

Freedom from Nicotine – The Journey Home

Chapter 6: Common Hazards & Pitfalls

Early Alcohol Use Risky

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

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

How risky? A 2016 study found recent alcohol use during the first 21 days of recovery made smoking nearly 4 times as likely.[2]

Ex-users may feel alcohol effects sooner

There are a number of nicotine/alcohol interactions. Most obvious is the combined effects (or synergy) of both alcohol and nicotine stimulating the user's brain dopamine pathways and satisfying wanting for more.[3]

Additionally, as explained in Chapter 4, as with stress, alcohol use causes urine acidification, which in turn causes the user's kidneys to accelerate removal of the alkaloid nicotine from their bloodstream.

A third interaction may leave the user feeling intoxicated sooner. Nicotine stimulates the body's central nervous system while alcohol depresses it. Alcohol stimulates GABA production (gamma-aminobutyric acid), which produces a sedating effect[4] while impairing muscle (motor) control.[5]

Nicotine stimulates fight or flight pathways, causing the release of adrenaline and noradrenaline.[6] This is why alcohol-induced feelings of becoming sedated or even sleepy can be diminished by stimulating the body with nicotine.[7] Here's what to expect.

When drinking, the user soon begins noticing alcohol's gradual sedation and anesthesia type effects. The more they drink, the more sedated their nervous system becomes. The more they drink, the more acidic their urine becomes and the quicker their kidneys eliminate nicotine from their bloodstream. Not only are they starting to feel tipsy, their nicotine reserves are declining faster than normal.

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

Adrenaline, noradrenaline, and cortisol are released into the bloodstream. Their heart pounds faster and their rate of breathing increases. Digestion is suspended so that extra blood can be diverted to their

muscles. Their pupils dilate, focus improves, hearing perks, and stored fats and sugars are pumped into their bloodstream, providing an instant source of energy.

An alcohol-depressed nervous system has just experienced some degree of stimulation. No saber tooth tiger to fight or flee, their newfound sense of alertness instead emboldens them to ask for another round. "Bartender, I'm ready for another drink!"

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

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

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

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Co-Dependency Concerns

Amazingly, roughly eighty percent of alcoholics smoke nicotine.[1]. As with nicotine, an inability to control use is the most glaring feature of dependency.

Has beer, wine, or liquor become central to daily life? Do you feel wanting and urges to drink? Have you noticed that you have gradually needed to drink a bit more over time in order to achieve the same effect?

Do you continue drinking despite alcohol adversely affecting your relationships, health, work, or life? Are you unable to drink in a controlled manner? Have you attempted to stop drinking? If so, do you experience the onset of withdrawal by the third day?

Remaining mindful that "denial" is huge with both nicotine and alcohol addiction, if not chemically

dependent upon it, is it possible that you're dealing with problem drinking (alcohol abuse), that you've conditioned your mind to use too frequently or to drink too much?

As Joel sees it, "If a person says that they know that their drinking will cause them to take a cigarette and relapse back to smoking, and if they then take a drink and relapse, they are in effect problem drinkers, for they have now put their health on the line in order to drink." [2]

Is alcohol use your nicotine recovery roadblock? If so, while mental health professionals are generally reluctant to suggest simultaneous alcohol and nicotine recovery, [3], "research shows that smoking cessation does not disrupt alcohol abstinence and may actually enhance the likelihood of longer-term sobriety. Smokers in alcohol treatment or recovery face particular challenges regarding smoking cessation." [4]

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

The study found that those who had stopped smoking within a year of entering substance use treatment had 240% greater odds of both remaining abstinent from drugs, drugs plus alcohol, or alcohol alone within the past year, than those who had continued smoking. [5]

So, whether you vape, smoke, dip, or chew nicotine, what can you do if alcohol use and its inhibition diminishing effects have become factors preventing you from breaking nicotine's grip upon your mind and life?

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

Research shows that while those with alcohol problems make fewer smoking cessation attempts, they are "as able to stop on a given attempt as smokers with no problems." [6]

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

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

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

"Note the sequence here," says Joel. "The ex-smoker has been off nicotine for an extended time period but the smoking sponsor says that the person can't stop both at once. It is unfortunate that most alcohol

and drug treatment programs just don't recognize smoking as another drug addiction."

Joel uses heroin to show the insanity of such advice. "You will not often see an AA sponsor say that you can't give up drinking and heroin at once, so if you have been off heroin for six months and now want to stop drinking, you should probably take heroin for a while until you get alcohol out of your system." [7]

Still, we are nicotine cessation educators only. Alcohol withdrawal syndrome is very real and can range from shakiness to the possibility of seizures, delirium tremens (the DTs), and death. While potentially life-threatening, treatment medications are available. It's why, if concerned about the possibility of co-dependency upon both nicotine and alcohol, enlist the assistance of your doctor and/or a quality alcohol treatment program.

In that alcohol diminishes inhibitions, it's the exception to the rule that we should try to quickly meet, greet, and extinguish all learned nicotine use associations.

We are each different. No one knows "you," your alcohol use patterns and history, or its effects upon your judgment and impulse control, better than you.

Generally, if not an alcoholic or problem drinker and able to control use, if you plan to continue alcohol use, obviously, it's important to allow yourself a few days to get your recovery legs under you and move beyond peak withdrawal before drinking. Even then, due to diminished inhibitions, the smart move is to devise and use strategies that break drinking alcohol down into more manageable challenges that present fewer potential crave triggering use cues.

Confronting alcohol-related crave triggers

As discussed in detail in Chapter 11, if a drinker, you've likely conditioned your brain to expect nicotine while consuming alcohol.

And even social drinkers should exercise extreme caution when attempting to extinguish alcohol-related nicotine use cues.

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

Additional use cues may include encountering a drinking acquaintance, friend or another nicotine user, being around lots of other users, seeing ashtrays, cigarette packs and lighters within easy reach, seeing a cigarette machine or visible packs or cartons for sale behind the bar, or even something as simple as seeing a jug filled with free matches.

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

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

Encountering a conditioned use cue can cause a brief crave episode that may take up to 5 minutes. Remain mindful that time distortion is normal during withdrawal, and that panic may activate the body's fight or flight response, making time seemingly stand still. It's why looking at a clock or a watch is valuable in helping gain an accurate time perspective.

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

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

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

Since half of all fatal vehicle collisions involve alcohol, if you do drink, make sure that driving isn't part of the plan.

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Avoiding Blood Sugar Swing Symptoms

Hypoglycemia is a big word for what occurs when our "blood sugar (or blood glucose) concentrations fall below a level necessary to properly support the body's need for energy and stability throughout its cells." [1]

Causes of low blood sugar in non-diabetics include skipping or delaying meals, eating too little,

increased activity/exercise, and excessive alcohol.[2]

Warning signs include an inability to concentrate, anxiety, hunger, confusion, weakness, drowsiness, sweating, trembling, warmness, nausea, dizziness, difficulty speaking, and blurred vision.[3]

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

One of recovery's greatest challenges is learning to again properly feed and fuel our body.

It's not a matter of consuming more calories but learning to spread them out more evenly over our entire day, by eating smaller portions of healthy foods more frequently.

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

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

If tolerable, cranberry juice is excellent. A 2008 study examined the effects of drinking 480 milliliters or 16 ounces of unsweetened, normal-calorie cranberry juice (280 calories) upon blood sugar.

It found that while low-calorie cranberry juice (38 calories) and water produced no significant changes in blood sugar levels, that normal-calorie cranberry juice resulted in significantly higher blood glucose concentrations within 30 minutes, which were no longer significant after 3 hours.[4]

As for fruit juices accelerating nicotine removal, the heart pumps about 20% of our blood through our kidneys. Our kidneys filter roughly 50 gallons or 189 liters of blood daily. This results in removal of about two quarts of waste products and extra water, which pass to the bladder as urine.[5]

The word "renal" means "of or relating to the kidneys." "Renal clearance" is defined as the volume of blood from which a chemical such as nicotine is completely removed by the kidney in a given amount of time (usually a minute).[6]

A controlling factor in determining renal clearance rate is the pH level of urine produced by our kidneys.[7] The more acidic our urine, the quicker nicotine is removed from the bloodstream.

A 2006 study found that drinking one liter of full-strength grapefruit juice (34 ounces or about 2 pints) will increase the rate by which the kidneys remove nicotine from blood plasma by 88%, as compared to when drinking 1 liter of water (231 milliliters of nicotine-free blood produced per minute using grapefruit juice vs. 123 milliliters of blood when drinking water).[8]

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

The pH scale ranges from 0 to 14 with 7 being neutral. The further below 7 a substance is, the greater its acidity. The higher a substance is above 7, the greater its alkalinity. According to the FDA,[9] the below fluids have the following pH ranges:

2.3 - 2.5	Cranberry juice
2.9 - 3.3	Grapefruit juice
3.3 - 3.6	Pineapple juice
3.3 - 4.2	Orange juice
3.4 - 4.0	Apple juice
3.9 - 4.0	Prune juice
3.9 - 4.3	Vegetable juice
4.1 - 4.6	Tomato juice
6.4 - 6.8	Milk
6.5 - 8.5	Water

Depending upon urinary flow rate, renal clearance of nicotine may be as high as 600 milliliters per minute in acidic urine having a pH of 4.4, to as low as just 17 milliliters per minute in alkaline urine having a pH of 7.0.[10]

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

A 2012 study found that the odds of successful smoking cessation for 14 months among the one-quarter of study participants consuming the greatest amount of fruits and vegetables daily was three times greater than among the one-quarter consuming the least.[11]

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

But don't overdo it. Remember, our primary goal is to stabilize blood sugar during the most challenging portion of recovery - the first 3 days - so as to avoid experiencing needless symptoms.

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Your Blood Caffeine Level Will Double

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

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

According to a 1997 study, "continuous caffeine consumption with smoking cessation has been associated with more than doubled caffeine plasma levels. Such concentrations may be sufficient to produce caffeine toxicity symptoms in smoking abstinence conditions." [1]

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

An earlier study found that the clearance rate of caffeine from blood plasma averaged 114 milliliters per minute in nicotine smokers and 64 milliliters per minute in non-smokers. [2]

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

Intoxication symptoms seen when more than 1 gram of caffeine is consumed per day include muscle twitching, rambling flow to thoughts and speech, irregular or rapid heartbeat, irritability and psychomotor agitation. [3]

Most of us can handle a doubling of our daily caffeine intake without getting the jitters. But how can we tell whether the anxieties we feel are related to nicotine cessation or to too much caffeine? It isn't easy.

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

Caffeine withdrawal symptoms can include headache, fatigue, decreased energy, decreased alertness,

drowsiness, decreased contentedness, depressed mood, difficulty concentrating, irritability, and a foggy mind. Symptoms typically begin 12 to 24 hours after caffeine use ends, reach peak intensity at 20 to 51 hours, and normally last 2 to 9 days.[4]

The following is a sampling of the number of milligrams (mg) of caffeine "typical" in various substances:[5]

85mg	coffee - 8 ounces drip brewed
80mg	"energy drinks"
75mg	coffee - 8 ounces percolated
40mg	espresso - 1 ounce servings
40mg	tea - 8 ounces brewed
28mg	tea - 8 ounces instant
26mg	baker's chocolate - 1 ounce
25mg	iced tea - 8 ounces
24mg	some soft drinks - 8 ounces
20mg	dark chocolate - semi sweet - 1 ounce
06mg	cola beverage - 8 ounces
05mg	chocolate mild beverage
04mg	chocolate flavored syrup
03mg	coffee – decaffeinated

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

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

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Avoid Crutches

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

Why lean or count heavily upon any person, place, thing, or activity? Why risk sudden removal? Why allow your freedom, healing, and possibly your life to depend upon the presence of a source of support whose reliability is beyond your ability to control?

