Breakout 8 — Nicotine Cessation — Breaking Free From Nicotine

One sentence for the board: Nicotine dependence is treatable — a quit date, a coping plan, and real support beat willpower alone.

Purpose	Teach nicotine cessation as recovery education: what nicotine dependence is and which products carry it, what tobacco and nicotine use do to health and what quitting gives back, and the evidence-based ways people quit — behavioral counseling and coping strategies, a written quit plan, and pharmacotherapy education with referral to medical providers. Every participant who wants one leaves with a personal quit plan: a quit date, named triggers, a coping step for each trigger, and a nicotine-free routine and environment to support it.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant who smokes, vapes, or uses smokeless tobacco or other nicotine products — whether they are ready to set a quit date today or only thinking about it. No participant is shamed for current use, and no participant is required to set a quit date in this group. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip chart and markers, and the topic resources named in this outline

Time	Segment	What happens

0–5 min	Welcome	Ground rules, confidentiality limits, right to pass. State plainly at the start: this group is education, not medical advice — medication questions go to medical providers.
5–30 min	Teaching	The teaching points below, in order, on the board: dependence, the neurobiology, and the products; health effects and the benefits of quitting; why nicotine is so hard to quit; what works to quit; quit planning; and quitting alongside the rest of recovery.
30–45 min	Discussion	Prompts below. Each client speaks from their own experience; no one is pressed to commit to a date before they are ready.
45–55 min	Practice — write your quit plan	Clients write a personal quit plan: quit date, triggers, a coping step for each, support people, and one change to their daily routine and environment. Plans stay with the client.
55–60 min	Close	Takeaways, quit dates shared by anyone who wants to share theirs, and the referral path for anyone who wants medical support to quit.

Teaching points

- **Nicotine dependence.** Nicotine is the addictive drug in tobacco products and in most vaping products. Dependence is not a character flaw and it is not simply a habit: nicotine changes how the brain responds, producing cravings, withdrawal discomfort when a person stops, and a strong pull to use again — which is why quitting usually takes planning and support, and why many people make more than one quit attempt before they quit for good. Each attempt teaches something the next one uses.
- **The neurobiology — receptors and dopamine.** Nicotine binds to nicotinic acetylcholine receptors — receptors built for the brain's own messenger, acetylcholine, which is involved in attention, learning, and alertness. The subtype most central to dependence is the alpha4beta2 receptor. When nicotine activates these receptors on dopamine-producing neurons, dopamine is released in the brain's reward pathways, including the nucleus accumbens — the same

reward circuitry other addictive substances act on — and that dopamine signal teaches the brain: this matters, repeat it. That is the start of dependence, and it is chemistry, not character.

- **Upregulation, desensitization, and withdrawal.** With repeated use, the receptors adapt. After activation, many receptors become desensitized — switched off for a time — and with chronic use the brain upregulates these receptors, increasing their number. The adapted brain now expects nicotine to feel normal: tolerance builds, and when nicotine clears — between cigarettes, overnight, or on a quit attempt — the system is left out of balance, producing withdrawal: craving, irritability, anxiety, restlessness, low mood, poor concentration, increased appetite, and disturbed sleep. The next cigarette, vape, or dip relieves that state quickly, so use is reinforced twice — by the reward when nicotine arrives, and by relief when withdrawal ends. This is why dependence is learned at the receptor level, why withdrawal eases as receptors readjust over time, and why medication that acts on this same system can take the edge off while new routines are built.
- **The products.** Cigarettes are the most common source, but they are not the only one. Cigars and other smoked tobacco, smokeless tobacco (chewing tobacco and snuff, including pouches), and e-cigarettes and vapes all deliver nicotine and all can maintain dependence. A client who has stopped smoking but vapes or uses smokeless tobacco has changed products, not yet broken the dependence — name that honestly and without judgment, because the quit plan has to cover every product the client uses.
- **Health effects.** The Centers for Disease Control and Prevention (CDC) is direct about the harm: smoking damages nearly every organ of the body and causes serious disease, including cancer, heart disease, stroke, and lung diseases such as COPD; smokeless tobacco causes cancers of the mouth, esophagus, and pancreas and harms the mouth and teeth; nicotine itself is harmful in pregnancy and to the developing adolescent brain. Secondhand smoke harms the people around the smoker, including children. There is no product switch inside this list that makes nicotine use safe.
- **Benefits of quitting.** Quitting helps at any age, and the body begins recovering soon after the last use — the CDC describes benefits that start within minutes to hours, including heart rate and carbon monoxide levels moving back toward normal, and continue for years as the added risks of heart disease, stroke, and cancer fall. Breathing, circulation, taste, and smell commonly improve. Quitting also protects the people the client lives with, and it removes a daily trigger and expense that press on the rest of recovery. No specific timeline or result is promised to any client — the honest claim is the CDC's: quitting is one of the most important steps a person can take for their health.
- **Why nicotine is so hard to quit.** Clients often ask how a legal product can be harder to put down than the illicit substances they have already stopped — sometimes including the substances that brought them to this program. The mechanisms explain it, and the comparative evidence agrees. Availability: nicotine is legal, sold nearly everywhere, and usable all day in most settings, so a craving is rarely more than minutes from an answer. Speed: smoked nicotine reaches the brain within seconds, and rapid delivery strengthens the learning that binds use to reward. Frequency: a cigarette is not one event — every puff is a small dose and a small reinforcement, repeated many times a day, every day, often for years, giving nicotine more daily practice than almost any other pattern of drug use. Pairing: because use is so frequent, nicotine becomes welded to ordinary life — waking, coffee, meals, driving, work breaks, stress, celebration, the phone, other people's company — so the triggers are not one

