there in making this “the baby’s” quit instead of its mother’s recovery? Quit for the baby? Is it the baby who needs help or its mom-to-be?

No longer in harm’s way, the precious seconds after having given birth are often soured by thoughts of relapse. Instead of savoring life’s richest moment, the birth of life, she’s plotting the act she knows may bring an early end to motherhood and life.

Quitting “for the baby” will likely make her pregnancy objective 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 mother. Let me share quotes from a few e-mails I’ve received:

- “I am 33 years old. I started smoking at age 13 and of course never thought I

224 Spitzer, J, [PMS and Quitting](#) September 14, 2004, <http://www.fff.nicotine.com/topic/12132>

225 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, Epub ahead of print.

226 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.

227 Spitzer, J, [Quitting for Others](#), WhyQuit.com, Joel’s Library, 1984.

would still be a smoker 20 years later, and a pack to a pack and a half each day. I quit 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 quit smoking each time I found out I was pregnant but it was 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 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.”

Roughly half of women who claim to have stopped smoking during pregnancy admit to relapse after giving birth.²²⁸ Adding it all up, it means that only about 1 in 5 women who smoked at conception will experience the joys of smoke-free motherhood.

The reasons given to try and justify having relapsed after giving birth 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 quit 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 quit 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 quit the cigarettes and started with the gum again. I finally quit the gum 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 unlikely that drug relapse improved either situation.

228 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.

Whether recognized or not, it likely made them worse.

Pregnancy is a golden opportunity to make a wonderful journey home, a period during which a mind, body and life are reclaimed in anticipation of the calmness and cleanliness of nicotine-free motherhood. Instead, roughly 4 out of 5 women who smoked at conception spend their pregnancy somewhere between the grips of penetrating guilt over the harms that continued use inflicts on the developing life within her womb, and a growing sense of self-deprivation that she will attempt to satisfy soon after having given birth.

The risks of harm are so significant that it isn't a matter of whether or not nicotine will damage the fetus but how bad the damage will be. The risks are so huge that fears flowing from them consume logic, reason and common sense.

Prior to news of her pregnancy, she likely had her own dream of someday becoming nicotine-free at a time, place and manner of her choosing. But gripped by worry of harm to the developing life inside, it became a forgotten dream. Instead of seeing here and now as the time to revive and live her dream, she abandoned it in favor of self-sacrifice for the growing life inside.

Although short-term safety concerns caused these women to forget about their own long-term glory, at least they made an effort. Many women reach for nicotine use rationalizations to bury fears of fetal harms, at least long enough to permit themselves that next fix. Here are more quotes from e-mails I received.

- “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 quit 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 Dr. and the hospital about smoking.”

There's also the rationalization that “Quitting for the baby is just too hard.” She's absolutely correct. The challenge truly is far greater when attempting to stop 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 a pregnant woman smoking. Society's disdain only increases her focus upon “quitting for the baby.”

- “I am 8 weeks pregnant and have been struggling with quitting for some time. Even before the pregnancy I was trying to quit. The scariest part for me is the anxiety that quitting creates. Is it dangerous to go through withdrawal cold turkey?”
- “I am 26 years old. I am 9 weeks pregnant. I have smoked a pack a day for 11 years. I have tried to quit smoking 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 quit 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 quit 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 a growing sense of feeling deprived overwhelms fears of harming an unborn child? How much anxiety and guilt would follow?

If the expectant mother has gone two weeks without nicotine, her brain has already substantially completed restoring neurotransmitter sensitivities. Although her mind contains 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, there is nothing missing, and nothing in need of replacement.

For her, relapse will not match expectations. Yes, there will be an underlying “aaah” explosion that her brain's pay attention pathways will, in the short term, make impossible to forget. But she was not in a state of withdrawal. The “aaah” may go almost unnoticed. Instead, her focus will turn to the sensations felt when scores of cigarette toxins strike healing tissues and carbon monoxide invades an oxygen rich mind. They will compel her dizzy and disrupted mind to turn its focus to her failed objective, “stopping for the baby.” She'll wonder whether the burning sensations produced of carbon monoxide, hydrogen cyanide, arsenic, sulfur, ammonia, and formaldehyde striking her tissues will also burn her unborn baby.

But it's too late. Once nicotine is inside relapse is almost 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 to 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 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 quit, 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 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.”²²⁹ But he has also written aiming directly 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, 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 women smokers who used to quit at least during pregnancy may begin using NRT throughout pregnancy. As a consequence, intelligence expressed by I.Q. standards may decline in the offspring, but as larger segments of the population are affected, this decline may not be readily discernible.”²³⁰

While warnings such as Dr. Ginzel’s make the expectant mother’s failure to place her recovery above “quitting for the baby” almost understandable, they also remind us of the critical importance of building a lasting recovery upon a firm, solid and lasting foundation.

229 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.

230 Ginzel, KH, [Why do you smoke?](#) WhyQuit.com, February 6, 2007.

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.²³¹

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.²³² The patch's continuous delivery of nicotine is believed to somehow overwhelm and saturate the ability of the placenta to perform limited nicotine filtering.

Professor Slotkin wrote in 2008 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."²³³

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, pus-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 second child I quit 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 its 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!

231 Slotkin TA, [Fetal nicotine or cocaine exposure: which one is worse?](#) The Journal of Pharmacology and Experimental Therapeutics, June 1998, Volume 285(3), Pages 931-945.

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

233 Slotkin, TA, Slotkin, [If nicotine is 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.

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 the ability to fully bond with your baby without nicotine coming between the two of you. Envision the rich calmness of nicotine-free motherhood. Try to reach back and seize upon your own pre-pregnancy dream of freedom and make recovery your gift of “you” to “you.” Exchange all fears of fetal harm for the celebration of using pregnancy as your time 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 that I quit.”
- “Now although I still know I am an addict, I concentrate on keeping my quit alive by celebrating my freedom. One thought I find very heartening is that I am doing "easy time." Compared with the first days of my quit, 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 US \$27,500)! I save so much I can easily justify a weekend away every quit anniversary. Best of all, I have a 10 week old son, who has a smoke-free mom.”
- “I had quit with my previous pregnancies (three older daughters), but I picked the habit right back up again with ferocity. After each quit, 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 quit during my pregnancy like 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 picked them back up again in my postpartum periods. I was still in post acute withdrawal. Riddled with anxiety, I did not approach my quit 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 standards used to assess depression, and whether or not the results included women experiencing depression prior to 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 A receptors.²³⁴ Emerging research suggests that these receptors could be a path to effective treatment.²³⁵ What no physician 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.”²³⁶ 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 quitting method.²³⁷ There's no such thing. But it certainly has proven effective in allowing the pharmaceutical industry to make mountains of money.²³⁸

Also, look closely to see if the pregnancy pharmacology cessation study examined cotinine levels (the primary chemical nicotine breaks down into) to see if women were truly able to get off nicotine. If cotinine levels were ignored, it tells us that those conducting the study were probably more interested in selling nicotine not preventing fetal harm.

Pregnant women would be wise to accept that knowledge is an extremely effective recovery tool. The highest known pregnancy cessation rates are associated with “counseling and behavioral interventions.”²³⁹ 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 the developing life inside you grows. 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. Yes you can!

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