Recovery buddies

A person or "quitting buddy" is the most obvious crutch. Creating and leaning heavily upon the expectation that some other person will behave in a supportive manner is dangerous.

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

While there's nothing wrong with enjoying their support when it's there, picture your recovery standing entirely on its own when it's not.

Envision 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 remain standing and saying "no" to wanting without the use of any crutch.

Waiting for another nicotine-dependent person to join us in recovery often turns into a double-deadly delay tactic. Either they die waiting, or they're waiting for a crutch.

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

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

Successful recovery isn't about learning from someone who likely knows less about successful cessation than you do. Although misery loves company, why fear your healing or delay for even a day the greatest awakening your mind and life will likely ever know?

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

While obedience to the Law provides 100 percent odds of success, how many smokers have ever heard of it? Statistically, only 1 in 8.7 who attempt un-educated recovery succeed in remaining nicotine-free for six months.[1]

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

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

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

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

Statistically, roughly half of adult smokers smoke themselves to death. The death toll is staggering. Smoking is blamed for 20% of all deaths in developed nations.[2] Here in the U.S., the average female claimed by smoking loses 14.5 years of life expectancy, while the average male loses 13.2.[3]

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

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

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

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

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

As Joel's "Buddy Systems" article proclaims, "Take heart ... your primary focus needs to be on your own [success] now." "Soon you will be the seasoned veteran." "Many programs use the phrase, 'To keep it, you have to give it away,'" writes Joel. "Nowhere is this more true than when dealing with addictions." [4]

Alcohol or other drugs

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

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

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

Using alcohol, other drugs, or addictive prescription medications as nicotine cessation crutches also elevate the risk of relapse due to diminished inhibitions while using them.

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

As Joel notes, "In many of these cases the end result will be a more significant problem than just the original problem, smoking. The new addiction can cause the person's life to end in shambles, and when it comes time to deal with the new dependence he or she will often relapse to cigarettes." [5]

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

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

"As far as stopping smoking goes, the advice should not be 'do whatever it takes to stop smoking,' but rather, 'do what it takes to stop,' " asserts Joel.

"What it takes to stop is simply sticking to your commitment to Never Take Another Puff!" [6] And to be a bit more inclusive, to never take another puff, vape, dip, or chew.

Exercise programs

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

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

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

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

Internet support

The Internet can also become a crutch. While online support groups such as Turkeyville [7] can be extremely supportive, take care not to lean too heavily upon them.

What if your computer crashes and you can't afford a new one? What if your Internet service provider

has problems and its servers crash for a week? Worse yet, what if the company hosting your online support site goes bankrupt or abruptly ends service? Picture your recovery and resolve remaining strong even without a computer.

Hope for the best, yet prepare for the worst. Consider printing your favorite articles. If keeping an online recovery journal, diary, or log, be sure to periodically 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.

Extra food

Food can become an "aah" wanting satisfaction crutch, as can other oral hand-to-mouth substitutes for cigarettes, e-cigs, 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!"

Consider building your recovery so as to enable it to stand entirely on its own. If you now realize that you have developed a crutch, picture continuing on and succeeding even if it's suddenly removed. You'll be fine.

The next few minutes are all we can control and each is entirely do-able.

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Nicotine gum, patch & lozenge a fraud, sham and hoax

I wish it were true, that approved smoking cessation products were effective and "double your chances." I wish I'd broken free during my very first Nicorette nicotine gum attempt (about 1986). Instead, my spirit was left shattered.

It wasn't just me. By any honest measure, over-the-counter nicotine replacement therapy (NRT) products (the nicotine gum, patch, and lozenge) undercut recovery and are a fraud upon smokers dying to quit.

I'd chewed my brains out. Still, when all the chewing and parking cycles ended, the wanting for more nicotine remained. And quickly, I was back to smoking as much as ever.

Was I somehow different? I'd just failed with the very best science had to offer. Was I hopeless?

Even in despair, I wasn't finished trying.

Thinking it was me, that I'd somehow misused it, I wasted three more valuable periods of cessation confidence attempting to wean myself off of nicotine by replacing it (once more with Nicorette gum and twice with the patch).

The cost was deeper than wasted time, crashed confidence, obliterated opportunities, and missing money. Pharmaceutical industry marketing assurances that nicotine was "medicine" and its use "therapy" muddled and clouded critical natural learning.

I'd not only lost sight of the enemy, I'd purchased and used it: a performance diminishing drug, the very chemical my brain dopamine pathways were physically dependent upon.

Pharma's nicotine-filled Trojan Horse had not only defeated me, it obscured, interrupted, and delayed natural school-of-hard-quitting-knocks learning.

Even so, year after year, the toll of smoke's toxins was becoming more noticeable and impossible to deny. I had to keep trying.

Although not known by name, additional failed escape attempts would eventually force me to self-discover successful recovery's only rule, the Law of Addiction (Chapter 2).

Although free and cherishing it since May 15, 1999, I remain angry about 36 years of sham science displacing and suppressing truth for hundreds of millions of smokers.

Yes, it's massively bigger than my missing teeth, an inability to run more than a couple of hundred feet, or millions of lost memories.

Knowledge is power. It's my hope that the following insights aid you in seeing the light.

Open lies and hidden truths

Nearly four decades of trickery, deceit, and outright lies, as I suggested in a 2012 letter published in the British Medical Journal, the most deadly health product consumer fraud in history involves the study, marketing, and sale of over-the-counter replacement nicotine.[1]

The pharmaceutical industry and its army of henchmen have consistently misrepresented that:

1. Over-the-counter replacement nicotine has proven effective in real-world use;
2. Most successful ex-smokers succeed by use of approved products;
3. Few smokers are able to quit cold turkey;
4. Clinical study findings are trustworthy, as participants were blind as to whether or not they were introducing nicotine into their body; and
5. Cold turkey quitters were soundly defeated by NRT users in clinical studies.

Understanding how the industry defrauds smokers helps make sense of the fact that cigarette companies are now selling NRT too.[2]

It also enhances appreciation of the very essence of our addiction, a recognition that dopamine pathway driven wanting, urges, and desires annually make the neo-nicotine industry billions.

Falsehood #1: Nicorette helps you "chew away your cravings"

Let's start with the most glaring consumer fraud, the underlying suggestion in every Nicorette nicotine gum advertisement we've ever seen, that nicotine gum has proven highly effective in helping smokers quit. Is it true?

Here in the U.S., Nicorette was first approved for sale by the Food & Drug Administration (FDA) on January 13, 1984. More than 30 years on the market, despite heavy Chantix advertising by Pfizer since 2008, nicotine gum remains the most marketed stop smoking product in history.

A July 2013 Gallup Poll asked U.S. ex-smokers how they succeeded in quitting.[3] Question: what percentage credited nicotine gum for their success?

1. 41%
2. 28%
3. 13%
4. 6%
5. 1%

Talk about fraud, the correct answer is number five, 1 percent.

Like an alcoholic toying with gradual stepped-down weaning schemes, it's pretty much impossible for the brain to adjust to functioning without nicotine while it continues to arrive. Especially if reached for during the exact same situations where nicotine was smoked, vaped, dipped, or chewed.

Falsehood #2: Most succeed by use of approved products

The same Gallup Poll also found that all approved stop smoking products combined, including Chantix, accounted for only a tiny fraction of successful quitting (just 8% or 1/12th).[3] The tail isn't just wagging the dog, it's killing it.

Now, at long last, in 2020, even the U.S. Surgeon General has openly acknowledged that "most smokers who quit successfully do so without medications or any type of formal assistance." [4]

It's entirely normal for a craving addict who is able to satisfy their craving within 8-10 seconds of inhaling nicotine to want a quick-quitting-fix too.

What isn't normal is for the very government charged with protecting them to assist in presenting pharma fabricated mirages that play and prey upon their conditioned impulsiveness.

Smoking cessation is textbook if looking for a great example of how ethicless corporate greed and its quest for profits can purchase and manipulate clinical science, author government cessation policy, and control group-think.

For example, the pharmaceutical industry effectively owns the Centers for Disease Control's (CDC) Office on Smoking and Health (OSH) and its SmokeFree.gov website, a storefront for GlaxoSmithKline and Pfizer quitting products.

SmokeFree.gov's "Find a Quit Method that Works for You" section devotes a topic tab to "Nicorette," another to "Nicoderm CQ", one to "Nicotrol," one to "Zyban" and another to "Chantix." [5]

Guess which method isn't once mentioned? Yep, cold turkey, America's ex-smoker production champ year after year after year, a method that generates \$0 profits.

Falsehood #3: Few are able to quit cold turkey

Truth is, there's a giant yet silent elephant in the room, one that never, ever advertises.

Reality is, as evidenced by the same Gallup Poll [3] and every long-term independent quit smoking method population-level study,[6] each year more nicotine addicts arrest their chemical dependence by going cold turkey than by all other methods combined.

How big an elephant? Up to three-quarters who arrest their chemical dependence are breaking free entirely on their own, without the use of any product or undergoing any procedure.[7]

According to the CDC, during 2014 the U.S. had 40 million adult smokers,[8] with roughly 6%[9] or 2.4 million successfully quitting each year. If 75% succeeded by going cold, that's 1.8 million success stories.

The billion-dollar questions are, how is it possible that such a massive truth - how most quit - is kept hidden? And how do approved products prevail inside clinical trials, yet get clobbered in real-world competition?[10]

First, ask yourself, is it your dream to continue feeding your chemical dependence until the day you die, or to arrest it?

If less than 72 hours away from ridding your body of nicotine and moving beyond peak withdrawal, what sense does it make to pay money to extend nicotine withdrawal for weeks or months, or risk ending-up the cure's permanent slave?

Cold turkey is fast, free, effective, and smart

You've been lied to by so many for so long that skepticism here and now is normal and warranted.

The flip-side of the industry lie that NRT is effective is that cold turkey isn't.

Again, in 2020, shockingly, the U.S. Surgeon General at long last acknowledged that numerous population surveys indicate "that cold-turkey quitters do as well or better than those who use over-the-counter NRTs." [4]

Despite the vast majority of successful ex-users having abruptly ended nicotine use without resort to products or procedures, industry influence continues to suggest that few succeed, that you'd need to be a super-hero to do so.

It's why quitting method surveys are relatively rare. The medicinization, nicotination, and successful commercialization of cessation are heavily dependent on you not knowing the truth.

Since 1984, billions in marketing have been spent on getting smokers to fear their natural recovery instincts.

Reflect on diminished worldwide confidence in cold turkey fostered by decades of bombarding smokers with the lie that they're twice as likely to fail unless they buy and use the nicotine patch, gum, lozenge, spray, inhaler, spray, Zyban, Chantix or Champix.

