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January 2000

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Morse, S. (2000). Hooked on Hype: Addiction and Responsibility. Retrieved from https://repository.upenn.edu/neuroethics_pubs/22

Postprint version. Published in Law and Philosophy, Volume 19, Issue 1, January 2000, pages 3-49.
The original publication is available at www.springerlink.com

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Comments

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STEPHEN J. MORSE*

HOOKED ON HYPE: ADDICTION AND RESPONSIBILITY

Thinking about the moral and legal responsibility of people for becoming addicted and for conduct associated with their addictions has been hindered by inadequate images of the subjective experience of addiction and by inadequate understanding of how explanatory models of addiction relate to responsibility. Even sophisticated people tend to think that the "man with the golden arm" is somehow an automaton, a puppet pulled by the narcotic strings of a biological disease, and to think that therefore the addict is not responsible for behaviors associated with his addiction. Conversely, many people think that addiction is purely a result of moral weakness. The metaphors characterizing addiction may be striking and contain a grain of truth and many models have great heuristic power, but for the purposes of law, the metaphors obscure rather than clarify and the models are rarely helpful.

I begin by considering the contrast between the legal and scientific images of behavior, using the disease concept of addiction as the prime example of the contrast. I then turn to the logic of the concept of addiction as a brain disease, demonstrating that the disease concept is problematic and that human action is fundamental to an accurate description of the allegedly biophysical disease entity.

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I suggest that the subjective experience of craving is a crucial aspect of addiction that morality and the law must consider. The next section of the paper addresses whether what we know about addiction suggests that it is usefully categorized as a brain disease for purposes of devising sound social and legal policy. In particular, I consider whether criminal justice responses to addictions are necessarily misguided. Then the paper discusses under what conditions, if any, addiction creates a complete or a partial excusing condition to crime. This section examines both the individualistic perspective and whether social conditions should affect the responsibility of addicts. I suggest that most addicts should be responsible for most criminal behavior motivated by addiction, but that addiction can in some cases affect the agent's ability to grasp and be guided by reason.¹ I conclude by recommending that the criminal law should adopt a generic mitigating excuse, "partial responsibility", as the fairest way to respond to claims that some addicts and others present.

I. IMAGES OF ADDICTION AND DISEASE

The concepts of illness and disease have powerful associations in our culture, most of which are inconsistent with the sufferer's responsibility for the features of the illness. People can of course be responsible for initially contracting or risking contracting diseases: A person who is overweight, does not exercise and smokes surely is responsible for risking hypertension; the person who in inappropriate circumstances engages in unprotected sex surely risks contracting sexually transmitted diseases. And the sufferer from many diseases can ameliorate the consequences by intentionally adhering to a prescribed medical regimen. But hypertension and infections are themselves mechanisms. The sufferer can not terminate all the signs and symptoms of the disease simply by intentionally choosing

¹ I borrow this felicitous phrase from Jay Wallace's superb book on responsibility. R. Jay Wallace, *Responsibility and the Moral Sentiments* (Cambridge: Harvard University Press, 1994). Wallace treats the phrase as encompassing both rationality and control defects. I prefer to limit it to the former, however, and will suggest that most control defects can be assimilated to rationality defects.

to cease being hypertensive or infected. Irreducible mechanism is at work.

Despite the potential contribution of human agency to the cause and maintenance of some diseases, no one denies that these are fundamentally diseases. Moreover, with many and perhaps most diseases, the sufferer is not responsible for contracting the disease and for many there is little or nothing the sufferer can do to help. Although people can sometimes be complicit in their own diseases, the disease model is so powerful that people who are sick are not in general considered responsible and judged accordingly. The dominant image of people with diseases is that they are the victims of pathological mechanisms who thus deserve sympathy and help.

The brain disease model of addiction borrows heavily from the powerful moral and social associations of the general concepts of illness and disease. Supported by highly technical anatomical, physiological and genetic research demonstrating that addictions appear to have a biological basis, the brain disease model inevitably suggests that the addict is sick. The signs and symptoms of the disease – primarily compulsive drug seeking and use – are seemingly the mechanistic consequence of pathological biological structures and functions over which the addict has no control once prolonged use has caused the pathology. For those whose thinking is driven by the brain disease model, this image is applauded and promoted. For example, a recent editorial in the *American Journal of Psychiatry* opens as follows:

American psychiatry has made remarkable progress in recategorizing the addictive disorders from moral failures to brain diseases, but the need for community education continues. The concept of moral failure is by no means gone from the discussion of addictive disorders, as evidenced by our country's investment in criminal justice rather than treatment ...²

Such thinking can in part reflect battles over turf, funding and the like, but it is doubtlessly sincerely motivated.

² Thomas R. Kosten, "Editorial: Addiction as a Brain Disease", *American Journal of Psychiatry* 155 (1998), p. 711; accord, Alan I. Leshner, Science is Revolutionizing Our View of Addiction – and What to Do About It, *American Journal of Psychiatry* 156 (1999), p. 1.

Virtually all mechanistic models of problems that bedevil society, including the medical model, are alluring because they imply that there are technical, "clean" solutions. Fix the "pathological mechanism", fix the social problem it produces; do not worry about refractory human behavior and messy moral accountability. I have used the medical model for rhetorical purposes because it is much in the news, and as we shall see presently, there is progress in the biological understanding of addiction. But any black-box mechanistic model of the phenomenon of addiction would have done as well.

