

Suggested Draft for Clive Turner's Reply to Mr. Morgan (Lundbeck)

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In response to my request for proof of your advertised claim that "there is now conclusive evidence that smoking is a true addiction" you kindly provided some references. However, these hardly provide conclusive evidence of true addiction. They merely demonstrate what is not in dispute, and that is that some people have claimed that smoking (and just about everything else under the sun) is an addiction. Such an allegation is not new: it is over sixty years since Sir Humphrey Rolleston remarked that "to regard tobacco as a drug of addiction may be all very well in a humorous sense, but it is hardly accurate"(1). Much more recently, a review came to the conclusion that "in spite of the fact that some well known investigators believe that cigarette smoking is an addiction, the majority of investigators in the field hold the view that smoking is best thought of as a habit"(2).

Not only is there no unanimity over the notion that smoking is an addiction, there would seem to be no consensus regarding the meaning of the word itself. An editorial in the British Journal of Addiction summarising the Addiction Society's Centenary Meeting concluded that "the Centenary Meeting was quite evenly divided between those who thought that they alone knew what was meant by addiction, and those who thought that nobody on the face of this earth knew what was meant by the term"(3). Professor Warburton has considered this confusion in a paper which I commend and enclose for your attention (4). He concludes that "it is clear that there is no agreement about the definition of the term 'addiction' in the medical and psychological literature ... the meaning is confusing not only to ordinary people but even to the scientific community"(4). He asks (with particular pertinence here) "if there is no consensus on the definition of addiction, how can the word be used ... on advertisements?"(4). The terms 'addiction' and 'dependence' (also used by you) are apparently what have been referred to as "fat words"(5) as they bring under single headings types of behaviour that are extremely disparate (4). To quote Professor Eysenck: "The persistence of the smoking habit is often blamed on 'addiction', but this is a largely meaningless word, or perhaps one should say, a word that has so many different meanings that it has no scientific status at all"(6).

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Now a specific comment on some of your references. Firstly, there is considerable dispute and even caution from Ashton & Stepney on whether smoking really affects an addiction model. They reported that "there are intriguing cases (relatively few but nevertheless disturbing for a straightforward addiction view of smoking) of heavy smokers who quit the habit suddenly and apparently without experiencing withdrawal symptoms. In addition, many smokers are able to refrain from smoking for relatively long periods, for practical or religious reasons, without apparently experiencing hardship - coal miners who cannot smoke at the pit face and orthodox Jews who do not smoke on the Sabbath are examples. It is unclear how the experience of these groups of people could be incorporated into a conventional addiction view of smoking"(p.65). It is particularly noteworthy that they concluded from this (and other considerations) that "the tendency for some medical authorities to label the use of cigarettes as an addiction may do a disservice to the smoker ... the rationale for labelling them as addicts is not convincing"(pp 140-141). And the "relatively few" intriguing cases referred to above are arguably a gross underestimate "moulded largely by that self-selected hard-core group of people who ... go to therapists ... the only easily available subjects for studies"(7). Professor Schachter concludes that "the rates of successful self cure of cigarette smoking are considerably higher than anything yet reported in the therapeutic literature ... people can and do cure themselves of smoking .. they do so in large numbers .. permanently" (7).

Henningfield (1984) has promulgated his widely-quoted study in a number of such publications ostensibly equating nicotine with opium use. However, it has subsequently been shown that Henningfield misinterpreted his data: "there are remarkable differences in the scales ... the results take on a different picture when plotted on the same scale ... (and) if the scores for the difference between assessment of the substance and placebo are plotted"(8). An independent re-assessment of Henningfield's study concluded "from the data it seems that nicotine ... does not act like other compounds in the maintenance of other kinds of substance self-administration, i.e. it is not like morphine in opium use" (8).

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NIDA Research Monograph 23 further highlights disagreement in the existing literature: e.g. "reluctance to label tobacco as a dependence-producing substance rests on doubts concerning the existence of a tobacco withdrawal syndrome" (Shiffman, p158), "simply because nicotine has many pharmacological effects in smoking doses, it does not follow that these effects are reinforcing" (Russell, p119), "despite extensive and long-term exposure to nicotine, we seem to have a non-addictable animal" (Schachter, p120), and "the social acceptability of tobacco use and dependence is at present in a class by itself" (Jaffe, p12).

Finally, in your letter, you state that "WHO recognised tobacco as drug dependence as long ago as 1974". But this was the document which denounced the description of tobacco use as an addiction and condemned the use of addiction as a useful term. One cannot have it both ways. Further, the American Psychiatric Association's DSM III, which you cited, has now been superseded by their DSM IIIR diagnostic manual. In this, tobacco withdrawal is not included. Nicotine dependence and nicotine withdrawal have, however, been substituted, which could render Nicorette susceptible to your own allegations!

*Sharon,*

*Any assistance  
appreciated!*

*Regards,*

*Dave*

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