Smoking Gun: Nicotine Use and Recovery from Chemical Dependence

by Carolyn Schaefer Placko

Abstract

Smoking has long been socially accepted, if not encouraged, in alcohol and other substance recovery programs, including Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). This acceptance comes despite the fact that, while drug and alcohol abuse has immediate consequences on the lives of abusers and their loved ones, the consequences of tobacco use are more subtle and long-term. Tobacco-related deaths cut short the lives of recovering people who could continue to pass along their wisdom and example. We as social workers have a duty and obligation to make sure that we do not ignore nicotine addiction in treating the chemically dependent.

Introduction

Smoking is very much a part of the recovering community. It is true that non-smoking meetings exist in communities around the country, and some recovering programs encourage participants to kick both habits - alcohol/drugs and nicotine - at the same time. Nevertheless, smoking has long been socially accepted, if not encouraged, in alcohol and other substance recovery programs, including Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). This acceptance comes despite the fact that, while drug and alcohol abuse has immediate consequences on the lives of abusers and their loved ones, the consequences of tobacco use are more subtle and long-term. Tobacco-related deaths cut short the lives of recovering people who could continue to pass along their wisdom and example.

Historical Context of Smoking and Recovery

Smoking and AA have been linked since the early days of the organization. The Oxford Group, the forerunner of the AA movement, was "actively against sin." Excessive drinking was included in the category of "sin," and the list of vices considered sinful by the Oxford Group also included smoking. In New York, the Oxford Group encouraged its members to give up smoking even if they did not drink. Members were labeled "maximum" when they were "truly on the program" and had quit smoking, drinking and other behavior the group considered vices. AA cofounder Bill Wilson, an early member of the Oxford group and a smoker, had no interest in giving up smoking, despite regularly being called to account on his nicotine use by other Oxford Group members (Hartigan, 2000). In contrast, AA cofounder Dr. Robert Smith ("Dr. Bob") was not pressured about his smoking habit by members of the Akron, Ohio chapter of the Oxford Group with which he was involved (Hartigan, 2000).

Wilson had a singleness of purpose while in the Oxford Group, which was to carry the message of recovery to other alcoholics. This sharp focus did not sit well with the founders of the Oxford Group, and the broad purpose of the Oxford Group to convert sinners from a variety of vices did not fit Bill Wilson (Hartigan, 2000). Wilson's focus on recovery is reflected in two of AA's central Traditions. The Fifth Tradition states that "Each group has but one primary purpose - to carry its message to the alcoholic who still suffers" (Alcoholics Anonymous, 2001). This Tradition has been a part of the movement since Bill Wilson's first efforts to pass along what he had been given, and AA as an organization has helped countless individuals because of this singleness of purpose (Twelve Steps and Twelve Traditions, 1952). But the organization has nothing to say about smoking and recovery in keeping with Tradition Ten: "Alcoholics Anonymous has no opinion on outside issues, hence the AA name ought never be drawn into public controversy" (Alcoholics Anonymous, 1952, p. 562).

In the 1950s and 1960s, Wilson experimented with a variety of therapies for alcoholics, including LSD (it was legal at the time) and megadoses of the vitamin Niacin (Kurtz, 1991). He suffered from depression and appeared to be looking - desperately - for a way to relieve this malady. Niacin in particular seemed to relieve his suffering, and he began to promote it. Many AA members believed this conflicted with Tradition Ten, and the organization's leaders or "trustees" asked Wilson to move the work of promoting Niacin from AA offices to his home, and not to identify himself with the promotional efforts (Kurtz, 1991).

Hartigan (2000) goes so far as to suggest that it would have been a different world if, instead of promoting Niacin, Wilson had quit smoking himself, and had spent the remainder of his days helping other AA members to do the same. By the 1940s, Wilson's health had begun to show the effects of smoking. Some suggest that he may have been trying to quit since that time. By the 1960s, he knew that he had

emphysema, yet he continued to smoke. He was believed to have quit smoking in 1969, but several people confirmed that he continued to smoke, hiding cigarettes in his car. The last few years of Wilson's life were not easy for him because of his health, and his scheduled appearances suffered; either he was unable to attend them, or he attended but could only speak briefly (Hartigan, 2000). On January 24, 1971, pneumonia and emphysema killed Bill Wilson. Hartigan (2000) says it well:

> It seems beyond comprehension, but the evidence is inescapable. The man who pioneered the approach to addictive illness that has helped millions free themselves from alcoholism and a myriad of other addictive problems - including smoking - literally smoked himself to death (p. 208).