Criminal law's concept of the person is the antithesis of the medical model's mechanistic concept. Although all honest people will admit that causes beyond the person's control can make an agent the type of person likely to commit crimes or can put the agent in the kind of environment that predisposes people to criminal activity, the law ultimately views the criminal wrongdoer as an agent and not simply as a passive victim who manifests pathological mechanisms. Unless either the person did not act or an excusing condition is present, agency entails moral and legal responsibility that warrants blame and punishment. Suffering from a disease *simpliciter*, such as schizophrenia, does not itself mean that the defendant did not act or that an excusing condition obtained, although diseases and other causes may negate action or produce an excusing condition, such as gross irrationality. Most mental and physical diseases suffered by people who violate the criminal law, even severe diseases, do not have these exculpatory effects because they do not affect agency concerning criminal activity.³ Sick people who behave immorally or who violate the criminal law are almost always responsible agents.

Why does it matter if we conceptualize drug-related problems as the product of a brain disease? After all, drugs undoubtedly cause vast and often catastrophic personal and social misery and perhaps the program of research and intervention that the brain disease

³ Mental disorders seldom negate the act requirement and equally rarely negate either the mens rea required by the definition of crimes or the intentionality of immoral conduct. See, Stephen J. Morse, "Crazy Reasons", *Journal of Contemporary Legal Issues* 10 (1999), p. 210 (considering the act requirement); "Craziness and Criminal Responsibility", *Behavioral Sciences and the Law* 17 (1999), pp. 161–164 (concerning mens rea).

model implies can ameliorate the misery. Why should internequine disputes among philosophers of biology and medicine about the status of the disease concept, or the law's model of the person, or the pure moralizing of many stand in the way? They shouldn't, of course; nothing should stand in the way of useful research and interventions. Unfortunately, however, otherwise useful images or models can have negative consequences if they exceed their rightful boundaries. The wrong images in an inapt domain can produce misguided policies.

I suggest that whether the law should treat addiction as a disease and what that would mean are open conceptual and practical questions. Let us begin the process of closure by examining the foundations of the disease model of addiction. Then we will return to whether law and morality should logically and practically be guided by this model.

II. THE LOGIC OF ADDICTION AS BRAIN DISEASE

Armed with the newest tools for assessing brain and nervous system structure and function, addiction researchers have learned much about the biology of how human beings respond to various substances that many people want an awful lot, although using these substances may not be good for them. In a recent issue of *Science* devoted to the "Frontiers of Neuroscience: The Science of Substance Abuse", an article entitled, "Addiction is a Brain Disease, and It Matters",⁴ breathlessly describes the current state of knowledge. The opening paragraph is worth quoting in full.

Dramatic advances over the past two decades in both the neurosciences and the behavioral sciences have revolutionized our understanding of drug abuse and addiction. Scientists have identified neural circuits that subsume the actions of every known drug of abuse, and they have specified common pathways that are affected by almost all such drugs. Researchers have also identified and cloned the major receptors for virtually every abusable drug, as well as the natural ligands for most of these receptors. In addition, they have elaborated many of the biochemical cascades within the cell that follow receptor activation by drugs. Research has also

⁴ Alan I. Leshner, "Addiction Is a Brain Disease, and It Matters", *Science* 278 (1997), p. 45. Note the similarity to the language of the editorial cited in note 2 supra.

begun to reveal major differences between the brains of addicted and nonaddicted individuals and to indicate some common elements of addiction, regardless of the substance.⁵

How is this disease entity, about which we have learned so much, defined? After all, the validity of the biological findings about the entity depends on a reliably measurable definition. The article defines the "essence" of addiction as follows:

compulsive drug seeking and use, even in the face of negative health and social consequences.⁶

Is this a consensus definition and what precisely does it mean? Although the definition is stated authoritatively in a state of the art review in our most prestigious general scientific journal, in fact it is a loose characterization at best of the definitions upon which it relies. Indeed, there is no consensus definition and any definition chosen will be problematic.⁷

Consider first the provenance of this definition. The article cites two sources: the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* and an Institute of Medicine publication, *Pathways of Addiction*.⁸ *DSM-IV* does not include compulsive seeking and use as a necessary criterion of either Substance Dependence or Substance Abuse, the diagnoses that would include

⁵ *Id.* I quote this article at length because it is an excellent state of the art review and exemplifies a particular type of thinking about addiction. Observe, however, that despite the concession to the behavioral sciences in the first sentence of the quoted paragraph, the remainder describes solely biological advances and the remainder of the article fails to note one "dramatic advance" in the behavioral understanding of addiction.

⁶ *Id.* at 46.

⁷ See Herbert Fingarette and Anne Fingarette Hasse, *Mental Disabilities and Criminal Responsibility* (Berkeley: University of California Press, 1979), pp. 145-152 (dated but still accurate account and explanation of why even clear theories and definitions would not make clear the relevance of the disease concept to criminal law).

⁸ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV* (Washington, D.C.: American Psychiatric Association, 1994) [hereinafter *DSM-IV*]; Institute of Medicine, *Pathways of Addiction: Opportunities in Drug Abuse Research* (Washington, D.C.: National Academy Press, 1996) [hereinafter *Pathways of Addiction*].

the disease more popularly termed, "addiction." Indeed, it is not mentioned as one of the set of criteria for either disorder.⁹

DSM-IV defines the generic "essential feature" of the class of substance dependence disorders as,

a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that usually results in tolerance, withdrawal and compulsive drug-taking.¹⁰

DSM-IV does state that "craving (a strong subjective drive to use the substance)", although not a specific criterion of the class of substance disorders or of any specific substance dependence disorder, is "likely to be experienced by most (if not all) individuals with Substance Dependence."¹¹

Pathways of Addiction defines addiction as,

drug seeking behavior involving compulsive use of high doses of one or more drugs, licit or illicit, for no clear medical indication, resulting in substantial impairment of health and social functioning.¹²

Although this definition also relies on *DSM-IV*, we have just seen that *DSM-IV* does not make compulsive drug seeking and use criterial for addiction. At most, *DSM-IV* includes repetitive drug use and craving as usual but not necessary features. *Pathways of Addiction* also cites generally The World Health Organization's *International Classification of Disorders*.¹³ But this classification system, too, does not make compulsive drug seeking and use a necessary

⁹ *DSM-IV*, note 8 supra, at 181–183.

