STATEMENT OF DR. THEODORE H. BLAU

Subcommittee on Health and the Environment
Committee on Energy and Commerce
United States House of Representatives

I am a practicing Clinical Psychologist from Tampa, Florida. During the past 39 years I have seen over 4,000 patients of all ages. Among the many kinds of disorders I have treated are addictions to a variety of drugs. These addicted patients have included children, teenagers, and adults.

In addition to my clinical practice, I have been retained by various organizations to assess the merit of scientific research. These organizations include the United States Army, the Department of State, the National Institutes of Education, various universities and state agencies, as well as private organizations.

I am Board Certified in Clinical Psychology, Forensic Psychology, and Neuropsychology. In 1976 I was elected President of the American Psychological Association, the scientific and professional organization of over 70,000 psychologists in the United States. A list of some of the other positions I have held and honors received is appended to this statement.

I have been closely studying the scientific literature on smoking for approximately 11 years. During that time, I have reviewed approximately 10,000 research articles on smoking behavior and drug abuse. I have also

conducted smoking cessation clinics, both in my office, and for the Manatee County, Florida Sheriff's Office, with whom I consult.

I am here today to address the statement that tobacco use is "addictive" in Sec. 2(3) of H.R. 5041 and the proposal to label tobacco an "addicting drug" under Secs. 3 and 4 of H.R. 5041. In my view, labeling tobacco use "addictive" is misleading and potentially harmful to the American public.

The distinctions between the terms "addiction," "habit," "compulsion" and "dependence" have become blurred during the past several decades. The word "addiction" has been used widely and loosely to describe many habits and everyday behaviors, including coffee drinking, love, video game playing and cigarette smoking. Some have attempted to replace the concept of "addiction" with that of "dependence." Rather than bringing clarity, use of the term "dependence" has resulted in added confusion as different individuals and groups have defined "dependence" in different ways for different purposes. The terminology in this area remains confused.

My view of "addiction" is the view of a practicing clinician who sees people who are in deep trouble through drug use. The "addictive drugs" used by these people generally share common features such as intoxication when taken, tolerance effects, and significant withdrawal

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responses when the drug is given up. Use of these addictive drugs also tends to lead to certain lifestyles and social relationships. Giving up these drugs usually requires sacrifices and changes not necessary in giving up other behaviors.

As a clinician, I regularly see a whole host of human problems and behaviors. Addictive drugs represent a problem different from problems related to voluntary behaviors and habits. Smoking is not an addiction. To label it as an addiction is to place it in a category where it does not belong. This is likely to lead to misdirected policies, waste of funds, and useless, if not counterproductive, efforts.

Taking an addictive drug causes major interference with thinking and judgment of the user. This condition is intoxication. The drug addict, when intoxicated, cannot make reasoned decisions, including the decision to use or not to use the drug. Rational thinking is distorted. On the other hand, smokers are always able to reason without interference from their habit. Surgeons, aircraft pilots, train engineers, and people at all levels of responsibility, can work effectively and successfully, making important, difficult decisions without interference from their smoking.

Further, when a drug addict gives up his or her drug, a severe withdrawal syndrome is very likely to result. Withdrawal can result in convulsions, hallucinations,

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significant pain, bodily dysfunction and in some cases death. During this withdrawal phase and for months or even years afterward the former drug addict is often unable to think clearly or act decisively in his or her own interest or within social and legal expectations. This is not true of smokers. The vast majority of those who have stopped smoking have done so with no help. Their lives have gone on with no disruption.

The addict's life usually involves friends who are also addicts and activities centered around the acquisition and use of a drug. The life of the addict precludes normal, law abiding family life, work or social pursuits. Consequently, successfully giving up an addictive drug requires that the former addict seek and develop normal friendships, social activities, and employment. For those who give up smoking, however, friendships, work and social activities remain essentially intact. No rebuilding of a life is required.

