

Quit to Win



Tobacco Cessation Program

Navy Environmental Health Center, Health Promotion, 620 John Paul Jones Circle STE 1100, Portsmouth VA 23708-2111
voice (757) 953-0959 (DSN 377) Fax: DSN 377-0688; homepage: www-nehc.med.navy.mil/hp/tobacco/index.htm



Nicotine Addiction and Effective Treatment for Successful Recovery

Nicotine is a highly addictive drug most rapidly absorbed through the lungs. Much of the pleasurable effects of tobacco is due to its nicotine content. Smoked, sniffed or chewed, nicotine enters the bloodstream through lung or mucosa, quickly reaching the brain where it stimulates the reward system. No one begins to use tobacco to become an addict. Tobacco use helps concentration, suppresses appetite, perhaps improves memory, and enhances a sense of friendship with other tobacco users. Addiction happens insidiously over time, when tobacco use increases from one or two times a day to many times a day; when the user loses control, and smokes or chews just to get the nicotine; and when thoughts of use has become more obsessive-compulsive rather than pleasurable. For many addicted to nicotine, non-use for more than a few hours results in feeling irritable, being less tolerant to stress, being unable to concentrate, and increasing intense craving for relief. For many smokers, the best, most pleasurable cigarette is the first one in the morning, sometimes smoked within five minutes of getting up. After sleep, it may have been eight hours since the last cigarette and the body's



nicotine level is way below baseline, and that first cigarette, inhaled, rapidly brings things back to "normal". At some level, many tobacco users in this state understand they have lost control and they are using just to use, without pleasure, but not wanting to stop because change might be worse. Many have experienced that change through the need or desire to stop over several periods, such as during pregnancy or in an environment, like basic training, where tobacco use is prohibited.

Over the past year, most smokers have wanted to quit and many have tried. Among those who are addicted, many will succeed for a small period of time, then relapse, perhaps labeling themselves as "failures", becoming hesitant to try again. For other addictions, there are several dimensions that might be assessed in order to place the person at the right intensity of care to better assure a successful recovery. These dimensions include: 1) intoxication/withdrawal problems, 2) biological problems, 3) emotional/behavioral problems, 4) treatment acceptance, 5) relapse potential, and 6) recovery environment. For other addictions, a significant problem on any one of these dimensions is cause to intensify treatment if the

hope is for a successful outcome. There is also a general tendency to follow the "Stages and Transtheoretical Processes of Change" model in which willingness to change guides intervention strategies for people at the following stages 1) "precontemplation", 2) "contemplation", 3) "preparation", 4) "action" and 5) "maintenance". The remainder of this article will describe strategies to move people from one stage to the next, taking into account additional strategies that might be useful to increase the probability patients will successfully quit, even if initially resistant to try.

First step for any health care provider wanting to help: "Know your limitations" (and capability). Do you truly believe addiction is a disease, and that addiction by definition is an uncontrolled behavior manifested by obsessive/compulsive use? People addicted to nicotine know what it's like to be addicted and the provider who doesn't understand loses credibility. Do you know the treatment options available within the next hour; thinking of counseling services,





medication and social support networks? If you start asking the question, the tobacco user may wonder: Are you just asking, or do you really want to know and help? If you see yourself as unable to be truly helpful within context of an intervention, then learn to whom you might refer the patient, and liberally use the referral.

The second step, assuming you are going to effectively treat the patient addicted to nicotine, is to establish a tobacco use history quickly enough to proceed to the effective intervention. This normally should include an understanding of the current bio-psycho-social context of use and Stage of Change assessment, realizing that most all tobacco users might already know a lot about the dangers of tobacco use. Specifically, is the person using tobacco within 5 or 30 minutes of getting up; raising the need for potential medication for those that do. How many cigarettes is the smoker using per day; 5 or less is quite different than 10 or more. What are the temptations to smoke; location, specific activities (like eating), and significant others are important temptations. What are the benefits of tobacco use; weight

and stress control might be two important ones. What are the negatives of tobacco use; decreased aerobic capacity, the smell and cost may be very important.

The bottom line here is to determine how close a current tobacco user might be to quitting: 1) not thinking about it; a “precontemplator”; 2) thinking about it within the next 6 months (adult) or one month (adolescent); a contemplator; or 3) have tried to quit and planning to quit within the next month (a person preparing to quit). The assessment must also include those who have quit tobacco use to determine if they have: 1) just started taking “action”, but are only a few months into it and are not yet comfortable or



2) entered a maintenance stage where tobacco use is comfortably part of their past. With this knowledge, the provider can then start an intervention can have over a 50% probability for long term success for those who can be pushed into the decision to quit.