¹⁰ *Id.* at 176. *DSM-IV* mentions compulsive use as a usual "essential feature" of substance dependence and discusses it as such in its general discussion of substance dependence. See notes 11–12 and accompanying text, *infra*. But again, it is not a necessary or sufficient criterion. Moreover, as I discuss below, the descriptive term "compulsive" suffers from various defects. See notes 15–20 and accompanying text, *infra*. I should also add that, for various reasons, *DSM-IV* does not use the term disease because it wishes to avoid some of the controversy associated with some of the connotations of the term.

¹¹ *Id.*

¹² *Pathways of Addiction*, supra note 8, at 19.

¹³ World Health Organization, *ICD-10: The ICD-10 Classification of Mental and Behavioural Disorders* (Geneva: World Health Organization, 1992) [hereinafter *ICD-10*].

diagnostic feature of the class of "dependence syndromes" or of any specific syndrome.

ICD-10 describes the dependence syndrome generically as follows:

A cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take psychoactive drugs ..., alcohol or tobacco.¹⁴

Two specific but *not* necessary *ICD-10* criteria for dependence are a "strong desire or sense of compulsion to take the substance", and "difficulties in controlling substance-taking behaviour."¹⁵ According to *ICD-10*, it is thus possible to be diagnosed as dependent in the absence of any analogue to "compulsive" behavior.

The failure of *DSM-IV* to include compulsive drug seeking and use in its necessary generic or specific criteria for Substance Dependence is not remedied by consulting other related criteria in the diagnostic system. For example, *DSM-IV* defines the "essential feature" of an Impulse-Control Disorder as, "the failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or to others."¹⁶ *DSM-IV* continues as follows in its generic introduction to impulse control disorders.

For most of the disorders in this section, the individual feels an increasing sense of tension or arousal before committing the act and then experiences pleasure, gratification, or relief at the time of committing the act.¹⁷

Again, this definition may be related in a loose way to what one might mean by compulsion, but it is surely overinclusive as a precise definition of the term.

Finally, *DSM-IV*'s formal use of the diagnostic term, "compulsion", which is defined as part of the anxiety disorder, Obsessive-

¹⁴ *Id.* at 75.

¹⁵ *Id.*

¹⁶ *DSM-IV*, supra note 8, at 609. This feature refers to "impulse control disorders not elsewhere classified", but *DSM-IV* makes clear that other disorders, such as substance-related disorders, "may have features that involve problems of impulse control." *Id.*

¹⁷ *Id.*

Compulsive Disorder, bears little relation to compulsive drug seeking and using. Compulsions are defined generically as,

...repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) the goal of which is to prevent or reduce anxiety or distress, not to provide pleasure or gratification. In most cases, the person feels driven to perform the compulsion to reduce the distress that accompanies an obsession or to prevent some dreaded event or situation By definition, compulsions are either clearly excessive or are not connected in a realistic way with what they are designed to neutralize or prevent.¹⁸

Addictive drug seeking and using is excessive, but it is surely realistically designed to prevent anxiety and distress among addicts for whom this is the primary motivation to take drugs. In either case, the compulsions of the person with Obsessive-Compulsive Disorder are distinguishable from the symptoms of Substance Dependence.

Neither "compulsion" nor "compulsive" is among the terms included in *DSM-IV's* "Glossary of Technical Terms."¹⁹ On the other hand, the most recent edition of the *American Psychiatric Glossary* does define "compulsive" as follows:

Refers to intensity or repetitiveness of behavior rather than to compulsive behavior strictly defined. Thus, "compulsive drinking" and "compulsive gambling" refer to *cravings* that may be intense and often repeated, but they are not viewed as compulsions [emphasis added].²⁰

Craving is not defined, but this definition of compulsive does seem akin to the generic definition of addiction under consideration.

In sum, the verbal definition of the "essence" of addiction in the quoted review at the beginning of this section depends on an extremely loose characterization of criteria from the two most influential diagnostic systems now in use in the United States and abroad. Moreover, the loosely-characterized criteria are neither necessary nor sufficient to indicate the presence of the disease. No consensual definition of the essence of addiction exists and any

¹⁸ *Id.* at 418; the specific criteria are listed at 423.

¹⁹ *Id.* at 764-765.

²⁰ Jane E. Edgerton and Robert J. Campbell III (eds.), *American Psychiatric Glossary* (Washington, D.C.: American Psychiatric Press, 7th ed. 1994), pp. 44-45 (1994).

definition of addiction seems to generate as much controversy as illumination.²¹

Let us assume, however, that some reasonable amalgam of the various definitions given is used. Imprecision would still bedevil attempts to work with the amalgamated criteria. However it is defined, the crucial criterial term, "compulsive", is frustratingly vague and dependent primarily on assessment of subjective states. For example, *DSM-IV's* criterion for Impulse-Control Disorder – the failure to resist a drive, impulse or temptation to engage in harmful activity – does not disclose whether the person is unable or unwilling to resist or how hard it is to resist, nor does it indicate how harmful the act must be.²² Further, the definition of Impulse-Control Disorder does not reveal how much inner tension and how much release-seeking behavior is necessary to qualify for the diagnosis of an impulse-control problem. *ICD-10's* criterion of an "often strong, sometimes overpowering" drive again does not specify how strong is strong enough and what is meant by overpowering. In the case of either of these criteria, if simply taking the drug repetitively (or, seemingly, even once if it leads to a predictably harmful outcome) is sufficient, then the definition is essentially circular.