place or one crowd a person can avoid; they are the whole day. Mild intoxication: nicotine does not visibly intoxicate the way alcohol or other drugs do, so use can continue alongside work, family, and even treatment, with no immediate consequence that interrupts the pattern. The comparative evidence matches the mechanisms: in the National Comorbidity Survey's comparison of dependence across substances (Anthony, Warner, & Kessler, 1994), the share of people who had used a substance and went on to develop dependence was higher for tobacco than for alcohol or the controlled substances compared. And relapse after a quit attempt is the common pattern in nicotine dependence, much as it is in other substance use disorders — which is why the clinical practice guideline treats tobacco dependence as a chronic, relapsing condition to be managed over time, not a bad habit to break once by force of will.

- **Behavioral counseling and coping.** The evidence is consistent across the sources in this outline's Sources & Evidence box: behavioral support works, medication works, and the two together work better than either alone. Behavioral counseling — individual, group, and telephone counseling, including quitlines — helps people plan a quit, build coping skills, and stay quit. Coping strategies for cravings are practical: delay (cravings peak and pass), deep breathing, drinking water, and doing something else with hands and attention; avoiding or reworking the situations tied to use; and telling support people what helps. This group is itself one piece of that behavioral support. The national quitline is 1-800-QUIT-NOW (1-800-784-8669): free, confidential telephone counseling that connects callers to their state's quitline.
- **Quit planning.** A quit plan turns a wish into a date and a set of steps. It names: a quit date, close enough to prepare for and soon enough to matter; the client's personal triggers — times, places, people, feelings, and routines tied to use; a coping step chosen in advance for each trigger; support people who will be told about the quit and asked for specific help; and a plan for the first hard days, including what to do with cigarettes, lighters, and ashtrays, and what to do instead during smoke breaks and after meals. Written plans are kept by the client and revised after any slip — a revised plan is progress, not failure.
- **Pharmacotherapy education.** Three kinds of medication are approved to help adults quit and are covered in this group as education only. Nicotine replacement therapy (NRT) — patch, gum, lozenge, inhaler, and nasal spray — supplies nicotine without the other harmful chemicals in tobacco smoke, easing withdrawal while the client breaks the routines of use; some forms are sold over the counter and others are prescription. Varenicline and bupropion are prescription medications that reduce cravings and withdrawal in different ways. Cochrane systematic reviews and the clinical practice guideline find that these medications, behavioral support, and especially the combination increase the chances of quitting successfully. Which medication, if any, is right for a client — and its dose, duration, interactions, and safety for that client — is a medical decision. Facilitators teach what these options are and refer every client who is interested to a medical provider; facilitators never prescribe, never recommend a specific medication or dose to a client, and never advise a client to start, stop, or change any medication. Ask your provider/pharmacist about risks before starting any cessation medication.
- **Quitting nicotine supports the rest of recovery.** An older idea in treatment held that a client should not try to quit nicotine while working on other substances — that quitting smoking would put sobriety at risk, so cigarettes were left alone, sometimes even treated as a lesser evil that helped a person cope. The evidence has moved against that idea. A meta-analysis of randomized trials of smoking cessation interventions delivered during addiction treatment