One wonders how many other recovering alcoholics died from smoking-related illnesses. To be fair, smoking was not popularly believed to be detrimental to one's health until the 1964 Surgeon General's report. AA as a movement was less than 30 years old at the time. But Wilson's unsuccessful attempts to quit smoking, possibly for as long as 20 years, speak to the addictive nature of nicotine. At the time of his death, Wilson had enjoyed 36 years of sobriety. He was clearly successful in kicking one addiction, even if the other killed him. The fact that the founder of AA was unable to give up nicotine may also indicate that quitting smoking may be more difficult than quitting drinking.

The Problem Today

Research suggests that between 80-95% of alcoholics smoke cigarettes - three times the percentage of the general population that smoke. About 70% of alcoholics are heavy smokers (more than one pack of cigarettes a day), compared to 10% of the general population who are heavy smokers. Varner claims that "the leading cause of death for recovering alcoholics is tobacco-related illness" (Varner, cited in Van Wormer, 1995, p. 103). A recent National Institute on Alcohol Abuse and Alcoholism (NIAAA) survey supports this contention. The survey found that of 845 people who had been treated for alcoholism and other drug addictions, 222 had died over a 12-year period. Of these 222 deaths, one-third were attributed to alcohol-related causes, but *one-half* were related to smoking (emphasis added) (NIAAA, 1998).

Many treatment professionals have refrained from addressing both addictions because of the commonly held belief that many addicted persons would not be able to handle the stress of abstinence from both alcohol and nicotine. Research now offers evidence that both can be treated simultaneously without endangering recovery from alcoholism (NIAAA, 1998). One recent study supports both the success of simultaneous treatment and the health risks associated with nicotine use (Van Wormer, 1995). Richard Hurt, M.D., of the Mayo Clinic, followed a group of 101 patients who were treated for drug or alcohol dependence. Fifty of those patients were in the control group, and received no special attention for their tobacco use. The intervention group of 51 patients received treatment for both smoking and the drug or alcohol problem that brought them to treatment. After one year, both groups had identical outcomes for the drug or alcohol problem. None of the control group had stopped smoking, while six in the intervention group had stopped. The only three to have died were in the control group, and two of the deaths were from diseases that can be caused by cigarettes (Van Wormer, 1995).

Of course, there are differences in the effects alcohol and nicotine addictions have on one's life. Alcoholism, while it may be harmful to the health, also causes chaos in other areas of life, and can be the source of social, employment and legal problems for the alcoholic (Kinney, 2000). This chaos creates an immediacy and priority for treatment. As noted earlier, the serious, negative health effects of tobacco use, though well-documented, are more subtle and long-term. Tobacco use, though it is known to be highly addictive (Shallit, 1991), does not generally drag the addicted person's life into chaos. This lack of chaos creates less of an urgency to treat nicotine addiction than is present for alcohol addiction.

Nevertheless, efforts are being made to help alcoholics quit both drinking and smoking at the same time. One widely respected approach is offered through Hazelden, an international organization that offers a treatment model in both inpatient and outpatient settings that is based on AA's 12-step approach. Hazelden's Inpatient Program does not allow smoking within the hospital, but patients can smoke outside at certain times. Patients are asked to bring a 28-day supply of cigarettes with them, as cigarettes are not sold at Hazelden. In addition, Hazelden requires patients to attend at least one smoking-cessation group. Mona, a representative of the Information Center at the Hazelden Center in Illinois, explained that many patients return after their inpatient stay and participate in smoking-cessation programs. However, she also indicated that Hazelden's research department does not have data on how many former inpatients try to quit smoking by returning for smoking-cessation assistance (personal communication, April 1, 2002).

A review of two other treatment facilities' web sites, the Menninger Clinic and the Betty Ford Center, did not reveal much about treating both smoking and alcoholism. Menninger's site (www.menninger.edu) states only that smoking is allowed outside. Betty Ford' website (www.bettyfordcenter.org) says that many receive help breaking other addictions, but it does not specifically state that the clinic will address nicotine addiction at the same time.