Such definitions will ultimately depend on a subjective assessment of the strength of desires and a normative assessment of when the seeking and using itself is sufficiently harmful to the agent to appear like a symptom, rather than like a bad or even harmless habit or a hobby. And how bad it will be for the agent will in turn depend a great deal on environmental variables that are entirely independent of brain states, such as the cost, availability and legality of the substance.²³

²¹ Institute of Medicine, *Dispelling the Myths About Addiction: Strategies to Increase Understanding and Strengthen Research* (Washington, D.C.: National Academy Press, 1997), pp. 13-14. [hereinafter *Dispelling Myths*].

²² Attempts to measure the strength of compulsions have been conceptually confused or methodologically suspect. See, Stephen J. Morse, From 'Sikora' to 'Hendricks': Mental Disorder and Criminal Responsibility, in Lynda F. Clausel & Richard J. Bonnie (eds.), *Mental Health Law in Evolution*, forthcoming.

²³ See Jon Elster, *Strong Feelings: Emotion, Addiction and Human Behavior* (Cambridge: MIT Press, 1999), pp. 166-169; Alan Schwartz, "Views of Addiction and the Duty to Warn", *Virginia Law Review* 75 (1989), pp. 517-523 (rejecting the "strong substance caused view" of addiction).

The definitional problems can be apparently remedied in various ways. First, compulsion (or addiction) could be defined operationally in terms of scores on various scales. There are many virtues to such an approach and I applaud it. Even if various scales are reliable, however, validity problems will remain because there is no diagnostic gold standard. Moreover, there is no consensual agreement on the scales. Second, compulsion can be defined in terms of objective behavior, without regard to subjective experience, or in economic terms, moves that have theoretical, measurement and esthetic advantages.²⁴ Indeed, there is clear evidence that classical and operant conditioning best explain some addictive phenomena and some researchers believe that any definition that includes subjective experiences such as craving will be circular. Nevertheless, a purely objective definition will fail to consider the addict's subjectivity, which most investigators and informed observers believe is crucial to adequate understanding.²⁵ If craving is crucial to the definition, including it does not threaten circularity because craving can exist in the absence of seeking and using behavior. Finally, addiction could be defined in terms of tolerance and withdrawal because these physiologically-related states might be relatively objectively measured. Indeed, these criteria are included in both *DSM-IV* and *ICD-10*, but they are neither necessary nor sufficient. Compulsive drug seeking and using can exist without them and they can exist without accompanying compulsive activity and consequent harms.

Consensual agreement about the definition of addiction is lacking and nagging doubts beset studies that compare addicts and nonaddicts. Nonetheless, I will make the assumption, and in fact believe, that craving, a subjectively experienced strong desire, is (or almost always is) a central part of the condition that raises biopsychosocial, moral and legal problems. And despite the cautions just considered, I also believe that dramatic scientific advances have been made. Studies that use definitions that are not utterly valid can nevertheless shed light on a class of associated problems.

²⁴ See generally, George Ainslie, *Picoeconomics: The Strategic Interaction of successive Motivational States within the Person* (Cambridge and New York: Cambridge University Press, 1992), esp. at 96–273.

²⁵ See Elster, supra note 23, at 62–65.

Many recent advances in our understanding of addiction involve biology, but the essence of the brain disease, addiction, is nonetheless primarily behavioral. Addiction is defined entirely by behavioral signs (drug seeking and use, which are intentional actions) and psychological states (the subjective experience of “compulsive” cravings). The *DSM-IV* and *ICD-10* criteria, upon which the summary beginning this section relied, necessarily include drug activity, which is undoubtedly intentional action. I substantially agree with this primarily behavioral and psychological definition of addiction to substances (and to other potentially addictive activities).²⁶

Although addiction is defined primarily by behavioral criteria,²⁷ the disease model considers it a disease for the following reason:

That addiction is tied to changes in brain structure and function is what makes it, *fundamentally*, a brain disease. A metaphorical switch in the brain seems to be thrown as the result of prolonged drug use. Initially, drug use is voluntary behavior, but when that switch is thrown, the individual moves into the state of addiction, characterized by compulsive drug seeking and use [A]ddiction is, *at its core*, a consequence of fundamental changes in brain function . . . [emphasis added].²⁸

Consequently, if a person does not compulsively seek and use drugs, the person is then not an addict, even if the brain function and structure is “addicted.” In such cases, the disease model would probably be unwilling to abandon the diagnosis altogether and would term the person as being “in remission.” After all, addiction is notoriously a “relapsing” illness.

Addiction thus has the following strange property: Although the addict's brain has been changed to produce the compulsive drug activity – the “switch” has been thrown by mechanistic brain physiology – we know that many sufferers can and do cure the disease temporarily and sometimes permanently. Addicts are somehow able to turn off the switch by intentionally choosing not to engage

²⁶ Jon Elster is more skeptical about the scope of what might count as an addiction. See Elster, supra note 23, at 56–58.

²⁷ By behavioral criteria, I refer to thoughts, feelings, perceptions, and actions. Addiction shares this feature with virtually all the specific mental disorders that *DSM-IV* includes: Behavioral criteria are entirely sufficient to diagnose the disorder; pathophysiological criteria are almost never required.