Going from the precontemplating” to “contemplating” stage:

It is at this transition that brief education might play the greatest role. The goal is not just to present information (most of which will already be known), but to make it specifically relevant to the nicotine user in a troubling way; raising a sense of cognitive dissonance. For example, most smokers know they are more physically fit and can run faster

than the non-smoking “nerds”, but internally, know they could do better themselves if they did not smoke. Many might not be aware that irritability and lack of concentration when tobacco is not used for a brief period is a withdrawal symptom and “reducing stress” is really early withdrawal treatment; no tobacco user likes being an addict. Most are aware of the impact smell might have on relationships they would like to have; and know that their tobacco-using significant others would be better off if no one smoked. Those contemplating quitting already have a strong sense that this is the “right thing to do” and that nicotine use is addictive.

Going from “contemplating” to “preparation” stage:

No one wants to be an addict and no one wants to use a drug that has gotten out of control. This is truly an attack on self-esteem and self-efficacy as a person. One can rapidly move from contemplation to preparation with this insight and that of course, “I can quit when I decide”. The paradox might be that quitting may be fraught with the potential for failure: even those who have quit for several years and relapse will see the entire effort as a “failure” even though there was clear success for three years. For many, even one day can be difficult. That one-day may, or three years must be re-framed in terms of success. Equally important with the realization that nicotine has become addicting is the hope that the quit attempt will be successful.

Addiction has been defined as a

chronic relapsing illness; however, the potential for relapse has much to do with the intensity of treatment offered, length of time treatment is available, and the presence of a positive social support network. Based upon what the health care system and provider network is willing to do will change long term abstinence rates from 5% for a given attempt to at least 50%. The provider must express a willingness to work with the patient through possibly many relapses in a non-intensive treatment approach, and can promise a high success probability for quitting when the most comprehensive approaches are available.

Going from “preparation” to “action” stage:

Using willpower will move the nicotine user to the “action” phase. This is an unpleasant move that affects the user’s entire life; subjecting many to withdrawal symptoms that will affect those around that person. Willpower alone may be insufficient to pull the user through more than a few weeks. Most relapses will occur within the first few months. Sheer willpower is not enough. The “ex-user” must become comfortable with the new lifestyle for long-term abstinence. It is within this time period, medication, such as nicotine patches/gum/spray or bupropion 150mg slow release tablets, can be especially helpful in dealing with withdrawal symptoms. Some may need medications for an extended period of time to remain physiologically

comfortable in the absence of tobacco use. Some might ask if it’s a good idea to give up other addictions as well; such as alcohol, marijuana, cocaine or heroin. The answer is “yes”. Many people with these other addictions frequently state that nicotine is the hardest addiction to give up. Successful quit attempts generally include healthy lifestyle changes.

Going from “action” to “maintenance” stage:

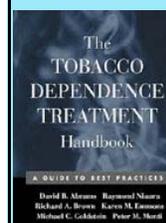
Enhancing successful abstinence for long periods requires healthy lifestyle changes across several dimensions; physical fitness, nutrition, weight management, spirituality, anger/stress management, establishing a healthy social support systems (perhaps new tobacco free friends), and living in an environment where tobacco use is not part of the culture. Many smokers will not smoke when it is not permitted at a specific site, but will smoke when possible later. Policies and medical advice might target external reasons to quit, such as during pregnancy or during military basic training, but not address internal motivation or reasons to do so. This may lull a provider into thinking that the person has actually been motivated to quit while, in the person’s mind, quitting (or stopping) will only be temporary. External reasons must be internalized and careful follow-up is indicated following the end of the external condition to assure the “quit attempt” has been incorporated into a healthier lifestyle, a tobacco-free environment with a supportive network of others who do not use tobacco.

As might be correctly surmised from reading this article, this approach might be applied to any one of a number of chronic diseases and conditions where lifestyle changes are needed to improve long-term prognosis and quality of life. Becoming expert in addiction treatment also provides the skills set needed to help any patient with a chronic problem achieve a healthier lifestyle and decrease morbidity over time.

Guest Editor

Ken Hoffman, M. D., MPH
Colonel Medical Corps, U.S.
Army Medical Director, MHS
Population Health Programs,
TRICARE Management
Activity, Co-Chair DoD
AATURC (Alcohol Abuse and
Tobacco Reduction
Committee), and Drug and
Alcohol Consultant to the
Army Surgeon General.

Recommended New Book



The Tobacco Dependence Treatment Handbook A Guide to Best Practices by authors Dr. David Abrams et al is

published by Guilford Press
<http://www.guilford.com>

Ideas?

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