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I am Edward V. Morse, a clinical Professor of Psychiatry at the Louisiana State University Medical Center in New Orleans, Louisiana. I hold a PhD from Cornell. My area of specialization is Sociology with a concentration in behavioral medicine.

For the last twenty five years I have taught and conducted extensive research in behavioral medicine -- the complex subject of the determinates of human behavior -- particularly risky behavior -- and how to develop effective public policies to alter peoples' health behavior patterns. Within the field of behavioral medicine, I have concentrated on health issues raised by the behavior patterns of children, and adolescents, and young adults.

I have served as a consultant to the United States Department of Health and Human Services, the State of Louisiana (public schools and school-based health care programs) and other private and government agencies to help translate research findings into effective public health policy. Most recently, I was invited by President Clinton to meet with him and to advise him with regard to the formulation of HIV policy and substance abuse -- to develop policies and programs to try to alter persons' risky health behavior patterns in an effort to stop the spread of the HIV infection. I have presented and published nationally as well as internationally in the area of determinates of HIV prevention behavior. A copy of my CV is attached.

During the last decade I have had an extensive opportunity to deal with health issues as they are related to the behavior patterns of children and adolescents. The most common mistake made by "Policy-Makers" in attempting to alter people's behavior is the false assumption that knowledge and attitudes work together to shape behavior practices. In the health field this is referred to as the "KAP" model -- Knowledge/Attitudes/Practices. The false assumption of this model -- upon which many programs have been based -- is the assumption that people's behavioral patterns can be controlled or altered by controlling or altering their "knowledge" about the behavior.

Time and again, policy-makers and the public have been disappointed -- and surprised -- that campaigns based on the KAP model have been unsuccessful in bringing about the desired change in people's behavior. In general, the KAP model is very attractive to policy-makers because it appears to offer an easy way to alter an individual's or group's behavior patterns. The theory is, simply alter a group's access to a particular type of information and the desired change in behavior will follow. As a practical matter, the reality is that human behavior is not so simplistic -- the determinates of human behavior patterns are complex, and are not simply changed by altering information resources. The KAP model totally ignores or discounts important cultural information, age differences, developmental differences, how these factors interact -- and change over time.

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The fact that human behavior patterns are extremely complex, and that public policy attempts to alter behavior patterns through controlling information are bound to be ineffective, has been demonstrated repeatedly in the behavioral research on HIV transmission. The nation's policies regarding AIDS and the prevention of the spread of HIV have depended heavily on the KAP model and to date have had no significant impact. FDA's proposed tobacco regulations are also firmly and directly based on the KAP model -- FDA is proposing to alter teenagers' smoking behavior by changing their exposure to cigarette advertising and health warnings. FDA's proposal is likely to be no more effective in altering the behavior patterns of adolescents than other, similarly miscast policies.

In reviewing the proposed FDA regulations, I noted that the agency has adopted the intuitive appeal of the idea that altering information available to an individual will be followed by a change in attitudes and behavior patterns. In my opinion -- and based on my experience and understanding of human behavior and the behavior patterns of children and adolescents -- such a policy is not likely to have any meaningful impact on underage smoking.

There are a number of specific reasons why FDA's proposed policy is not likely to be effective in reducing underage smoking.

First, children and adolescents already have the "knowledge" and the "attitude" that smoking is unhealthy.

Second, we know from decades of research and observation that childrens' and adolescents' "patterns" of smoking behavior are most likely to be determined by the smoking behavior patterns of their peers and parents. The smoking behavior patterns influenced by peers and parents are most likely (1) the choice to smoke or abstain, and (2) what brand is the peer approved brand to smoke.

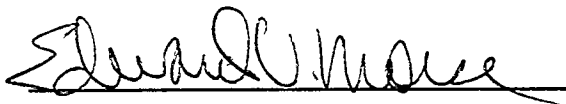
Third, adolescents are known to engage in high-risk behavior patterns. Adolescents love risk. They engage in unsafe premarital sex, drive fast, tend not to use seat belts, experiment with drugs and alcohol, and do not use condoms; the list goes on. No companies (that I know of) advertise to adolescents to motivate them to engage in such risky behaviors, yet they engage in these behaviors nevertheless. Most likely these behaviors are primarily manifestations of peer pressure and, normal rebellion.

FDA is proposing a simplistic solution to altering a highly complex pattern of behavior. The naivete of the FDA's proposal to alter adolescent smoking patterns by altering exposure to cigarette advertising and modifying cigarette health warnings is apparent in the fact that smoking rates are declining most rapidly among inner city black male teens and smoking is virtually non-existent among black female teens -- a group that, according to anti-smoking activists, has been unfairly targeted with advertising for cigarettes. This is just one bit of anecdotal evidence that the determinates of smoking behavior are far more complex than the simple view taken by FDA.

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For all of these reasons, in my opinion and based on my research, training and experience the policy FDA has proposed can be predicted to be ineffective in reducing underage smoking.

Submitted by,

A handwritten signature in cursive script, appearing to read "Edward V. Morse", written over a horizontal line.

Edward V. Morse, Ph.D.

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Date

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