²⁸ Leshner, supra note 4, at 46.

in the criterial actions, a choice that may include intentionally activating precommitment strategies and other techniques to avoid use. Some quitters who met the criteria for addiction continue to have the persistent subjective craving or desire to continue drug activity, but they do not act to satisfy the craving. Other quitters lose the craving altogether²⁹ and are entirely sign and symptom free, although their brains, too, were by definition previously changed. More interesting, perhaps, most people who use medically-prescribed, potentially addicting analgesics over prolonged periods and therefore surely change their brains in the requisite way do not become addicted and cease use altogether when the medical need ends.

A more textured reading of the implicit causal account is possible. The brain disease model seems to suggest that brain changes are sufficient and perhaps necessary causes in all cases of the disease manifested by compulsive drug seeking and use. Now, some brain changes surely accompany any drug use (and all other exposures to internal and external stimuli),³⁰ but the changes must evidently be of the right sort to qualify as diagnostic for the brain disease, addiction. It is entirely plausible, however, that the definitional brain changes are neither necessary nor sufficient causes of addiction. That is, some people may engage in compulsive drug seeking and using without prolonged prior use or without the diagnostic brain changes. And some people, such as the quitters and the medically-prescribed users, have the requisite brain changes after prolonged use, at least for some period of time, but do not engage in compulsive drug activity, despite the brain changes. At the least, the brain changes do not seem sufficient in all cases because even compulsive drug activity is sensitive to and can be terminated by a change in the addict's setting. In sum, it is virtually certain that all compulsive drug seekers do not have the criterial brain changes and all with changes probably do not behave compulsively. Still, having the right type of brain changes may predispose the agent to engage in compulsive drug activity. Perhaps, however, compulsive drug seeking and using is not the indicator of a unitary disease mechanism.

²⁹ Arnold M. Ludwig, *Understanding the Alcoholic's Mind* (New York and Oxford: Oxford University Press, 1988), pp. 34–35.

³⁰ See the discussion below.

Shorn of special pleading, we know from the new biology that there seems to be a quite specific biological substrate to much, but an undetermined amount of, compulsive drug seeking and use. This should come as no surprise to any thinking person and it does not imply that the activity is the symptom of a disease. There is a biological substrate to all behavior and the brain is always changing in response to stimuli. This is tautological. Environmental stimuli are always interacting with the recipients' unique brains and nervous systems, thus affecting the recipients' initial responses to those stimuli. Moreover, it is virtually certain that any prolonged exposure to particular stimuli is likely to change brain structure and function. We know more about addiction because it is a problem we study, but imagine what researchers might discover if they performed sophisticated brain studies on people who exposed themselves persistently to Bach or to various types of television programs. Changes would be found. Prolonged exposure to some stimuli will surely affect the brain more than exposure to other stimuli, but the brain will always change.

It is surely plausible that many potentially persistent desires for pleasure-seeking behavior will tend not to persist in the absence of predisposing brain changes. But deciding whether biologically-driven, persistent and intense desires and the related activities to satisfy these desires are symptoms of a disease requires an independent definition of disease. A biological substrate alone is insufficient. All human behavior has a biological substrate and if this were the criterion, all human activity would be the symptom of a disease.

The lack of a consensual definition of "disease" or "illness" among philosophers, physicians and social scientists is well-known.³¹ Virtually any criteria, especially if they encompass intentional behaviors as "symptoms", will be both over- and under-inclusive and suffused with non-biological, normative and social criteria.³² Consider, for example, *DSM-IV*'s generic criteria for

³¹ See, e.g., Arthur L. Caplan, H. Tristram Engelhardt, Jr. & James J. McCartney (eds.), *Concepts of Health and Disease: Interdisciplinary Perspectives* (Reading, MA: Addison Wesley Publishing Company, Advanced Book Program, 1981).

³² See, e.g., Jerome C. Wakefield, "The Concept of Mental Disorder: On the Boundary Between Biological Facts and Social Values", 47 *American Psychologist* 47 (1992), p. 373.

when a "clinically significant behavioral or psychological syndrome or pattern" qualifies as a mental disorder:

present distress ...or disability ...or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.³³

Is "clinically significant" independent of the further criteria? If not, what work does it do? The further criteria are inevitably blurry and require normative judgments. As *DSM-IV* itself admits, "no definition adequately specifies precise boundaries."³⁴ Just because physicians and psychologists can point to biological findings, term addiction a disease, treat addictions, and are reimbursed for such treatment does not make addiction a disease. More work needs to be done. Characterizing a condition as a disease and characterizing associated features as symptoms does not require, however, that a consensual, incontrovertible precise definition must be in place. Indeed, there are virtues to calling some addictive states a disease. Nonetheless, biological findings alone are insufficient to qualify addictions as diseases.

The new biology has not yet led to major discoveries of successful biological interventions to cure the disease.³⁵ Other drugs, such as methadone, may help some addicts kick some addictions, but no one claims that these drugs cure the underlying pathophysiology or anatomical pathology. That is, there is yet no evidence that these treatments reverse or ameliorate the brain changes that prolonged use allegedly produces. Understanding the supposed basic brain mechanism of addiction has not produced magic bullets. Even quitting for long periods of time, with or without treatment, does not guarantee that compulsive seeking and use will not recur. If the brain disease story is right, prolonged use changes brain structure and function, but prolonged abstinence does not, or at least, not enough. Although the brain is famously resilient, the brain disease model

³³ *DSM-IV*, supra note 8, at xxi.

³⁴ *Id.* See also, Jerome C. Wakefield, "Disorder as Harmful Dysfunction: A Conceptual Critique of *DSM-III-R*'s Definition of Mental Disorder", 99 *Psychological Review* 232 (1992), p. 232 (addressing same generic definition *DSM-IV* uses).