Imagine being a cold turkey quitter and hit with that message while in the process of navigating early withdrawal.

The "double your chances" fraud has eroded confidence, increased relapse, and contributed to costing millions of freedom-seeking dreamers their lives.

Never in history has a greater array of approved products promised to double success.

And the coercive pressures upon smokers to stop smoking have never been more intense (higher cigarette prices, graphic pack warnings in most nations, the clean indoor air movement resulting in fewer places to smoke (or vape), and a steady stream of studies, articles, and victim television commercials on smoking's harms).

Do you really think that you'll stop once the price goes up a few more dollars, euros or pounds? So did millions of Australian nicotine addicts who in July 2015 found themselves paying an average of \$16.11

per pack (New Zealand \$14.67, Norway \$14.48 and the UK \$12.25 per pack).[11]

Reflect on the millions of addicts here in the U.S. since 2006 who repeatedly listened to commercials sharing a long and frightening list of Chantix side effects, who were thereafter willing to risk their lives in giving it a try.

What's depressing is that the #2 quitting method behind cold turkey isn't Chantix/Champix or the nicotine patch or nicotine gum. It's smoking yourself to death.

Here in the U.S., we experienced 2.5 million U.S. smoking-related deaths from 2004 to 2010. Still, during those same six years, the decline in the U.S. adult smoking rate was only one percentage point, from 20 to 19 percent.[12]

And that's despite billions spent trying to convince smokers to purchase replacement nicotine, to risk popping Chantix or Champix pills,[13], to receive scopolamine injections that make you too sick to smoke (a "cure" invented by a quack who went to prison for a weight loss fraud scheme), to purchase magic herbs such as "Smoke Remedy"[14] or buy a power bracelet, or undergo hypnosis, acupuncture or laser therapy.

A 2006 Australian study analyzed the smoking patients of 1,000 family practice physicians. It found that 88% of all successful ex-smokers succeeded by going cold turkey and that those going cold were twice as likely to succeed as those using the patch, gum, inhaler, or Zyban (bupropion).[15]

Still, nicotine addicts make extremely easy prey. Why? Because thousands of daily urges for more were satisfied within seconds of use. Because the bars formed by a mountain of old urge satisfaction memories compel their prisoner to dream of a fast, surefire, and painless escape.

And we dream in an arena where the most ridiculous or even fraudulent scheme imaginable "should," statistically, generate success testimonials by 10-11% of users at six months.[16]

That rate reflects the per attempt 6-month odds of successful smoking cessation by those stopping entirely "on-their-own," without education, counseling, or support.

Don't fret. It's why this book exists, to shine light on darkness, to emphasize that it's IMPOSSIBLE to fail so long as all nicotine remains on the outside.

To aid in understanding cessation fraud, pretend that together we invent a new magic stop smoking product. Let's call it "Billy Bob's Lima Bean Butter."

Unless our product somehow undercuts natural cessation (as OTC NRT at 7% in fact does),[17] 10-11 percent who use our butter should succeed and still be smoke-free at 6 months.

The sad part about cessation fraud is that nearly all who succeed while using Billy Bob's Lima Bean Butter will deeply believe that our butter was responsible for their success. In fact, even after telling them the truth, we probably won't be able to convince them otherwise.

And we can improve upon our sham even more. We can substantially inflate the number of success

stories and testimonials by creating a study in which our butter gets paired with other recovery interventions that have their own proven effectiveness.

For example, we could combine butter use with coping skills development, behavioral therapy, or individual or group counseling, all of which have been proven to at least double success rates.[18]

While our study would generate headlines, we'd have to downplay or even hide the secret to our butter's success. Unfortunately, it's a success rate inflation formula used in nearly all clinical studies of NRT, Zyban, and Chantix/Champix.

For example, Pfizer's five original Chantix studies broke records for the number of participant counseling sessions (up to 25). And to this day, Pfizer marketing continues to award full credit to Chantix.[19]

While approved products defeat the expectations of placebo users inside clinical trials rich in support and counseling, real-world performance has been a disaster.

California,[20] Massachusetts,[21] Minnesota,[22] Quebec,[23] London,[24] Western Maryland,[25] Nottingham,[26] Australia,[27] the National Cancer Institute,[28] England's Stop Smoking Services,[29], 2002-2003 TUS-CPS data,[30] English households,[31] the GfK's U.S. Knowledge Panel,[32], U.S. 2013-2015 PATH data,[33], 2010-2011 TUS-CPS data,[34] and U.S. 2013-2016 PATH data,[35] after three decades of widespread use, real-world cessation surveys continue to show that, overall, those buying and using OTC approved products are wasting recovery opportunities, money, time, and life.

Despite cessation method surveys being inexpensive, quick, and easy to conduct, in relation to hundreds of expensive clinical trials they're relatively rare.

Pharma's economic muscle is massive, penetrating, and corrupting. Ineffectiveness findings make NRT marketing claims laughable. It's why population-level effectiveness findings must be avoided, kept hidden, and attacked.

Still, with an unbroken string of cold turkey survey victories, the absence of favorable NRT real-world performance evidence was becoming glaring. Something had to be done.

So, how did pharma and its most trusted researchers respond? They started writing and conducting their own surveys.

In doing so, they wrote surveys that grossly overemphasize approved products via repeated questioning about them, while totally avoiding any mention of cold turkey. Instead, cold turkey quitters were either forced to pick "other" or "none," or have their method ignored [36] [37]

It also allowed financially conflicted researchers full control over raw survey data, the ability to exclude participants and "adjust" findings before publication,[38] and to keep damaging data and findings suppressed or ignored.

While successful ex-users have absolutely no reason to lie about how they finally achieved success,

unless the quoted survey was generated by pharma's influence it's quickly dismissed as "unscientific."

It's true. Even the U.S. Surgeon General in his January 2020 "Smoking Cessation" report questions whether ex-smokers should be trusted to accurately recall what, for many, was their greatest accomplishment ever.[4]

Imagine asserting that ex-smokers can't be trusted to correctly recall the last quitting method they used, whether it involved approved products, or whether it brought them success (recall bias), unless pharma funded the survey.[36].

With straight faces, pharma and friends argue that the reason so many go cold turkey is because most lack insurance coverage and can't afford NRT.[4]

This when Walmart's cheapest pack of cigarettes is roughly \$4.00, while the per unit price of a 21mg 24-hour Walmart nicotine patch is \$1.85, and the per-unit cost of the maximum recommended number of pieces of 4mg. nicotine gum per day (10) costs \$1.81.[39]

Pharma influence also suggests that the reason that cold turkey appears more effective in surveys than NRT is because of "selection bias," because "highly addicted smokers are those most likely to use NRT, but these smokers also have a lower likelihood of success." [4]

The argument ignores that super-selection bias that occurred when more than 200 NRT clinical trials dangled free NRT or "medication" as study recruiting bait. Imagine generalizing the findings from such studies as reflecting "your chances" when those dreaming of going cold weren't present.

Which is more deadly, hiding the big picture and truth about how most succeed, or lying to smokers about "their chances" when trusting their natural instincts? [30]

While true that heavy smokers tend to gravitate more toward NRT than light smokers, that tells us nothing about the outcome.

It ignores a 2012 population-level study which found that at 3 months into cessation, that cold turkey was 40 percent more effective than NRT among heavy smokers (more than 15 cigarettes per day), with nearly 3 times as many heavy smokers succeeding by going cold.[30]

Lastly, pharma and friends blame NRT's real-world ineffectiveness on improper use of NRT, that it's being used for "short periods of time or at lower-than-recommended doses," without "support available from tobacco cessation quitlines." [4]

So who is to blame for NRT being horribly ineffective? Let's see, blame memory, blame cost, blame real-world recovery for not mirroring clinical trials, and blame NRT users for improper use.

The real blame is greed that perverted science into labeling nicotine "medicine" and pushing it as "therapy" upon those addicted to it.

Frankly, what can't be trusted and should be dismissed as junk and unscientific is every smoking cessation clinical trial efficacy finding whose validity is rooted in the use of placebo controls.

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Placebo Isn't a Quitting Method

Placebo isn't a nicotine dependency recovery method and it certainly isn't cold turkey.

Why care? Because if you've ever tried replacement nicotine, sham placebo studies were key in motivating you to waste your money and squander your dreams. Because understanding how pharma cheats may prevent you from being cheated again.

Webster's defines "placebo" as "1. usually pharmacologically inert preparation prescribed more for the mental relief of the patient than for its actual effect on a disorder. 2. an inert or innocuous substance used especially in controlled experiments testing the efficacy of another substance (as a drug)."

Placebos have historically served as the gold standard in clinical research. Study participants are randomized to either the drug being tested or to a placebo look-alike. The objective is to "blind" participants as to the type of treatment they're receiving, so that assignment awareness doesn't affect their response to it.

Falsehood #4: Placebo-controlled clinical trials were blind

While placebo is the gold standard in most research, in smoking cessation it's license to steal. The blinding problem is two-fold. Either the expectations of the addict who is experienced in attempting recovery are fulfilled or they suffer.

Pretend for a moment that you're still hooked, using, wanting to stop, and curious about NRT but not wanting to spend any money. You hear about a new 4-session nicotine gum stop smoking study at a nearby medical school.

The study is offering a three month's supply of free nicotine gum, counseling, plus travel expense reimbursement. There's only one catch. Half signing up for the study will be randomly assigned to receive nicotine-free placebo gum instead.

Imagine being handed a piece of nicotine gum or a nicotine lozenge while experiencing strong urges to smoke, dip, vape or chew. How long would it take you to tell whether or not it contained nicotine, or was instead a nicotine-free placebo look-a-like?

Not all of us can do it. The more attempts we've made, the more expert we became at recognizing our withdrawal syndrome.

Still, 3 to 4 times as many of us would be able to correctly say whether we'd been given a placebo, as

would declare wrong, and that's within 24-48 hours of attempting to stop (peak withdrawal).[1].

As I wrote in a letter published in the Canadian Medical Association Journal in November 2008, "pharmacologic treatment of chemical dependency may be the only known research area in which blinding is impossible." [2]

We cannot fool cessation savvy nicotine addicts as to whether or not wanting and urges flowing from their brain dopamine pathways have been satisfied.

A June 2004 study was entitled "The blind spot in the nicotine replacement therapy literature: Assessment of the double-blind in clinical trials." [3] It teaches that anyone asserting that NRT studies were blind is not being honest, as far more study participants were able to correctly declare their assignment than couldn't.

Assignment awareness within the active NRT group can be revealed by the fact that nicotine is a psychoactive drug that stimulates the nervous system via the release of adrenaline. This makes the heart pound 10 to 20 beats per minute quicker while elevating blood pressure.

Even more noticeable, nicotine causes the release of dopamine which, at least briefly, satisfies the addict's wanting and desire for more.

Assignment awareness within the study's placebo group (the study's control arm) is even greater than in the NRT group, as their need for nicotine isn't satisfied.

Expecting to sense diminished urge or crave intensity, the vast majority will instead endure their full withdrawal syndrome: a rising tide of anxieties, anger, dysphoria, concentration difficulty, and sleep fragmentation, all within 24 hours of ending nicotine use.