Dr. Jack Henningfield testified before this Committee in July 1988 that nicotine is as addicting as heroin or alcohol. At this same Committee hearing, the then Surgeon General of the United States, Dr. Koop, testified that "the addictive properties pharmacologically, and physiologically are the same for heroin, cocaine, and nicotine." Dr. Koop also testified that if tobacco use was illegal, like heroin and cocaine, then tobacco "addiction"

would cause people to commit crimes in order to get tobacco. For example, Dr. Koop testified that "You take tobacco off the streets and there will be people breaking into liquor stores to get money to buy tobacco." I cannot agree with these statements in light of my review of the research and my clinical experience.

I have observed the effects of the use of addictive drugs. Individuals using cocaine are agitated, confused, unable to listen to other people, given to grandiose state-ments about themselves, and unable to face the destructive aspects of their own behavior while using this drug. Judgment is severely impaired. I have seen the heroin addict under the influence of this powerful drug acting unaware of the real world, unable to deal with any kind of an emergency, and thinking of nothing but the pleasure he or she gets from this substance. I have seen teenagers come to my group therapy sessions after having smoked marijuana. They don't hear what we talk about. Serious matters of family, school, and the expectations of society mean nothing when they are intoxicated by this drug. They are unable to deal with the realities of the future.

I have also treated and observed heroin addicts, cocaine addicts and alcoholics who are in the process of giving up these drugs. They, too, lack judgment, but in addition to this, their personalities are fragmented. They are fearful. They can tolerate little or no stress. In

most cases they are so ill that they should be hospitalized and detoxified before long-range treatment is begun. They shake, they sweat, they have tremors. Some have gone into convulsions. The acute effects of withdrawal last for only a week or two, but it may be years before the individual can tolerate any kind of normal stress without going back to the use of these addictive substances.

Those who state that cigarette smoking should be labeled an "addiction" suggest that "withdrawal symptoms" which some smokers report when giving up the smoking habit are similar to the symptoms experienced in giving up narcotic drugs. This is inaccurate. The alleged "withdrawal" symptoms experienced by some who stop smoking are generally the same kinds of frustrations that one would expect to see when someone discontinues any well established and well liked habit. Such symptoms as missing the habit and mild irritability are similar to the reactions experienced by those who give up coffee or sweets.

In addition to my clinical observations of smoking and smoking cessation over the past 39 years of practice, I have reviewed over 10,000 research articles relating to the subjects of smoking behavior and drug abuse. My evaluation of this research supports the following conclusions:

1. Few, if any, specific non-essential behaviors have been studied as extensively or produced more literature than the smoking habit.

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2. People choose to smoke for many reasons. Each smoker usually has a variety of reasons why he or she chose to begin smoking, or chooses to continue the smoking habit. The same smoker may smoke for different reasons at different times.

3. The use of materials containing nicotine is not equivalent to the use of addictive drugs such as heroin, cocaine, barbiturates, or the excessive use of alcohol. Nicotine has some effect on people. The specificity of the effect is still, after many hundreds of studies, relatively unknown and variable. Some studies say nicotine affects heart rate, brain activation, appetite, motor performance, and a host of other psychological factors. When efforts are made to replicate these studies, the results are frequently different. The many thousands of studies on the smoking habit in the past 27 years do not demonstrate that nicotine in tobacco is an addictive drug. These studies do not support the concept that smoking is a psychiatric disorder. The role of nicotine in tobacco smoking is much more like the role of caffeine in coffee drinking.

4. People can and do choose to stop smoking. The process of quitting the smoking habit is very different from giving up addictive drugs. Those

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who choose to quit on their own are more likely to do so than those who are told to quit or who attend professional smoking cessation clinics. A small number of people have chosen to stop smoking through the use of professional help or smoking clinics. On the other hand, according to government figures, over 36 million people have quit smoking, entirely on their own, with no external help.

5. Those who quit smoking on their own are more likely to continue to decide not to smoke than those who seek external help, or who prefer to view their habit as something they "can't control." The attachment of the label of "addictive" to cigarette smoking increases the likelihood that people will not quit smoking. They tend to blame their smoking on their "inability" to govern their own behavior. The labeling of smoking as an "addiction" serves as an excuse and as a rationalization to maintain the habit.