³⁵ But see, *Dispelling the Myths*, supra note 21, at 73–87 (more optimistic view based on recent research, but still admitting limited effectiveness and substantial knowledge gaps).

implies that prolonged drug use is an apparently exceptional insult that changes the brain for the worse on a permanent basis.

Despite the basic biological advances, the most successful treatment strategies to date have been behavioral and social, including the quasi- (and not so quasi) religious regimens associated with Alcoholics Anonymous and the like. In fact, those committed to the brain disease model do not deny the importance of behavioral variables and of social context and cues. Keeping the addict away from the setting in which use typically occurs is powerfully prophylactic, for example. To the best of my knowledge, no one claims that successful behavioral interventions work by fixing the underlying brain pathology that hypothetically produces compulsive seeking and use.

Finally, if one accepts that behavioral criteria are the primary characteristics of addiction, as the brain disease model does, then addiction need not be limited to compulsive seeking and using of potentially abusable substances. According to the behavioral definition, one could be addicted to other substances, such as chocolate or pistachio nuts, or to various activities, such as golf, gambling, eating and sex, and to human relationships, such as intense attachments.³⁶ Indeed, this is suggested by the *American Psychiatric Glossary*'s definition of "compulsive", which refers specifically to "compulsive gambling."³⁷

Most of these other potential addictions do not cause negative health or social consequences, but such consequences cannot be a necessary part of the behavioral definition of addiction. Consider a young and otherwise healthy nicotine or ethanol addict who learns, alas, that he or she has a fast-moving and fatal illness neither caused by nor potentiated by the addiction. In such cases, there might be no adverse consequences to the addiction – indeed, curing it might be dreadful – but the person is surely an addict. And in most of these other addictions, there may be no evidence of distinct brain

³⁶ Even the skeptical Jon Elster concedes, for example, that compulsive gambling shares many characteristics with substance addictions and might well qualify as an addiction and that being in love is like being addicted to speed. See Jon Elster, *Gambling and Addiction*, in Jon Elster & Ole-Jorgen Skog (eds.), *Getting Hooked: Rationality and Addiction* (Cambridge and New York: Cambridge University Press, 1999), pp. 208, 229 (1999); Elster, note 23 supra, at 5.

³⁷ *American Psychiatric Glossary*, supra note 20.

changes that differentiate addicted and non-addicted brains. But such changes would probably be found if researchers looked hard enough with the right tools.

III. BRAIN DISEASE V. MORAL FAILURE

Researchers have made genuine gains in our understanding of the behaviors that are called the disease, addiction. Many of these advances promise to lead to interventions to help those who want substances so much that gaining control of their desires is apparently a gargantuan hurdle. Nevertheless, the disease model is far from triumphantly obliterating all alternative ways of thinking about addiction.

Assuming the validity of the biological findings, here, in a nutshell, is what I believe we confidently know or can assert plausibly about drug addiction, most of which is consistent with many of the alternatives to the biological disease model. Some people use substances for which they develop a craving. That is, they develop a very intense, insistent level of subjective desire for the substance that is apparently satisfied by use only temporarily. The desire quickly reasserts itself and again the craving returns. Other people use potentially addicting substances regularly, but do not develop an addiction. They are the well-controlled social drinkers or recreational heroin "chippers," for example. Indeed, the majority of the regular users of any drug do not develop classic addictions.³⁸ Prior to initial use, virtually all potential users know that some percentage of users will develop the craving for the drug and will consequently suffer from the health, social and legal problems that result from

³⁸ It is sometimes claimed that some drugs, such as crack cocaine, are counterexamples, but there is little evidence that this is true. In general, the more experience is gained with a drug, the less it appears inevitably addicting. See Timothy Egan, "A Drug Ran Its Course, Then Hid With Its Users", *New York Times*, section 1, p. 1 (September 19, 1999) (discussing, *inter alia*, the declining rate of crack usage, the effect on potential users of seeing the drug's effects, and the natural cycle of drug usage). Jon Elster cites the case of a particularly debased crack addict to demonstrate that, at least during binges, crack addicts are reward-insensitive. But the most interesting part of the anecdote is that the other participants in the crack party evidently did not inevitably start bingeing and become reward-insensitive. See Elster, *supra* note 23, at 166-167.

seeking and using continuously to satisfy the craving. Some users develop the craving soon after initial use; others do so later. For some, the craving is so strong that seeking and using the substance becomes a central life activity and even central to the agent's identity. The search for and use of the drug become one's life.³⁹ Seeking and using appear to have a compulsive quality for many such people, who report a subjective experience of intense craving that drives them. Seeking and using is intentional action, even in cases marked by intense craving and compulsive seeking and use. In a substantial number of cases, the drug activity threatens and causes adverse social, health and legal consequences. Thus, the agent has very good long-term reasons not to engage in drug seeking and use. Nevertheless, addicts tend to be steep time discounters when they evaluate drug seeking and using, and for some, use may be rational in the short-term. Thus, many continue to use and to imperil their lives. There seems to be a biological substrate for such an outcome, but there is no specific biological treatment. Various behavioral and social interventions are successful in some cases, but no one is sure why. In some cases, people who have been compulsive seekers and users simply quit. For some the craving disappears; for others it does not. Many who quit start again.

If addiction is properly characterized as a disease, there is nonetheless an enormous and highly unusual amount of human agency involved. Indeed, intentional action is more central to addiction than to most other physical or serious mental disorders. Only other disorders of desire, such as Impulse-Control Disorders, or personality disorders, which are problematically considered diseases, seem so infected with agency.