Back to our imaginary study, would you stick around and allow yourself to be toyed with for the next 3 months if convinced that you'd been given placebo gum instead of the real thing? Neither did many of them.

In study after study, 80 to 90 percent of participants reported a history of prior stop smoking attempts. Those attempts taught them to recognize the onset of their withdrawal syndrome. Again, the more prior attempts they'd made, the more expert they became.

But the remaining placebo group members received the exact same counseling, correct? True, but the primary counseling objective in every nicotine replacement study was to foster successful nicotine dependency transfer to an alternative form of delivery, not the lessons and advice needed to minimize the effects of abrupt nicotine cessation (the focus of this book).

If NRT clinical trials weren't blind as claimed, if efficacy findings reflect fulfilled and frustrated expectations, what's the value of an NRT study which finds that twice as many nicotine gum users stopped smoking than among those given placebo? Zero.

Imagine the lack of intellectual integrity required to label victory by default - results rooted in frustrated expectations among a group of smokers who went to great lengths to receive free NRT - as

having been "science-based."

The placebo story is far more disturbing than time and space permit telling here.

Briefly, ask yourself, who manufactured the placebo devices used in hundreds of trials and who verified their contents? We know that in some trials pharma resorted to putting small amounts of "unbuffered" nicotine into placebo gum and patches. What we don't know is how often "active" placebo use occurred.[4]

Were active placebos spiked with just enough nicotine to keep users in the tease and throws of withdrawal: not delivering enough to satisfy cravings, nor allowing them to get clean, begin re-sensitizing, and move beyond peak withdrawal within 3 days?

The evidence is undisputed and aids in understanding NRT's real-world ineffectiveness. I wish it wasn't so but, to my mind, declaring clinical trials blind and science-based when they clearly were not, makes pharma nearly as culpable as Big Tobacco in robbing, defeated, and killing smokers.

Falsehood #5: NRT defeated cold turkey in clinical studies

This might surprise you, but those wanting to stop smoking cold turkey have never been invited to compete in clinical trials against self-selecting smokers seeking months of free replacement nicotine, bupropion, or varenicline.[5]

Unlike those going cold turkey, those seeking free "medicine" joined the study in hopes of diminishing their withdrawal syndrome, not quickly meeting, navigating, and moving beyond it.

Why are there no head-to-head clinical studies pitting "medicine" against cold turkey? Because if honest competition had occurred, NRT, bupropion, and varenicline would have lost, would have never been approved for sale, and there would have been no need for this explanation.

Smoking cessation studies in which the senior researcher has no history of having accepted funding and/or personal payments from the pharmaceutical industry are rare.

Is it reasonable to expect financially conflicted researchers to bite the hand that feeds them? If they did, they know that they'd never receive any pharma money or pharma research project again.

The industry cannot allow its paid army of researchers to conduct intellectually honest studies. They'd cost it billions in lost profits.

It's why smoking cessation clinical trial research is nearly void of scientific integrity. It's why most calling themselves researchers are little more than glorified nicotine salesmen.

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

Last time I looked, the National Institute of Health's clinical trials registry identified more than 200 new smoking studies that are expected to use placebo controls.[6]

Why? Industry research is about the quest for corporate profits and satisfied shareholders. I'm convinced that pharma is fully aware of the facts I've just shared and intentionally exploits them.

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

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

Principle 32 of the World Medical Association's (WMA) Declaration of Helsinki commands that the "benefits, risks, burdens and effectiveness of a new intervention must be tested against those of the best current proven intervention" and that placebos should not be used unless "compelling and scientifically sound methodological reasons" are demonstrated.[7]

Let's not forget that WMA Principle 32 is totally meaningless when the credibility of cessation's "best current proven intervention" is totally rooted in fraud. Still, how many desperate addicts, who are down to their final confidence opportunity before bad news arrives, will cessation researchers rob and sentence to death?

The primary reason researchers continue to use placebo instead of pharma's "best current proven intervention" is that placebo promises the greatest margin of victory possible and the biggest news headlines.

Also, in pitting cessation products against each other, unless a tie, one product wins and the other loses.

Think about GlaxoSmithKline, maker of Nicorette gum, the Commit nicotine lozenge, the Nicoderm CQ patch, and Zyban. If in GSK's shoes, would you want any of your products to lose to another?

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

Unfortunately, the lives of clinical trial participants are being sacrificed by a near ethic-less smoking cessation research industry, researchers driven by the quest for personal pharma income, study funding, news headlines, and university tenure.

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Big Pharma's Smoking Cessation Secrets

Pharma's best-kept secret? As just reviewed, it's that clinical smoking cessation studies reflect the most lethal junk-science ever perpetrated upon humans.

Clever bait and switch ploys, the result is almost always the same, lower odds of success for millions and millions of real-world addicts than if they'd simply left quitting products alone.

Should you trust GlaxoSmithKline, the U.S. seller of Nicorette and Nicoderm products, and Pfizer, maker of Chantix and Nicotrol, with your life?

Are you aware that U.S. Justice Department criminal investigations resulted in both GlaxoSmithKline[1] and Pfizer[2] admitting guilt in committing felony consumer fraud?

Have you ever stopped to reflect on the fact that you've never once heard any Chantix, Nicorette, or Nicoderm commercial suggest that, "Smoking causes lung cancer, emphysema, and circulatory disease, that you need to purchase and use Chantix, Nicorette, or Nicoderm because smoking kills"?

You haven't and never will. But why?

As hard as this may be to believe, the pharmaceutical and tobacco industries are in bed together. Since 1984 they've operated under a nicotine marketing partnership agreement. The once-secret documents evidencing their agreement are many and suggest that neither is permitted to directly attack the other's products.[3]

The partnership's purpose is to keep you in the family, to ensure your purchase and use of their nicotine. While it's their objective to keep you handing them your money to satisfy your dependency's wanting, I hope it's your dream to permanently arrest and silence it, and defy them.

Regretfully, science turned its head as financial stakeholders redefined "cessation" from meaning

ending nicotine use to replacing it.

They remained silent as the pharmaceutical industry re-labeled a natural poison "medicine" and termed its use "therapy."

And why total silence when seeing apples compared to oranges?

What sense does it make to compare the accomplishment of someone who has stopped using nicotine to stimulate brain dopamine pathways, to someone who continues stimulation via NRT, e-cigarettes, smokeless tobacco, Zyban, Chantix or Champix?

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

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

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

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

What percentage of over-the-counter (OTC) NRT users are still not smoking at six months or one year? Would this be important to know?

I challenge you to locate an answer to this critical question on any government, commercial, or health website advocating NRT use. Good luck.

A March 2003 study, conducted by paid NRT industry consultants, combined and averaged all seven U.S. OTC patch and gum studies.[4]

OTC studies are important because their design is as close as possible to the way these products get used in the real world. Study participants simply walk into the pharmacy, purchase or are given the product, and then use it without any formal counseling, education, or support.

Researchers found that only 7% of OTC study participants were still not smoking at six months. That's right, a product with a 93% failure rate. It's actually worse.

The same industry consultants also published a November 2003 study which found that as many as 7% of successful nicotine gum users were still hooked on the gum at six months.[5]

Obviously these were two different studies. Even so, the math supports the July 2013 Gallup Poll finding that quitting with nicotine gum is nearly impossible.

What are the odds of success during a second or subsequent NRT attempt? Do the user's odds improve or get worse? Again, I challenge you to locate an answer to this rather important yet elementary question on any government or health organization website advocating replacement nicotine use.

The pharmaceutical industry, government health agencies, and health non-profits have known since as early as 1993 that if you've already tried and failed while using the nicotine patch, that your odds during a second patch attempt drop to near zero.[6]

Unlike cold turkey, where each failed attempt actually increases the odds of eventually self-discovering the Law of Addiction, the odds of success for the repeat NRT user dramatically decline following failure.

Why would governments hide such findings?

Although kin to e-cig users, nicotine addicts are also not told that by 2003 at least 36.6% of all continuing nicotine gum users were chronic long-term users of greater than 6 months.[7]

Let me share the first paragraph of an email I received.

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

If able to get our brain's dopamine pathways adjusted to functioning without nicotine while at the same time continuing to use it, we should be extremely proud, because we are in fact super-heroes.

But if among the 93 out of 100 first time OTC NRT users who quickly relapse, or among the nearly 100% who fail during a second or later attempt, rest assured, your brain dopamine pathways functioned as designed.

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

Replacement nicotine use defies the very purpose of withdrawal and recovery, the time needed to move beyond nicotine's influence.

The few NRT users who do succeed are not breaking free because of weeks or months spent toying with replacement nicotine but in spite of having done so. Frankly, it's testimony as to their drive and determination.

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

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

But should this book serve as a tool in aiding your recovery, do understand that it was still "you" who put its lessons to work, you who did all of reading, reflecting and lifting, and the glory remains 100 percent yours!

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Varenicline: Chantix & Champix

A few words of caution about paying between \$1,200 and \$1,700 for a 90 day supply of varenicline or Chantix (sold outside the U.S. as Champix). Never in the history of smoking cessation products have we seen such a wide array of serious potential side effects, including death.

The Medication Guide for Chantix is available at Chantix.com.

Anyone considering taking Chantix should carefully read the Guide prior to doing so. Not only does it share the risks associated with taking Chantix, it also lists the things that smokers should tell their doctor prior to receiving a prescription.[1]

The following are quotes from parts of the February 2019 version of the Medication Guide:

- Some people have had serious side effects while taking CHANTIX to help them quit smoking, including: New or worse mental health problems, such as changes in behavior or thinking,

aggression, hostility, agitation, depressed mood, or suicidal thoughts or actions.

- Seizures. Some people have had seizures during treatment with CHANTIX. In most cases, the seizures have happened during the first month of treatment with CHANTIX.
- New or worse heart or blood vessel (cardiovascular) problems, mostly in people, who already have cardiovascular problems. Get emergency medical help right away if you have any of the following symptoms of a heart attack, including: chest discomfort (uncomfortable pressure, squeezing, fullness or pain) that lasts more than a few minutes, or that goes away and comes back, pain or discomfort in one or both arms, back, neck, jaw or stomach shortness of breath, sweating, nausea, vomiting, or feeling lightheaded associated with chest discomfort.
- Sleepwalking can happen with CHANTIX, and can sometimes lead to behavior that is harmful to you or other people, or to property.
- Allergic reactions can happen with CHANTIX. Some of these allergic reactions can be life-threatening.
- Serious skin reactions, including rash, swelling, redness, and peeling of the skin. Some of these skin reactions can become life-threatening.
- Stop taking CHANTIX and get medical help right away if you have any of the following symptoms: swelling of the face, mouth (tongue, lips, and gums), throat or neck, trouble breathing, rash with peeling skin, blisters in your mouth.
- The most common side effects of CHANTIX include: nausea, sleep problems (trouble sleeping or vivid, unusual, or strange dreams), constipation, gas, vomiting.[1]

And here's the problem. We can't accurately predict who will and won't 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 Pfizer marketing suggests.