(Prochaska, Delucchi, & Hall, 2004) found that taking part in a cessation intervention was associated with a greater likelihood of long-term abstinence from alcohol and illicit drugs — not a lesser one. Later systematic reviews, including a Cochrane review of tobacco cessation for people in treatment for or recovery from substance use disorders (Apollonio and colleagues, 2016) and a systematic review and meta-analysis by Thurgood and colleagues (2016), found that cessation treatment helped people stop tobacco and did not worsen substance use outcomes. Recent national evidence points the same direction: a National Institute on Drug Abuse (NIDA)–funded analysis of the national PATH Study, published in JAMA Psychiatry, found that adults who had quit cigarette smoking were more likely to be in sustained remission from their other substance use disorder than when they continued to smoke. The pattern makes sense in the room: continued nicotine use keeps the daily rituals of addiction practiced — craving, ritual, relief — and keeps a person tied to the places and company where other substances circulate. Quitting nicotine removes a standing trigger, builds lived proof that cravings can be survived, and lets one recovery reinforce the other. The choice and the timing of a quit attempt still belong to the client, made with their treatment team — but no one in this group will be told that protecting their recovery requires keeping nicotine.

- **Relapse prevention, nicotine-specific.** Nicotine has its own relapse pattern, and it deserves its own plan inside the client's wider relapse-prevention work. The common nicotine-specific risks: the “just one” cigarette, dip, or hit off a vape, which commonly reopens full use; alcohol and other substance use, which lower resolve and are often paired with smoking; other people smoking or vaping nearby, and being offered a product socially; stress and strong emotion; and the built-in daily pairings — waking up, coffee, driving, meals, breaks, and the phone. For each risk, the plan names the coping step in advance. A slip is data: what happened, what the plan missed, what changes. It is never a verdict, and it never erases the days already quit.
- **A nicotine-free routine and environment.** Quitting holds better when the day itself is rebuilt. Clients plan a nicotine-free routine: new break activities and break places, a different route or morning order where the old one was built around use, hands and mouth occupied (water, gum, a toothpick, a task), and regular meals, movement, and sleep protecting the basics. And a nicotine-free environment: tobacco, vaping devices, lighters, and ashtrays out of the home, room, and vehicle; clothes and spaces aired and cleaned; support people asked not to offer products or use around the client where that can be arranged. Environment is willpower's backup — set it up while motivation is high.

Cut points — teaching (25 minutes): teach the points in order. If time runs short, compress “Why nicotine is so hard to quit” and “Quitting nicotine supports the rest of recovery” to one sentence each, and shorten the product list — never cut the quit-planning steps, the pharmacotherapy-education and referral lines, the quitline number, or the practice. Cut teaching, never skill practice.

Discussion prompts

- “Which product or products carry your nicotine use right now — and which daily moment is most tightly tied to using?”
- “What have you already noticed, in your body or your day, that makes you want your health back from nicotine?”

- “What got in the way on a past quit attempt — and what would a plan do about that specific thing this time?”
- “Who would you want in your corner for a quit — and what exactly would you ask them to do, or not do?”

Practice — write your quit plan (10 minutes, your plan stays with you)

1. Set a quit date. If you are not ready to set one, write the date you will decide by — and what you will do between now and then to get ready.
2. List your top three triggers — the times, places, people, or feelings most tied to your use.
3. For each trigger, write one coping step you will use instead: delay, breathe, water, walk, call, or leave the spot — chosen now, not in the moment.
4. Name your support: one person you will tell, the specific help you will ask for, and whether you want a referral to a medical provider to talk about medication options.
5. Choose one routine change and one environment change to make before your quit date — a new break plan, and tobacco, devices, and lighters out of one space you control.

Facilitator boundaries — Nicotine Cessation

- **Education only; referral always.** This group teaches cessation options as recovery education. Facilitators do not provide medical advice, do not prescribe, and do not recommend a specific medication, product, or dose to any client. Every question about whether a medication is right for a client, and every medication decision, is referred to the client's medical provider or program medical staff — the same day the client asks.
- **Medication decisions belong to providers.** Facilitators never advise a client to start, stop, or change any medication — including any medication for addiction treatment. A client using cessation medication exactly as their provider directed is affirmed, the same as any client using medication as prescribed.
- **No shame for use or for slips.** Nicotine dependence is a treatable, relapsing condition, and a return to use is handled like any return to use in this packet: as information for the next plan, never as shame, discipline in group, or a verdict on the client's recovery. Do not single out clients who still use, and do not use group time to police use outside the room — program rules are staff's to enforce through program procedure, not through this group.
- **Care is never replaced.** A quit plan supports a client's care; it does not replace medical evaluation, treatment for tobacco-related disease, or the client's treatment plan. Chest pain, breathing difficulty, or any other medical concern raised in group is referred to medical staff the same day.
- **Warrior close:** Close with the plan, not the pressure: “Nobody in this room has to white-knuckle this. You have a date, a plan for the hard moments, people in your corner, and medical help you can ask for. That is how warriors take ground — prepared, supported, and one day at a time.”