Discovery of biological causes does not negate agency. Most important, causation *per se* does not negate agency and is not itself an excuse. Moreover, the relation between biology and responsibility is often misconceived. For example, those hooked on the disease model often point to evidence for a genetic predisposition to addiction and its associated common neural changes. What does genetic predisposition mean, however? It surely doesn't mean that there is a genetic repertoire for going to the liquor store or to one's

³⁹ See Philippe Bourgois, *In Search of Respect: Selling Crack in El Barrio* (Cambridge and New York: Cambridge University Press, 1995).

corner drug dealer, paying the money for the substance, and then drinking or ingesting one's drug of choice. Perhaps it means that some people are more inclined to have the brain changes associated with craving. Still, the agent is not an addict unless the person seeks and uses the drug. And when she seeks and uses, she acts. She is not legally unconscious, even according to the most extravagantly narrow definition of action, and she surely acts intentionally. Pathology may be the source of a desire and satisfying it may produce harmful consequences, but activity to satisfy it is nonetheless action. The definition of addiction as brain disease admits this much.

Finally, addiction is a disease that can be eliminated by a large number of craving sufferers simply by intentionally ceasing, by hook or crook, to seek and use. Presumably this occurs because the addict finally has sufficient reason to do so. This fact is not part of the definition of addiction as a brain disease, but it is true. Even if addiction is properly and most usefully characterized as a disease, at the extreme its necessary behavioral signs are virtually all reward-sensitive or reason-responsive: An addict threatened with instant death for seeking and using will not seek and use unless she already wishes to die at that moment or doesn't care if she does.⁴⁰

According to the dominant legal model of the person, the criminal law operates by providing rules and consequences for violating the rules that give potential miscreants good reasons not to offend. It assumes that the creatures to whom these reasons are addressed are generally capable of using these reasons as premises in practical reasoning that should in most cases lead to the conclusion that the agent should not violate the law. Of course, society is delighted if other forms of social control, such as internalized conscience, informal sanctions, and a host of others also tend to limit criminal conduct.

No sensible person thinks that the criminal law is sufficient to reduce the level of criminalized harms to acceptable levels in a world of morally imperfect beings who inhabit a non-police state. Non-criminal justice approaches to addiction can be extremely useful, even if criminalization can also help. There is no reason to believe

⁴⁰ See the discussion below.

that our thinking about addiction must be polar, that it is only brain disease or only intentional conduct, that it is best treated only medically or psychologically or only by criminalization. Addiction can be both brain disease and moral weakness, both a proper subject for treatment and for moral judgment.

Let us return to the editorial quoted above that bemoaned the failure of the community to accept totally the brain disease model as exemplified by the use of criminal justice rather than treatment.⁴¹ First, it is marked by either/or thinking and a tone of unattractive medical imperialism. Its assumption that behavior symptomatic of brain disease cannot also be evidence of moral failure is question-begging. Perhaps, as the next section will discuss, some symptomatic behavior is excusable, but if so, the reason is that a genuine excusing condition obtains and not per se because the behavior is symptomatic.

Most important, the editorial evidences a superficial understanding of the role of criminal justice. No one suggests that we should criminalize and punish the status of being an addict. Indeed, doing so would be unconstitutional.⁴² Moreover, failure to criminalize is no guarantee of an effective social response. Two of the most addictive drugs, ethanol and nicotine, which cause untold personal and social harm, are entirely lawful, freely available and relatively inexpensive. The medical model's preferred mode of response to seeking and using these lawful substances is largely unfettered by nasty criminalization, but the problems these substances cause remain grave and when people manage to quit – as many do – it is more a response to reason than a result of medical or psychological intervention in the brain and nervous system.

Few people who adopt a unitary medical model suggest that production, possession, sale, and use of currently illicit drugs should be entirely decriminalized and deregulated. There is apparently a necessary role for criminal justice concerning these drug activities. Seeking and using drugs are distinguishable from production, sale and other criminal activities related to drug use. Even if one wanted on "medical grounds" to decriminalize possession for personal use and such use itself, few argue further that we should decriminalize

⁴¹ Kosten, *supra* note 2.

⁴² *Robinson v. California*, 370 U.S. 660 (1962).

or deregulate production, possession for sale, sale itself, or other property and personal crimes that may be part of the drug life or necessary to support addiction. Unless the authorities have some legal tool, such as the threat of criminal sanctions or enhanced punishment, to coerce users to accept treatment, many, perhaps most, will not do so willingly. Most addicts already know other good reasons to try treatment, albeit many engage in denial and other defense mechanisms that may prevent them from keeping such reasons present to their minds. Finally, given the undoubted but limited success of available treatment programs, the criminal justice response may ultimately reduce drug use more than treatment, and indeed, may protect liberty more than a parentalistic, treatment approach.⁴³ Indeed, some sophisticated observers believe that decriminalization would produce catastrophic increases in addiction.⁴⁴

The important questions, of course, are what the proper role of moral evaluation and criminal justice should be and whether this role is inconsistent with sensible medicalized responses, such as treatment. Common sense suggests that all such approaches are not necessarily inconsistent and can be simultaneously and usefully employed.

IV. ADDICTION AND RESPONSIBILITY

The central theoretical problem in using a broad view of addiction is determining whether the person is in fact *uncontrollably* dependent on that particular action, substance or source of satisfaction.⁴⁵

⁴³ In *Powell v. Texas*, Justice Marshall writing for the plurality and rejecting a claim that the Constitution requires states to provide an excuse to crime based on the compulsion allegedly associated with the disease, alcoholism, was unwilling to reject the usefulness of criminalization as one means of addressing the problem. Based on our limited knowledge and treatment success, Marshall wrote that there might be deterrent and civil liberties virtues to using the criminal justice system to respond to the behavioral consequences of alcoholism. *Powell v. Texas*, 392 U.S. 514, 528-531 (1968).