The author has professional experience in one Chicago hospital's psychiatric ward, where smoking is not allowed. Patients who smoke and are admitted for psychiatric disorders or alcohol/drug detoxification are given a nicotine patch but no smoking-cessation counseling. In addition, an internet review (http://findtreatment.samhsa.gov) of other Chicago-area treatment centers does not specify whether the facilities allow smoking or include smoking cessation in their treatment programs.

Non-Smoking in AA

The AA meeting directory for both Chicago and the surrounding suburbs lists non-smoking meetings. This is compared with similar data from other cities as cited in Table 1 below. California cities are not included, as only two meetings in San Francisco were named "non-smoking," yet the state has passed legislation banning smoking in all public buildings which may include AA meeting locations as well. New York City did not specify whether meetings were non-smoking, and this, too, may have been a factor of local laws prohibiting smoking in public places. Note that this information was gleaned from meeting lists or directories; some meetings may not report that they are non-smoking meetings. In addition, some meetings listed in the Chicago and suburban directories were not listed as non-smoking when, in fact, they were held at hospitals or other locations that prohibit smoking on the premises. Non-smoking meetings may also allow participants to take a break for smoking outside of the meeting area.

Some believe that recovering alcoholics are simply substituting one addiction for another - alcohol for nicotine and/or caffeine (Abbott, 2000). Van Wormer (1995) proposes that psychological dependence on alcohol may be more devastating than physiological dependence. He suggests that there may be an underlying psychological predisposition to behavior in the extremes, which may be a factor in compulsive cigarette smoking and coffee drinking, as well as other addictions.

Kathleen F., age 48, speaks to the phenomenon of substituting addictions. She is a recovering alcoholic and non-smoker who has not had a drink for seven years:

> Sometimes I find myself substituting addictions. Like when I was drinking, I was never obsessed about the cleanliness of my house the way I am now. Even in recovery I spend too much money, and although I'm not ready for debtors anonymous, I don't think I'm doing the emotional damage toward my family as I was with my drinking. But it's something I'm aware of. I've come to the conclusion that I'm human and I will probably struggle with these other addictions for the rest of my life (personal communication, March 30, 2002).

In other cases, people who quit smoking before they quit their addiction to alcohol or drugs begin smoking again when they're in recovery. Dr. Hurt's study also showed that, "during the study period, when smoking was permitted in a designated area on the unit, at least four patients who had been abstinent from tobacco for years relapsed to smoking while they were in residence" (Van Wormer, 1995, p. 282). Consider the experience of 44-year-old Dee T., a two-year recovering addict, who was an ex-smoker (she had not smoked for two years) until the day she got out of treatment. She reports that in a moment of weakness

Table 1: Comparison of Non-Smoking 12-Step Meetings

CITY	TOTAL # OF MTGS.	SMOKING	NON-SMOKING	NON-SMOKING AS % OF TOTAL
Chicago (city only) [1]	1230	756	474	38.5%
Chicago (suburbs only)[2]	1545	1105	440	28.5%
Akron, OH [3]	274	120	154	56.2%
Dallas, TX (metro area)[4]	929	600	3295	35.4%
Philadelphia, PA (city only)[6]	615	34	581	94.5%

[1] Source: October 2001 Chicago (City) Complete Meeting Directory (weekly meetings only)
[2] Source: October 2001Chicagoland Suburbs Complete Meeting Directory (weekly meetings only)
[3] Source: www.akronaa.org
[4] Source: www.dallas-aa.org
[5] Includes 120 smoking meetings with alternate non-smoking room.
[6] Source: www.sepennaa.org

she felt she had a choice - smoke a joint or smoke a cigarette. She chose the cigarette, and is now trying to quit smoking again. Dee said that during detox, she had no urge to smoke, and four years ago she was able to quit smoking "cold turkey." Now she says she is finding quitting harder than she ever imagined. She believes that not having the other crutches of alcohol and drugs is what makes quitting nicotine so difficult. Dee is a member of NA and reports that no NA meetings allow smoking during the meeting (although there may be a cigarette break for smokers to go outside the building); she also cannot smoke at her job. Her goal is to quit smoking so she can announce both her clean time and the time she has been off of cigarettes (personal communication, April 1, 2002).