Three randomized clinical trials pitted varenicline against NRT: Aubin 2008, Tsukahara 2010, and Dhelaria 2012. In each, varenicline failed to show statistical significance over NRT when looking at the percentage of quitters within each group who were still not smoking at 24 weeks.[2]

The Aubin study notes that two varenicline users experienced severe depression, with suicidal ideation causing one to be hospitalized 11 days after ending use. It found that among 376 Chantix users and 370 patch users that the likelihood of a Chantix user experiencing vomiting was 5.5 times greater, that decreased sense of taste was 5.3 times greater, abdominal pain x5, disturbances in attention x4.5, nausea x4, flatulence x4, constipation x3, headaches x2, dizziness x2, diarrhea x2, with 2.3 times as many Chantix users complaining of fatigue.

Does it make sense to assume all these risks without a significant increase in your odds of success?

England's "Stop Smoking Services" (NHS SSS) may offer the most comprehensive government-sponsored cessation services of any nation. Services include free individual or group counseling and support.

A 2008 study analyzed NHS SSS program performance. It found that at four weeks after starting varenicline use (Champix in the UK) that 63% of 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 the use of any product.[3]

While at first blush it appears 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.

A 2005 English study examined one-year NHS SSS success rates but didn't include varenicline (Chantix in the UK) as it wasn't yet on the market.[4] It found that while 25.5% of those who attempted to stop without using any pharma product were still smoke-free at one year, only 15.2% of NRT users and 14.4% of bupropion (Zyban) users were still not smoking.

Can you see why I've been concerned since 2008, when Chantix first failed to prevail over NRT, that it could be undercutting cessation and costing lives?

What about more recent real-world Chantix success rates? Two key factors in valuing quitting methods are its productivity and effectiveness.

The July 2018 PLoS One Weaver study was the most comprehensive population-level quitting method study yet. There, according to Table 7 data, cold turkey generated 5 times more ex-smokers than all approved quitting products combined, while being twice as effective as Chantix and Zyban combined, 3 times as effective as NRT, and 2.6 times as effective as e-cigarettes.[5]

Joel has written extensively on pharma industry cessation products. He was warning about nicotine gum's ability to foster relapse or become a crutch as early as 1984.[6]

Joel encourages those contemplating using industry products to take their own poll of all successful long-term ex-users who have remained nicotine-free for at least a year.[7] He encourages us to believe our own survey findings.

But don't ask Ray Liotta how he quit. Remember his 2018 Chantix commercials? "Hi, I'm Ray and I quit smoking with Chantix."

Well, there's just one problem with that. Ray's 2016 social media posts indicate that he stopped smoking in 2002, when Chantix wasn't approved for sale until 4 years later in 2006.[8]

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E-cigarettes: Unsafe & Unnecessary

As if keeping up with a pack and lighter wasn't enough, imagine not feeling comfortable leaving home until your e-cig battery is charged and its tank full of juice.

As if non-smoker stares and disdain weren't enough, reflect on how silly it looks to them that the cigarette has grown, with some nearly as big as a baby bottle, and often sucked just as hard.

E-cig user testimonials often start something like these:

1. "I tried going cold turkey and lasted about two days before a stressful situation proved my downfall."
2. "I smoked real cigarettes for over 15 years and had never been able to quit."
3. "I'd tried everything ... gum, patches, Chantix, you name it. I was even hypnotized once."

See the common thread? Each was a failure at quitting. But why?

I may want to bake cookies but without a recipe, trial and error could prove frustrating and messy.

And successful nicotine dependency recovery is really that simple. Notice, I didn't say "easy." It's as simple as reading, accepting, and applying the Law of Addiction (Chapter 2).

Most current e-cig users were smokers. Most were totally convinced that a key reason they continued smoking was for the aromatic smells and ultra-fine flavors experienced when inhaling fine tobacco.

"Come to where the flavor is!" This use belief fit snugly into years of Marlboro logo brainwashing.

What's mind-boggling is how quickly new e-cig users abandon this core use conviction. What's amazing is that even while selecting their e-cig juice nicotine level (0, 6, 12, 18, and 24 milligrams per 1 milliliter of e-liquid), most do so without being slapped hard by the epiphany that, no different from the alcoholic or meth addict, "I'm slave to a drug."

Is transfer from the deadliest nicotine delivery device to one where science doesn't yet know the long-term health consequences worthy of celebration? If buying the message being pushed by e-cig peddlers it certainly is.

Are e-cigarettes safer than cigarettes? Absolutely. Let's say that again. Absolutely. Are e-cigs unsafe?

Absolutely!

Forget for a moment that animal studies have linked nicotine to cancer promotion,[1] circulatory disease,[2] diabetes,[3] DNA damage,[4] fertility concerns,[5] and fetal harm.[6]

What if you were to become a slave to vaped nicotine yet unable to stop smoking?

A 2015 study found that 72 percent of the most dedicated e-cig users of all - the every-day vape bellowing e-cig tank users - are still smoking cigarettes too, as are 89% of daily pen-like e-cig users.[7]

Forget for a moment concerns about a lithium-ion battery exploding in your mouth or pocket, or nicotine poisoning of a child or pet who stumbled upon and toyed with your e-juice bottle. Like nicotine, vaporized e-juice sugars stimulate brain dopamine pathways.

Sugars are intended to be chewed, swallowed and digested, not inhaled into our lungs and transported to the brain within seconds.

Physiologically, once ready to reclaim your brain, how challenging will it be to say "no more" to dopamine "aaah" wanting relief sensations tied in whole or part to e-cig sugars?

Psychologically, forget for a moment all the new conditioned use urge triggers created by being able to vape in places where you couldn't or didn't smoke. How difficult would it be to eventually stop using e-cigs if deeply convinced that vaping is safer than smoking?

How much of the motivation to quit smoking is rooted in life-threatening concerns about smoking-induced cancers, emphysema, strokes, or heart attacks: 10%, 25%, 50%?

Neo-nicotine industry marketing uses smoking's risks to prey upon the never-ending cycle of wanting within a chemically enslaved mind. It sells risky as safe, bondage as freedom, and electronically fed drug addiction as new, exciting, and fun.

What it cannot tell you is this. What are the long-term health risks associated with inhaling vaporized nicotine and a wide array of e-cig additives and flavorings into lungs already damaged by years of smoking?

What it won't tell you is that nearly all comfortably recovered nicotine addicts arrested their chemical dependency by going cold, via abrupt nicotine cessation.

What it will never volunteer is that nicotine withdrawal peaks within 3 days of ending use, or that being free, home, calm and comfortable is infinitely more wonderful than feeding a never-ending chemical need, an urge that will demand satisfaction every waking hour of every day until silenced by death.

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Negative Support

*"If this is what you're like not smoking,
for God's sake, go back!"*

*"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."*

Negative support is likely what got you here. Years later, why let it keep you here?

No person's comment, look, laugh, stare, or offer can destroy our freedom. Only we can do that. According to Joel, most of the time the person making comments or offers such as these have not considered their implications.[1]

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

"Of course, if analyzed by any real thinking person, the comment won't be made, because most people recognize that chemotherapy is a possible last-ditch effort to save the other person's life. The decision to stop the treatment is a decision to die. So we put up with the bad times to help support the patient's effort to save his or her life."

What's often overlooked, reminds Joel, is that stopping smoking too is an effort to save their life.

"While others may not immediately appreciate that fact, the person stopping has to know it for him or herself. Others may never really appreciate the concept, but the person stopping has to."

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

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

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

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

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

"How many times did a family member ask you to stop smoking and you never listened? Well if you don't stop for them, you don't relapse for them either. You stop for yourself and you stay off for yourself."^[1]

"Here, have a cigarette!"

"I left a pack on the kitchen table."

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

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

Innocent offers of a cigarette or e-cig are far different from malicious ones.

If well-meaning, use the opportunity to educate the person as to the fact that you are a nicotine addict, that you're in recovery, that most smokers end up smoking themselves to death, and that you'd appreciate their support, including not offering or leaving cigarettes or e-cigs laying around.

When declining cigarette offers don't say "No thank you, I can't have a cigarette," suggesting that you really wish you could but that you're depriving yourself of great joy.

As Joel notes, the truth is, you can inhale nicotine and relapse anytime you want. But there's a catch, there's no such thing as just one. Just once and we must accept the consequences of relapsing to our full addiction and going back to our old level of consumption.[2]

An analogy shared by one of Joel's clinic participants, "saying 'I gave up smoking,' is like a recovered cancer patient saying 'I gave up cancer.' You don't give up cigarette smoking, you get rid of it." Instead, we could simply say "I choose not to smoke." [2]

What if you've already politely made the person aware that you're in recovery and they persist in making offers?

Joel recommends that you "look at the person, maybe even with a little bit of sadness and defeat in your eyes, and say to him or her that you can't take the pressure anymore and sure give me a cigarette if you must. When he or she hands you the cigarette, walk over to the nearest garbage can, crumble it up and throw it out." [3]

What happens next? As Joel shares, you can either say nothing and wait to see if they learned from the incident or say, "Thank you, that felt great. Would you like to give me another one?"

"If the person is gullible enough to offer you another, take that one too and repeat the destruction and disposal. Keep it up for as long as the person keeps offering. At some point, you may want to say that this could go a whole lot faster if you would like to give me your pack. You can destroy all of the cigarettes that way in one fell swoop."

What if they leave their cigarettes, e-cig, or other tobacco product lying around after you've kindly asked them not to. Although this sounds harsh, destroying them sends a loud and clear message.

If feeling the need, offer the money needed to replace what you destroyed, letting them know that you're fighting to reclaim your freedom, health, and life and that you'd appreciate their support.

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

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 nearly 20 years.

Don't misconstrue this. It's not a smart move for someone struggling in early recovery to keep cigarettes on hand. In fact, as reviewed in Chapter 5, it's insane.

But if a family member or best friend smokes, vapes or uses tobacco, or our place of employment sells tobacco or allows smoking around us, if a cashier who sells cigs or a waitress or bartender who cleans up after smokers, we may have no choice but to immediately confront and begin extinguishing tobacco

product, smoke, smoker, and vaping cues.

And, just one recovery opportunity at a time, it's entirely do-able!

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

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

And millions more broke free while their husband, wife, mother, father, child, partner or best friend smoked or vaped like a chimney.

Feeling teased is a normal early recovery emotion. As Joel notes, whether happenstance or intentional, temptation cannot destroy our glory. Only we can do that.

Recovery is about taking back life, not fearing it. Strive to savor, relish, and embrace reclaiming it.

Instead of hiding from the world, speak out, stand up, and take it back. Don't allow negative support to wear you down.

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Breathing Secondhand Smoke or Vape

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

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

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

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

that nicotine was present.

The average of three studies reporting cotinine levels in the saliva of smokers was 260 ng/ml in women and 337 ng/ml in men.[1] Ng/ml stands for nanograms per milliliter. A nanogram is one billionth of a gram and a milliliter is one-thousandth of a liter.

A 2006 study used spectrometry (a scope that measures wavelengths or frequency) to analyze cotinine levels of non-smokers after spending 3 hours in a smoke-filled bar.

Although they experienced an 8-fold increase in cotinine levels, their total average increase was still only 0.66 ng/ml or a little more than half of a nanogram.[2] That's nearly 400 times lower than the 260 ng/ml found in the saliva of female smokers in the above study.