Smoking of tobacco is a habit. Those who choose to give up smoking usually do so on their own. I have worked and continue to work with people who have chosen to give up smoking. I can provide behavioral support and encouragement to them, but clinical experience, as well as

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research, shows that the inner decision to quit, coupled with the belief that one can do so, is most likely to lead to success. This is what one would expect with any habit. Those who call smoking an "addiction," who say smoking is out of their control, who claim to be victims, and who won't make a serious decision to quit, are not likely to quit smoking. Again, this is just what one would expect with any habit.

The underlying argument for placing an addiction label on cigarette smoking seems to be that by doing so smoking will decrease. In truth, if the goal of labeling cigarette smoking an addiction is to cause people not to smoke, then all evidence is that, if anything, such a label may have just the opposite effect. There is no evidence that labeling smoking an addiction will keep people from starting smoking. As to quitting, the scientific studies we have indicate that people who believe that smoking is an addiction are less likely to quit than persons who believe that smoking is a habit.

A very real concern in placing an addiction label on smoking should be the misinterpretation of science in the name of public policy.

As Dr. Koop testified in 1988, "There are public health implications to all of this, such as how should we address the problem of tobacco use now that we recognize it as an addiction." If the Congress of the United States says

that smoking is to be labeled an addiction, then treatment programs, research grants, neighborhood centers, directions of scientific research, insurance payments, and a host of other matters will be geared to this belief of the United States Government. The information to the public from science and government will be that smoking is an addiction, just like cocaine and heroin. If this is not true, then significant amounts of time, money, and public confidence in the government's understanding of drugs and addiction may be lost.

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Partial List of Positions Held
and Honors Received by Theodore H. Blau, Ph.D.

1. President of the American Psychological Association (1977)
2. President of the Florida Psychological Association (1954)
3. President, American Psychological Association, Division of Psychotherapy (1968-69)
4. President, American Psychological Association, Division of Clinical Psychology (1973-74)
5. President, American Psychological Association, Division of Consulting Psychology (1965-66)
6. President, Society for Personality Assessment (1972-73)
7. President, American Psychological Foundation (1982-83)
8. Member, Board of Directors of American Psychological Association (1968-71)
9. Vice-Chairman, Board of Directors of American Psychological Association (1976)
10. Chairman, American Psychological Association, Commission on Accelerating Black Participation in Psychology (1969-70)
11. Chairman, American Psychological Association Committee on the Practice of Clinical Psychology (1962-64)
12. Chairman, American Psychological Association Board of Professional Affairs (1966-68)
13. Trustee, American Board of Professional Psychology (1969-74)
14. Trustee, Association for the Advancement of Psychology (1974-77)
15. Trustee, Southeastern Region, American Board of Professional Psychology (1978-81)
16. Trustee, Florida School of Professional Psychology, Miami, Florida (1981)
17. National Consultant in Clinical Psychology to the Surgeon General of the United States Air Force (1972-77)
18. Consultant, Clinical Psychology, to the Medical Service Corps of the United States Army (1976-Present)

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19. Distinguished Contribution Award, Florida Psychological Association (1968)

20. Outstanding Achievement Award, Division of Psychotherapy, American Psychological Association (1971)

21. National Distinguished Service Award, The Florida Psychological Association (1976)

22. Distinguished Professional Award, American Association of Psychologists in Private Practice (1976)

23. Distinguished Practitioner and Member, National Academy of Practice in Psychology (1982)

24. Distinguished Contribution Award, Philadelphia Society of Clinical Psychologists (1985)

25. Distinguished Service Award, American Board of Professional Neuropsychology (1986)

26. Distinguished Contribution to Clinical Psychology in the Navy, Department of Medicine, United States Navy (1986)

27. Distinguished Service Award, William Beaumont Army Medical Center (1989)

28. Distinguished Contribution Award, National Academy of Neuropsychology (1989)

29. Distinguished Contribution Award, California Psychological Association (1990)

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