Smoking Cessation and Recovery

Carol Southard, Smoking-Cessation Specialist at Northwestern Memorial Hospital in Chicago, reports that 20-25% of her clients are people in recovery. She says that a popular protocol suggests that people in recovery wait at least three months after addressing their alcohol or drug addiction before they give up smoking. "The norm is to do one, then the other," she says. Southard goes on to say that many of her clients, as well as research she has seen, indicates that "it's really hard [to quit smoking in recovery]. It's hard enough withdrawing from one [addiction]." She believes it may be harder for recovering addicts to quit than it is for the general population, and suggests that further research is warranted.

Unfortunately, managed care reimbursement practices are another issue in smoking cessation. Insurance companies are erratic in their treatment of smoking cessation. If they reimburse for it at all, they often limit reimbursement to once a year. Southard reports that, currently, most people must pay out-of-pocket for smoking-cessation programs. She indicates that the expense may be prohibitive for some people and may be a factor in people not seeking assistance when they try to quit smoking (personal communication, April 1, 2002).

Implications for Social Work

Smoking is a serious health issue in the recovering community. While nicotine addiction may not have the chaotic effects on users' lives that alcohol or drug abuse does, it can cut short the lives of addicts and alcoholics whether in recovery or not. Perhaps most importantly, social workers and other treatment professionals should not ignore the smoking problem simply because it is not the most immediate fire the individual in treatment must put out. Social workers and other counselors could begin to address the issue by increasing their own awareness of the marriage of chemical and nicotine dependence. They could also make it a point to ask about tobacco use in interviews with clients and apply substance abuse therapies to helping clients get off nicotine. Taking it a step further, treatment professionals could increase efforts to prohibit or limit smoking during treatment. They might at least offer nicotine education, if not full-fledged cessation programs, during treatment. Resources in the community are available to help smokers quit, whether or not the smokers are recovering alcoholics.

More data is needed on the extent of the smoking problem among recovering alcoholics. For example, AA does not currently track smoking in its membership survey. More research on smoking and recovery can be hoped for as more people become aware of the problem and include tobacco dependence in treatment programs.

Conclusion

Long-time sober members of AA are an extremely important resource in the fight against alcoholism. Their lives are important not only to themselves but to others. They can be meaningful examples for newer members and for the active alcoholic unsure if s/he wants recovery or not. There is an axiom in AA that says that if you want long-term sobriety of 25 or more years, then "don't drink and don't die." While this may seem crass to some, it fits with the premise of this paper: that nicotine cuts short the lives of recovering alcoholics and addicts. Recovering alcoholics/addicts can find hope and wisdom in the long-term sobriety of those who have traveled the road of recovery longer. Living life to its natural end is a way to honor the Fifth Tradition, that of carrying the message to other alcoholics. To die prematurely because of cigarette smoking is a loss not only for the recovering community but for all of humanity as well. We as social workers have a duty and obligation to make sure that we do not ignore nicotine addiction in treating the chemically dependent.

References

Abbott, A. A. (Ed.) (2000). *Alcohol, tobacco, and other drugs: Challenging myths, assessing theories, individualizing interventions.* Washing-

ton, DC: NASW Press.

Alcoholics Anonymous, (edition d.). (2001). New York: Alcoholics Anonymous World Services.

Hartigan, F. (2000*). Bill W.: A biography of Alcoholics Anonymous cofounder Bill Wilson.* New York: Thomas Dunne Books.

Kinney, J. (2000). *Loosening the grip: A handbook of alcohol information* (6th edition). New York: McGraw Hill.

Kurtz, E. (1991). *Not-God: A history of Alcoholics Anonymous.* (expanded edition). Center City, MN: Hazelden.

National Institute on Alcohol Abuse and Alcoholism. (1998). Alcohol and Tobacco – Alcohol Alert No. 39 – 1998. Bethesda, MD: NIAAA.

Substance Abuse and Mental Health Services Administration. Substance Abuse Facility Locator. Retrieved June 6, 2003 from the World Wide Web. http://findtreatment.samhsa.gov/facilitylocatordoc.htm.

Schilit, R. and Lisansky Gomberg, E. (1991). *Drugs and behavior*. Thousand Oaks, CA: Sage Publications.

Twelve steps and twelve traditions (1952). New York: Alcoholics Anonymous World Services.

Van Wormer, K. (1995). *Alcoholism treatment: A social work perspective.* Chicago: Nelson-Hall Publishers.

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