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."[3]

What about inhaling secondhand e-cigarette vapor instead of cigarette smoke? A 2014 study found that, as with cigarettes, e-cig cotinine levels were roughly 100 times lower in exposed non-users than commonly seen in smokers.

"We did not find statistically significant differences in cotinine concentrations from the non-smokers exposed to e-cigarette vapour versus those exposed to tobacco smoke. This is also in agreement with a laboratory study from Flouris et al (2013) that found that e-cigarettes and tobacco cigarettes generated similar effects on serum cotinine levels after a passive exposure of one hour (2.4 vs. 2.6 ng/ml respectively)."[4]

An e-cigarette industry marketing ploy is to entice teens and comfort e-cig users by teaching them that nicotine is also found in nightshade vegetables (tomatoes, potatoes, eggplant, and peppers).

A 1999 study of nicotine in nightshade vegetables found that "on the basis of the observed concentrations and the respective food consumption data for different countries, a distributive analysis of the results suggests that the mean daily dietary nicotine intake for the population of the countries for which consumption data were available is approximately 1.4 micrograms per day."[5]

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

Still, a critical fact that bears repeating is that just one puff of mainstream nicotine is enough to stimulate up to 50 percent of the brain receptors that sustain nicotine addiction.[6] And once "cheating" rings dependency's bell it cannot be unrung.

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

According to Joel, "as far as secondhand smoke and nicotine go, 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." [7]

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

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

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

What they're saying is, "I'm so concerned about a risk that is many times less than I used to face, that I'm going to relapse back to the greater risk and take a 50% chance that I'll smoke myself to death 13 to 14 years early.[8]

Such thinking makes you wonder why it never, ever occurs to non-smokers to take up smoking for the same reason. Such logic only makes sense to 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 such smoke-screen junkie-thinking obscure the path home? Just one challenge at a time "endeavor to persevere," strive to see through it!

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Bad Days & Disturbing Dreams

Have you had a bad day yet?

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

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

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

As Joel teaches, if the bad day happens during the first week after ending nicotine use then feel free to blame recovery as "it is probably the reason." "But as time marches on you need to be a little more discriminating."

Acknowledge bad days but allow your healing to live.

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

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

And imagine all the bad days they'll force loved ones to endure if among the 50% of U.S. adult smokers losing an average of roughly 5,000 days of life.[1]

All this talk about bad days, let's talk about what's really happening. This next paragraph is the "conclusion" from a 2014 study that combined the results of 26 studies that assessed the mental health of smokers and ex-smokers.

"Smoking cessation is associated with reduced depression, anxiety, and stress and improved positive mood and quality of life compared with continuing to smoke. The effect size seems as large for those with psychiatric disorders as those without. The effect sizes are equal or larger than those of antidepressant treatment for mood and anxiety disorders."[2]

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

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

Nightmarish Smoking, Dipping or Vaping Dreams

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

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

Picture a horizontal body of a new ex-user as they sleep during the early days of recovery. Mouth and throat tissues suddenly begin healing and re-sensitizing after years of being deeply marinated in nicotine, flavorings, or toxin rich tobacco tars.

If a recovering smoker, picture the sweeper brooms lining lung bronchial tubes (your cilia) quickly regenerating and beginning to sweep mucus and tars up to the back of your throat. Add to that, rapidly healing and substantially more sensitive senses of smell and taste.

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

The dreams that seem to cause the most concern are those that occur later in recovery, weeks, or even months after full acceptance that this time is for keeps.

Although nearly always described as a "nightmare," they are sometimes mistaken by the ex-user as a sign that, deep down, they want to start using again.

It's here that we point out the obvious conflict. If a nightmare and not real, then why would any rational person want to invite their nightmare to become a real and destructive part of daily life? As Joel notes, seeing smoking as a nightmare is a healthy sign.

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

And as for having smoking dreams long after ending use, such dreams are normal, yet not nearly as

vivid as during the first week or so.

We can no more erase from our mind our thousands of old nicotine use memories than we can our name. They reflect who we once were. What's amazing is that such dreams happen so infrequently.

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Recovery Weight Gain

According to the Surgeon General, about half of smokers believe that smoking nicotine helps them in controlling their weight. The obvious question becomes, do weight-concerned smokers endorse exaggerated beliefs associated with nicotine suppressing body-weight?

Research suggests they do.[1] It also suggests that education may help correct exaggerated weight control beliefs, making recovery more inviting.

Sadly, escalating weight gain can gradually erode recovery motivation to the point of making 50% odds of the average smoker losing 13-14 years of life seem more appealing than another pound.

There, it's critical to note that a female smoker who is 64 inches tall (163cms) would need to gain 93 pounds (42kg) before experiencing the elevated risk of chronic heart disease generated by smoking.[2]

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." [3]

For many, initial weight gain associated with nicotine cessation can be frightening. It isn't unusual to see up to 5 pounds of water retention weight gain during the first week.[4] It's normally associated with physiological changes and the pounds are easily and quickly shed.[5]

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

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

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

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

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

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

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

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 others necessary for life are synthesized or created.[6]

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." [7]

Addicted to a fight or flight stimulant which activates hypothalamus acetylcholine receptors, nicotine prepares the body to fight to the death or run for its life.

Will arresting our addiction decrease our BMR, resulting in 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." [8]

But 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." [9]

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

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

A 1991 study found slightly greater weight increases than reported by the Surgeon General (2.8 kg or 6.2 lbs in men and 3.8 kg or 8.3 lbs in women). But it also found that while smokers weighed less than never-smokers before commencing recovery, "they weighed nearly the same" at one-year follow-up.[10]

Echoing that finding, while a 2009 study found average cessation weight gain of 3 kg for women and 5 kg for men, it found "no significant differences in weight gain over the 11-year period existed between never smokers and former smokers who had stopped at least five years ago." [11]

Theories as to potential causes are many[12] including genetics,[13], metabolic changes, hand to mouth oral gratification replacement, improved senses of smell and taste (most notably sweets and salts), diet changes, substituting food for nicotine in stimulating dopamine release, diminished exercise (isolation), and binge eating.[14]

It isn't easy pinpointing the cause for consuming or burning even one extra calorie, especially when our metabolism naturally slows a bit more, each and every year.

Also, keep in mind that study weight findings reflect averages. As seen above, up to 4% clearly go hog-wild with food during recovery. Also not reflected by averages is the fact that body-weight remains unchanged for many, while actually declining for some.

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

As a general rule, it takes 3,500 extra calories to add one pound of body weight, and burning 3,500 to shed a pound.

A study of 6,569 middle-aged men who stopped smoking found that at one year they consumed an average of 103 fewer calories per day, which the study attributed to metabolic change.[15]

While a slower metabolism means fewer calories burned by a more relaxed body, millions of ex-smokers offset potential weight gain by putting recovery's gifts to work (their enhanced blood flow, increased oxygen levels, and improved lung function).

How to gain lots of extra weight

Recovery heralds an end to both nicotine's arrival and replenishment's "aaah" wanting relief sensations. Some find themselves camping out inside the refrigerator or potato chip bags where they "aaah" themselves sick with food.

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

Why do the 4 percent who go-hog wild continue such destructive behavior to the point of having nothing to wear? I suspect that few had any understanding of the dopamine pathway relationship between food and nicotine.

While normal healthy eating stimulates dopamine, during the first few days of recovery, stimulation from normal eating may not be sufficient to satisfy the wanting being felt.

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

Still, some try. Instead of allowing the brain time to restore natural dopamine pathway receptor counts and sensitivities,[16] it's as if the up to 4 percent gaining more than 20 pounds attempt to make their brain's dependency wiring operate on taste's "aaah" influence instead of nicotine's.[17]

A 2012 study used brain-imaging studies to contrast eating food to smoking. It found that "food and smoking cues activate comparable brain networks" and "there is significant overlap in brain regions responding to conditioned cues." [18]

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

The saddest part about attempting "aaah" relief replacement using large quantities of extra food is that, should the addict use their demoralizing weight increase as justification for relapse, the extra pounds are likely to remain.

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

Now, instead of the former smoker's bloodstream being filled with oxygen reserves sufficient to allow prolonged vigorous physical activity, the significantly heavier relapsed smoker feels the effects of an oxygen-starved bloodstream that is once again occupied by large quantities of toxic carbon monoxide. Instead of extra pounds being counterbalanced by greater self-esteem and self-worth at having broken free, the relapsed addict is heavier, less healthy and likely more depressed.

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

Binge eating

Binge eating reflects a loss of control, that is, being unable to stop eating or control what or how much food is consumed.[19] The primary psychological binge-eating cue is waiting too long before eating and sensing the onset of hunger.[20]

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

As mentioned, there is substantial overlap between eating and dependency pathways. Former smokers who relapse to smoking often report an increase in the amount smoked, over the amount smoked prior to their attempt.

Akin to binge eating, it's as if their brain goes into starvation mode upon relapse and begins hoarding nicotine, resulting in establishment a higher level of tolerance and need.

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

So, what happens when nicotine is no longer there? Can the addition of hunger cravings atop early nicotine withdrawal result in binge eating? Research suggests that it may be more of a concern for those having a high BMI.[21]

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

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

It is critical that we quickly re-learn how to properly fuel our body. Trial and error, it may take a bit of practice. But we should expect to confront hunger if we insist on skipping meals.

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

satisfying hunger sooner.

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

But what if you forget to eat and hunger arrives? If you should find yourself reaching for extra food, reach for healthy, low-calorie foods such as fresh vegetables and fruits.

It's best to have them washed, pre-cut and in the refrigerator in a bowl of cold water, available and ready to eat within seconds of need.

Fear's unburned calories

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

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

Bodyweight will climb if the amount of daily energy expended substantially declines, while the number of calories consumed remains the same or increases. Also, consider that 12 of 15 studies since 2006 have found that exercise reduces smoking cessation cravings.[22]

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

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Recovery Weight Control

Reaching for a Zero Calorie "Aaah"

The cornerstone of our dependency was nicotine's ability to release dopamine and briefly end wanting. And yes, an extra mouthful of food also provides a short-lived burst of dopamine (see Chapter 1). But reflect on how many times and how long each day that you devoted to nicotine use.

What if, day after day, you started reaching for and eating extra food as often and long as you reached for and used nicotine? Clearly, consuming extra food as a compensation crutch for missing nicotine would be a "huge" mistake.

Most researchers classify increased eating as a symptom of nicotine withdrawal.[1] If so, it's clearly one within our ability to minimize.

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

Give your favorite person a big, big hug. Feel it then, too? Take your normal walk, even if just around the yard but this time go a little further or a little quicker than normal. Do you feel accomplishment's "aaah"?

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

Reach for the healthy zero calorie "aaah."

Picking mealtime

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

Instead of eating large meals, consider eating little and often to enhance appetite control. One study found that eating more often resulted in 27% fewer calories being consumed.[2]

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

Ending Mealtime

Many of us conditioned our minds to believe that eating was complete and mealtime was over by inhaling nicotine or tasting tobacco within our mouth. Now, without a new cue, there may be no clear signal to our brain that our meal has ended. It could result in reaching for extra food with zero leftovers.

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

Diminishing body weight

A "diet" is a temporary program for losing weight, which by definition ends, hopefully when a weight loss goal is achieved.