Sources & Evidence

Clinical evidence: Centers for Disease Control and Prevention (CDC), Office on Smoking and Health — health effects of cigarette smoking and smokeless tobacco use, the harms of nicotine in pregnancy and adolescent brain development, secondhand smoke, and the benefits of quitting, which begin soon after quitting and continue over years. American Lung Association — tobacco and nicotine cessation education for the public and for people helping others quit. Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline, 1-800-662-4357, for treatment referrals. U.S. Preventive Services Task Force (USPSTF), Tobacco Smoking Cessation in Adults, Including Pregnant Persons (2021) — a Grade A recommendation that clinicians ask all adults about tobacco use, advise them to stop, and provide behavioral interventions and U.S. Food and Drug Administration–approved pharmacotherapy for cessation to nonpregnant adults who use tobacco; the USPSTF found the evidence on e-cigarettes as a cessation aid insufficient and directs patients to interventions with proven effectiveness. National Institute on Drug Abuse (NIDA) — research and research reporting on tobacco use disorder and on the association between quitting smoking and improved recovery from other substance use disorders. Substance Abuse and Mental Health Services Administration (SAMHSA) — tobacco dependence addressed as part of substance use disorder treatment in behavioral health programs. Wittenberg, R. E., Wolfman, S. L., De Biasi, M., & Dani, J. A. "Nicotinic Acetylcholine Receptors and Nicotine Addiction." Neuropharmacology (2020), and De Biasi, M., & Dani, J. A. "Reward, Addiction, Withdrawal to Nicotine." Annual Review of Neuroscience, 34, 105–130 (2011) — nicotine acting mainly through alpha4beta2-containing nicotinic acetylcholine receptors, increasing dopamine neuron firing and dopamine release in reward pathways; chronic exposure producing neuroadaptations including receptor upregulation and long-term desensitization; a withdrawal syndrome developing when nicotine is removed.

Recovery-support evidence: Treating Tobacco Use and Dependence: 2008 Update, Clinical Practice Guideline (Fiore, M. C., et al., U.S. Public Health Service) — tobacco dependence treated as a chronic condition; effective treatments include behavioral counseling and the approved cessation medications, and combining counseling with medication is more effective than either alone. Cochrane systematic reviews of nicotine replacement therapy, varenicline, bupropion, and behavioral support for smoking cessation — each finds that the treatment increases the chances of quitting successfully compared with placebo or minimal support. Anthony, J. C., Warner, L. A., & Kessler, R. C. "Comparative Epidemiology of Dependence on Tobacco, Alcohol, Controlled Substances, and Inhalants." Experimental and Clinical Psychopharmacology, 2(3), 244–268 (1994) — among people who had used each substance, dependence developed in a higher share of tobacco users than of alcohol users or users of the controlled substances compared. Prochaska, J. J., Delucchi, K., & Hall, S. M. "A Meta-Analysis of Smoking Cessation Interventions With Individuals in Substance Abuse Treatment or Recovery." Journal of Consulting and Clinical Psychology, 72(6), 1144–1156 (2004) — cessation interventions during addiction treatment were associated with an increased likelihood of long-term abstinence from alcohol and illicit drugs. Apollonio, D., Philipps, R., & Bero, L. "Interventions for Tobacco Use Cessation in People in Treatment for or Recovery From Substance Use Disorders." Cochrane Database of Systematic Reviews (2016), and Thurgood, S. L., and colleagues, systematic review and meta-analysis (2016) — cessation treatment increased tobacco abstinence and did not worsen substance use outcomes. Parks, M. J., and colleagues, JAMA Psychiatry (2025) — an analysis of the national Population Assessment of Tobacco and Health (PATH) Study, funded by the National Institutes of Health and the U.S. Food and Drug Administration and reported by the National Institute on Drug Abuse (NIDA): quitting cigarette smoking was associated with greater odds of sustained remission from a non-tobacco substance use disorder. No statistics or quit rates are claimed in this outline, and no outcome is promised to any participant: which medication, if any, is appropriate is decided by the client with a medical provider, never in this group.

Note: No outcome is promised for any group in this packet.