A 2020 study review examined 121 weight loss studies involving 21,942 patients that participated in 14 named diets. It found that most diets "over six months result in modest weight loss and substantial improvements in cardiovascular risk factors, particularly blood pressure. At 12 months the effects on weight reduction and improvements in cardiovascular risk factors largely disappear." [3]

The key to sustained weight control isn't dieting. Instead of a weight loss goal, it's in committing to minor changes in our daily calorie intake or activity level that become a routine part of the fabric of daily life.

Involving the same brain dopamine pathways taken hostage by nicotine, relapse prevention mindfulness is as important to lasting weight change as it is to never taking another puff, but with a huge difference. An eating or activity lapse now and then doesn't all but guarantee relapse.

So then, how? How do we use the same mindfulness skills that helped free us of nicotine to alter activity or intake? First, let's look at how too much dedication can backfire.

If shedding a pound of body weight requires expenditure of 3,500 calories, attempting to burn all 3,500

during a single day is likely to leave us tired and sore. It's likely to discourage us from being active again tomorrow.

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

It can be exercise or a bit more of any physical activity that we enjoy, like, or love.

Consider gardening, walking your favorite path, visiting or caring for a neighbor, extra house or yard work, a lap around the block, a bike ride, or any other activity that expends energy.

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

If we also consumed 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 (5.44 kilograms) within a year!

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

Small adjustments can be made anytime. As mentioned, we can eat more can result in eating less, focus upon, savor and chew each bite longer, take just one less bite, get comfortable leaving something on our plate, use a tad less butter, choose baked over fried, make plants the foundation of every meal, better portion control, use a smaller plate, cook less food, eat one cookie (50 calories) instead of two, stop eating after a certain hour (7 pm), plan tomorrow's meals today, eliminate evening snacks, or trade empty carbohydrates for longer-lasting ones.[4]

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

If already impaired or disabled by smoking, your physician should be able to help in developing an increased activity or exercise plan tailored to your abilities, even if done while on oxygen, in a wheelchair, or in 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 is slowly on the rise.

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

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

What if it doesn't work?

But what if your dopamine pathways seemingly refuse such simplicity when it comes to activity and food?

I could close by saying that I'd rather be slightly bigger and alive, than a tad smaller but dead. While true, let me suggest mindfulness training that may aid in pulling back and looking behind the weight-control curtain.

Like the hum of a well-working engine or the purr of a kitten, what if you could train yourself to sense and have a good idea of your blood sugar level (glucose reading) when feeling your best or most productive, or just prior to feeling hungry, or before over-eating?

First, you need to involve your family doctor in this suggestion as everyone's health and blood glucose histories differ, including 30 million in the U.S. with diabetes, with 8 million as yet undiagnosed.

As the American Diabetes Association (ADA) teaches, "It's important for blood glucose levels to stay in a healthy range. If glucose levels get too low, we can lose the ability to think and function normally. If they get too high and stay high, it can cause damage or complications to the body over the course of many years."

Blood sugar or glucose meters and test strips are cheaper than cigarettes or e-juice and available to all over-the-counter.

Does it make sense to eat when the meter says that our blood is already overloaded with glucose?

Is the urge you're feeling to eat the result of a true need for food? Does your body need breakfast right now or will you eat out of habit? How does your walk or bike ride affect your blood glucose? Which foods spike your blood sugar and which are longest lasting in helping keep it most stable?

What if you were able to share with your doctor a 30-day journal of your glucose readings upon waking each morning, before a meal, after eating, before exercise, after exercise, and before bed?

What if your journal also documented the types and amounts of food you consumed, the times you'd eaten, your body weight each morning or before bed, and your energy level and thinking clarity?

Armed with such insights, imagine the quality of the feedback your doctor could provide.

Growing sensitivity and awareness of what true calorie need feels like, and which foods serve you best, I suspect that it won't be long before you're able to predict the reading on tomorrow's bathroom scales.

Again, the goal is mindfulness and awareness which aids in making lasting change, not yo-yo dieting.

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Menstrual Cycle Considerations

A woman's menstrual cycle lasts an average of 28 days. A complex interaction of hormones causes 80 to 90 percent of women of childbearing years to notice some degree of physical, psychological, or emotional change related to their menstrual cycle.

The most profound symptoms are known as "premenstrual syndrome" or PMS. PMS normally occurs between menstrual cycle days 23-27, subsides once menstruation begins, and is experienced by 30-40 percent of reproductive-age females.[1].

While most experience mild to moderate discomfort, and symptoms don't interfere with their personal, social, or professional life, 5% to 8% experience premenstrual dysphoric disorder (PMDD) and have moderate-to-severe symptoms that can cause significant distress and functional impairment.[2]

PMS and PMDD symptoms can include constipation, diarrhea, bloating or a gassy feeling, breast tenderness, cramping, headache or backache, clumsiness, lower tolerance for noise or light, irritability or hostile behavior, feeling tired, problems sleeping (too much or too little), appetite changes, food cravings, trouble with concentration or memory, tension or anxiety, depression, feelings of sadness, or crying spells, mood swings, and less interest in sex.[3]

It's why this is an important nicotine cessation topic because no one needs to be left behind, including women experiencing PMDD.

The menstrual cycle can be broken down into two primary segments, the follicular and luteal phases. The follicular phase announces the first day of a woman's cycle, normally lasts 2 weeks, starts with the period of menstrual bleeding, and ends at ovulation.

The luteal phase commences at ovulation, normally lasts two weeks, and ends the day before the next period. The second week is where premenstrual symptoms, if any, are normally encountered.

So here's the often asked question. When is the best time to stop smoking, vaping, or using other nicotine products, during the follicular phase or the luteal phase? Which offers the best odds of success?

The answer may surprise you.

While study findings have been conflicted and mixed, with some finding no difference, some declaring follicular the winner, and others the luteal phase, most had few participants or involved participants toying with NRT or using other chemicals known to stimulate brain neuro-chemicals.

The largest raw study to date was published in 2008, offered counseling only, excluded women using nicotine from sources other than cigarettes, and the findings included 100 percent of the study's original participants (intent-to-treat analysis).

The study's primary aim was to determine whether the menstrual phase during which a woman attempts to stop smoking affects her risk of smoking relapse.

A total of 202 women were randomly assigned to either commence recovery during the luteal phase or the follicular phase. They tracked their menstrual cycle prospectively and were told to either stop smoking between follicular days 4 and 6 or between luteal days 6 and 8. Day 1 was defined as the first day of their period.

The results? After 30 days, 34% of women who started during the luteal phase were still not smoking, compared to only 14% who started during the follicular phase.[4]

Yes, you read that correctly, the luteal phase. The researchers were shocked too. "Our original hypothesis is not supported by the results."

But why? Although poorly understood, is it likely that women already knew how to get as comfortable as possible being temporarily uncomfortable during their premenstrual days?

Withdrawal peaking and beginning to improve within 72 hours of ending use, imagine beginning to feel better and it happening during the luteal phase.

Is it possible that, for some, nicotine withdrawal is actually easier when combined with expected and normal PMS symptoms that may have included varying degrees of irritability, sleep disruption, appetite changes, food cravings, trouble with concentration, tension, anxiety, depression, feelings of sadness, crying spells, or mood swings?

The question now being asked is, is addiction to smoked 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.[5]

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

When is it best to face challenge? Early on or delay it? As Joel often states, commencing recovery during a period of significant anxiety increases the odds that anxiety will never again serve as an excuse for relapse. Keep in mind that the smoking woman's subconscious has likely been conditioned to reach for a cigarette during specific menstrual cycle hormonal or symptom related events. But take heart!

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 will likely 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, WhyQuit's first cold turkey support group.[6]

"Go back one month and see how many of the women 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." [7]

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

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"Help me, I'm pregnant and smoking!"

Please God, allow her to see the way home. Awaken her to the realization that by filling the beautiful, beautiful brain you gave her with knowledge and understanding, that she can easily become vastly wiser than her dependency is strong.

Are you feeling a "fierce urgency of now" because of a developing life within? Do you fear that your chemical dependency will harm or destroy it? For nicotine addicts, especially smokers, news of pregnancy is often an emotional train wreck.

Why "Quitting for the Baby" Fails

Upon learning she's pregnant - often within minutes - the mother-to-be makes the biggest mistake of her pregnancy and life. Instead of accelerating her personal long-held dream of someday breaking free, she decides to "stop for the baby."

But how can something that sounds so right be so destructively wrong?

Only about half of women "claim" they were successful in ending nicotine use during their pregnancy.[1] Sadly, the real figure is probably closer to a third.

Researchers conducting third-trimester blood tests on women who claimed to have stopped smoking found that 25 percent lied.[2] But why do so few succeed?

Stopping for others, including the unborn, is a formula for relapse.[3]

It means spending an entire pregnancy either feeling deprived of smoked, vaped or chewed nicotine, or gradually growing numb to the fears of harm that the fetal teratogen and developmental neurotoxin nicotine

will inflict, and eventually surrendering to it.

What logic is there in making this "the baby's" recovery instead of its mother's? Stop for the baby?

Is it the baby who needs help or a mom-to-be who for years has been destroying her insides and committing slow suicide by many times daily inhaling smoke's hundreds of tissue-damaging toxins?

If only she had to wear on the outside the damage already done within.

Why feel deprived and denied when you can reclaim, award, and bestow? Why invite reluctance and dread to defeat confidence, freedom, and wonderful?

And it's true. Being home again is vastly more incredible than an addict's endless dopamine wanting/use cycle allows them to remember or sense. A hallmark of addiction, it's a cycle that long ago buried all memory of the tranquility of life as you.

The choices? Choice "F"? Envision every waking hour of your pregnancy either battling or surrendering to urges and wanting for smoked, vaped, or chewed nicotine.

Choice "A"? Visualize a temporary journey of re-adjustment which leads to Easy Street; to the beginning of entire days where a calm and quiet mind never once thinks about wanting to use.

"Quitting for the Baby" Stories

Assume for a moment that you were able to stop "for the baby." No longer in harm's way, will the precious seconds surrounding childbirth be soured by fixation upon relapse?

Instead of savoring life's richest moments, will you be plotting the toxic act that will substantially shorten both your life and motherhood?

During delivery, will you get hammered hard by the use-cycle delusion that smoking is a stressbuster? Will each contraction and push birth thoughts that you've sacrificed long enough, that the danger of harming the baby is about to end?

Can you see how months of feeling pushed, robbed, deprived, forced, or compelled to stop "for the baby" makes pregnancy cessation vastly harder and far more unlikely?

The harsh truth? Doing it "for the baby" may as well be an open declaration that, "Hey, this child is going to have an actively feeding drug addict for a mom!"

These are quotes from e-mails I received. Most show where a "quitting for the baby" mindset leads:

- "I am 33 years old. I started smoking at age 13 and of course, never thought I would still be a smoker 20 years later, and a pack to a pack and a half each day. I stopped for nine months while I was pregnant and could not wait for the entire pregnancy for just one cigarette. The minute I was home from the hospital I started again."
- "I stopped smoking each time I found out I was pregnant, but right after they were born I was back to a pack a day."
- "I'm 38 years old with three children and have smoked since I was 17, stopping when pregnant only

to re-light within hours of giving birth."

- "I started smoking at 13 (well I couldn't draw back like all the other girls) but by the time I was 14, I was smoking at every opportunity. The only time I stopped smoking is whilst I was pregnant and breastfeeding. Then, as soon as my babies weaned, I started again."
- "When I was pregnant with my first child I gave up smoking as soon as I found out, the same for the second pregnancy. My mistake is I started back up. I'm stopping smoking today even though I'm about to wean my daughter."
- "My daughter is 5 months pregnant and still smokes occasionally. Actually I don't know how much she smokes. For someone who is trying to be so protective of her unborn child, she isn't. She is an intelligent person but putting her baby at risk."
- "I am concerned about my neighbor's smoking. She is pregnant again but still smokes. She was smoking while pregnant with her 1st son who is 4 years old now and deaf."

Approximately half of women who stop smoking during pregnancy relapse within six months of giving birth.[4] Adding it all up, it means that, unbelievably, only about 1 in 5 women who smoked at conception will experience the joys of smoke-free motherhood.

It means that 4 out of 5 babies are forced to bond to the thousands of smoke chemicals deposited upon mom's hair, skin, and clothing.

Imagine your baby feeling extremely comfortable in the arms of a smoker off the street, especially one who smokes your brand. Imagine your newborn never knowing its mother's natural scent and fragrance.

As these email quotes suggest, the reasons given in trying to justify relapse after childbirth vary greatly:

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

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

Nicotine-Free Motherhood

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

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

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

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

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

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

Their dream obliterated by fear, some are able to temporarily suspend use for the benefit of the fetus while others do not. Those that don't are forced to invent new nicotine use rationalizations in order to suppress the harms being inflicted. Here are two e-mail examples.

- "My daughter just found out that she is pregnant and she smokes. She was going to just stop but then a midwife told her that if she did, her fetus would go into shock and that she should just taper off."
- "I did attempt to stop when I found out I was pregnant the first time, but after thinking about all the people I knew who smoked while pregnant and had normal kids, I kept right on smoking." "I kept my mouth shut, as I had lied to the doctor and the hospital about smoking."

There's also the rationalization that "stopping for the baby is just too hard." And this one is true. Whether attempting to quit for the father, your doctor, a parent, or best friend, the challenge is vastly greater when trying to quit for others.

Think about the day-to-day agony and anxiety endured by these women. Imagine the disapproving stares and verbal abuse by those who notice them smoking. Society's disdain only heightens focus upon quitting for others, including the baby.

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

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

As for the third woman, her fear of withdrawal is normal and natural. Years of being able to satisfy an urge or crave within seconds of smoking conditioned her to fear holding out longer.

What thousands of old urge satisfaction memories (dependency's bars) prevent her from seeing is that the

only path to permanently ending wanting for more is in mustering the courage and commitment to say "no" to it.

Recovery

What's difficult to appreciate is that recovery is good and wonderful not bad. While true that increased estrogen is causing nicotine to be eliminated from the bloodstream faster than normal, thus increasing the need and desire to replenish,[5] within 3 days of ending use withdrawal will peak in intensity and then begin to gradually decline.

The period of greatest challenge will have passed.

Within 2 to 3 weeks, the brain will have substantially completed restoring neurotransmitter sensitivities and counts. Although the tease of thousands of old nicotine replenishment memories will continue to be felt, those memories were created by and belonged to an actively feeding drug addict whose blood-serum nicotine reserves were always on the decline.

Truth is, after that, the balance of recovery is nearly all psychological, as there is nothing missing and nothing in need of replacement.

By then, relapse would not match expectations. There will not be an underlying "aaah" wanting relief sensation as the brain had fully adjusted and nothing was missing.

But lapse would immediately re-fire dependency's engines. Nicotine drenched dopamine pathways would re-assign using again, the same priority as that circuitry assigns to eating food.

While most who attempt cheating when quitting walk away feeling like they've gotten away with it, brain scans show that just one puff and up to 50% of dopamine pathway receptors become occupied by nicotine. And it won't be long before the cheater finds their brain wanting, plotting to get, or even begging for more.

Additionally, the circumstances of lapse will be documented in high-definition memory, breathing life into thousands of old use memories that will, in the short-term (the time needed for recovery) make lapse nearly impossible to forget.

The expected "aaah" missing at the moment of lapse, her focus will instead turn to the sensations felt when scores of smoke toxins strike healing tissues, and carbon monoxide invades what was an oxygen-rich mind.

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

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

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

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

Valid Nicotine Harm Concerns

Let's not kid ourselves. The draw of quitting for the baby instead of you is huge. In fact, once pregnant it's impossible to avoid hearing how damaging smoking and nicotine are. So let's get it out-of-the-way now. Let's acknowledge fetal risks in order to drive home the point that fetal toxin harms will continue unless healthy motherhood dreams are put first.

As you read, reflect on a simple truth. Unless coming home and staying clean and free are embraced, the baby's quality time with its new mom will be constantly interrupted by an addict's never-ending need to replenish missing nicotine.

The late Dr. Heinz Ginzel was my friend, a physician, and a retired University of Arkansas pharmacology and toxicology professor. He devoted decades to the study of nicotine.

In researcher speak/talk, Dr. Ginzel was deeply concerned over "fetotoxicity and neuroteratogenicity that can cause cognitive, affective and behavioral disorders in children born to mothers exposed to nicotine during pregnancy." [6] This is his message to expectant mothers:

"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 smokers who would have stopped during pregnancy may begin using NRT throughout pregnancy."

"As a consequence, intelligence expressed by I.Q. standards may decline in their offspring, but as larger segments of the population are affected, this decline may not be readily discernible." [7]

Are you realizing the importance of making your #1 recovery priority "you," and allowing your baby to inherit the fruits of mom's wisdom? Still, given Dr. Ginzel's fetal nicotine risks review, it's easy to see why such a massive percentage of women make the mistake of "stopping for the baby."

Duke Medical University Professor Theodore Slotkin is probably the world's current leading nicotine toxicology researcher. He's deeply concerned that nicotine, including replacement nicotine, may cause as

much or more harm to the developing fetus than crack cocaine.[8]

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."[9]

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

In 2008, Professor Slotkin wrote that "nicotine by itself is able to reproduce the net outcome from tobacco smoke exposure; that is not to say that the other components are not injurious, but rather, the replacement of tobacco with NRT is likely to produce less improvement than might otherwise be thought, and as shown above, may actually worsen some of the critical outcomes."[10]

What does Slotkin think about nicotine altering normal fetal brain development, as discussed by Dr. Ginzel? A 2013 article quotes Professor Slotkin as saying, "It would be the equivalent of trying to play this piano piece and some clown comes along with a chunk of two-by-four and slams a bunch of keys down and holds them down."[11]

Vaping E-cigarettes

Research suggests that vaped nicotine is destructive too. Quoting from a 2019 journal article in Tobacco Induced Diseases: "[T]here is a growing body of experimental studies in animals that suggest that nicotine in electronic nicotine delivery systems alters DNA methylation, induces birth defects, reduces the birth weight, and affects the development of the heart and lungs of their offspring."[12]

Lifetime Regret

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

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

And what will the child say?

- "I hate, hate, hate cigarette smoking, secondhand smoke and smokeless tobacco! My mother smoked while she was pregnant (both times) and smoked until I was 17 years old. I was born with a

head tumor which continues to give me trouble after two surgeries and more than 35 years of life."

- "My mother smoked, even when pregnant with me. So I guess, being born that way, I've always been addicted to nicotine." "At age 22, my mother died of a sudden and massive stroke caused by hypertension, elevated by smoking. That's exactly what was put on the coroner's report. Even then, I kept smoking."

Liberty's Blessings

Are you sensing the importance of embracing recovery as your own loving gift of "you" to "you"?

Can you see that all fears of fetal harm are best and well served by celebrating pregnancy as a golden opportunity to reclaim your mind, priorities, hands, time, mouth, coins, lungs, emotions, health, freedom and life?

Now, together with these mothers, picture your new baby basking in liberty's blessings.

- "I am very happy to say that I have been nicotine-free for six months now! My kids have not missed any days of school this year. I have started to workout three times a week. I feel better. Most people tell me I look a lot better. My house and car are cleaner. I am so glad I stopped."
- "Now, although I still know I am an addict, I concentrate on keeping my recovery alive by celebrating my freedom. One thought I find very heartening is that I am doing "easy time." Compared with the first days, it is so easy for me not to smoke today. Most of the costs have gone, but I still get the benefits. Smoking is expensive in the UK, and so far I have saved £14,000 (that's U.S. \$27,500)! I save so much I can easily justify a weekend away on my annual stopping anniversary. Best of all, I have a 10 week-old son who has a smoke-free mom."
- "I had stopped with my previous pregnancies (three older daughters), but I picked it right back up again with ferocity. After each failure I increased my nicotine intake more and more. At 2 to 2 1/2 packs a day, I saw not much hope for an end. But this pregnancy scared me. Now, I was much older and this baby was counting on me to not just stop during my pregnancy, like with the sisters, but for the rest of my life. I visited WhyQuit and read, and read, and read. I finally learned WHY every time I had picked them back up again in my postpartum periods. I was still in post acute withdrawal. Riddled with anxiety, I did not approach stopping with a recovery mind-set but with a 'suspended sentence' on smoking. For our fifteenth anniversary, I gave my husband another daughter ... and a nicotine-free wife."

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

Among studies reporting new cases of depression arising after childbirth, 6.9% of 280 new moms in Israel reported postpartum depression at 6 weeks,[13] 12.5% among 1,584 Swedish women at 8 weeks, which declined to 8.3% by 12 weeks,[14] 5.8% among 465 Wisconsin women between months 1 and 4,[15] and 3.7% of 403 Minnesota woman during the first year following childbirth.[16]

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

It's believed to be associated with a large increase in progesterone-derived neuro-steroids during pregnancy,

and its sharp decline following childbirth, which may have significant effects on GABA receptors.[17]

Emerging research suggests that these receptors could be a path to effective treatment.[18] Clearly, what no physician on earth will suggest as a treatment course is relapse to the highly addictive, fetal teratogen nicotine.

As for replacement nicotine, even its most vocal advocates are forced to admit that, "there is no evidence that NRT is actually effective for smoking cessation in pregnancy." [19]

It's my hope that this article has helped alert you to the importance of knowledge and understanding as extremely effective recovery tools. The highest known pregnancy cessation rates continue to be associated with "counseling and behavioral interventions." [20] It's what I refer to as "smart turkey."

It's my dream that you'll continue reading and discovering, that you'll allow the magic unfold as your nicotine-free body heals, mends and repairs, while at the exact same time growing a healthy new life within.

Baby steps, just here and now, these next few minutes, yes you can! And there's only one rule ... no nicotine just one hour, challenge and day at a time!

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Freedom from Nicotine – The Journey Home

Originally released on January 1, 2009, the 4th revision was completed October 15, 2020. Individual book topics are shared below and a full 10.8MB 415 page PDF is available at WhyQuit.com/FFN.pdf.

All images have been removed from the following PDF chapters so as to make the files smaller and faster opening on mobile devices. All chapter topics (136) are available with images as [topic web pages](#) in HTML format.

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Only one rule. No nicotine today!

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