⁴⁴ See, James Q. Wilson, "What To Do About Crime", *Commentary* 25 (September, 1994).

⁴⁵ Roy F. Baumeister, Todd F. Heatherton and Dianne M. Tice, *Losing Control: How and Why People Fail at Self-Regulation* (San Diego: Academic Press, 1994), p. 134. The authors believe that the concept of addiction should be limited to

People are morally and criminally responsible if their intentional action, accompanied by an appropriate mental state, violates a moral expectation or a criminal prohibition. Action is excused if the agent was incapable of rationality or compelled to act.⁴⁶ Thus, if prohibited activity does not meet the criteria for intentional action or if it is excused action, the harmdoer will be exculpated. The term "uncontrollably" suggests that the symptoms of genuine addiction, including behavior, are mechanisms and therefore the genuine addict should not be responsible for those symptoms.

This section considers responsibility for initial use and for becoming an addict. It then addresses whether addicts should be held responsible for drug seeking and using and for other drug-related activity. Finally, it considers briefly whether "social responsibility" for addiction undermines individual responsibility.⁴⁷

A. *Becoming an Addict*

Let us start with pre-addiction use. Before they reach the age of reason, some children and early adolescents have substantial experience with alcohol, nicotine and other drugs, and a small number of them become problem users. Moreover, early experimentation with substances such as nicotine is highly predictive of later behavior that risks health. Still, let us make the simplifying assumption that virtually all people have their first substantial experience with potentially addicting substances when they are mid-adolescents, an age at

physiological and psychological dependence on *substances* that leads to some loss of control and aversive reactions such as "withdrawal" when the substance is absent. *Id.* at 133.

⁴⁶ I will assume that justified conduct does not violate a moral or criminal prohibition. A more formalistic criminal law analysis holds that justified conduct does violate a prima facie criminal prohibition, but ultimately the conduct is judged right or at least permissible. See Michael S. Moore, *Placing Blame: A General Theory of the Criminal Law* (Oxford: Clarendon Press; New York: Oxford University Press, 1997), pp. 31-33, 64-67 (arguing that justification should be treated as part of the special part of the criminal law). In either case, illicit drug activity is almost never justified under current legal doctrine.

⁴⁷ Virtually the entire discussion and all the examples are drawn from criminal law, but suitably adjusted, the mode of analysis applies equally well to purely moral evaluation of statuses and conduct that are not criminal.

which adolescents are in general cognitively indistinguishable from adults.⁴⁸

By the age of reason, any competent person knows generally about the dangers of addicting substances. On the other hand, they may under-estimate the risks of becoming addicted and especially how bad it will feel to be addicted.⁴⁹ Experience with and empathy for those already addicted is simply no substitute for the real thing. Consequently, perhaps addicts aren't fully responsible for their addictions because they operate with insufficient information. This claim appears plausible and not unlike one objection to advanced directives for health care. For example, if one has never faced death or has never faced it while fully competent, how does the person know what she would really want under the circumstances? Although plausible, this claim seems too strong. There is sufficiently good information as a result of both observation and indirect sources about the perils of addiction to warrant the conclusion that those who take drugs understand the risks sufficiently to be held responsible if addiction ensues. After all, as long as people have general normative competence, including the ability to gather relevant information, perfect information is hardly required for responsibility.

One can deny that any drug use is within the limits of rationality because all drug use is immoral and choosing immorality is always irrational. Claiming generically that immorality is irrational is philosophically controversial, of course, and in this specific context it suggests a highly moralistic, virtue ethics. Why, precisely, is limited experimentation immoral? Because it feels good? Does all such use degrade the moral personality? Perhaps so. But, after all, limited initial experience genuinely hooks almost no one – especially if the diagnostic brain changes almost always require prolonged use.

The usual response to claims that experimentation is not necessarily irrational is that the process of addiction is insidious. No single instance of use seems to cross a threshold; the process is instead stealthily additive, a slippery slope. At some point, however, the addict is hooked without realizing it. Because no initial user

⁴⁸ See Stephen J. Morse, "Immaturity and Irresponsibility", *Journal of Criminal Law and Criminology* 88 (1997), pp. 15, 52–56.

⁴⁹ See Elster, *supra* note 23, at 185.

can predict whether and when he or she specifically will become addicted, it is always irrational to start or to continue, even if one is not yet hooked. There is truth to this response, but the insidiousness of the addiction process is well-known generally and proto-addicts are usually aware that they are developing a problem before the problem becomes an identifiable addiction. They may of course be "in denial" or using other defense mechanisms, such as rationalization, to avoid insight into their own conditions, but use of defense mechanisms, anyway an imperfect shield at best, is not an excusing condition that morality and law will recognize when serious harms occur. Again, one need not act on perfect information to be responsible. It is difficult to resist the conclusion that most and perhaps all use prior to addiction is conduct for which the user is responsible and, consequently, that most addicts are responsible for becoming addicted.

I should also like to suggest briefly that it is rational in some cases to choose intentionally to become an addict and to enter the addictive "life." This claim should be distinguished from the controversial arguments made by Gary Becker and others that addiction is itself rational.⁵⁰ My argument is that it can be rational to choose to become irrational, assuming, *arguendo*, that at least some addicts are irrational about their lives when they are addicted. Imagine a young person who has lived an extraordinarily deprived life and therefore has little human capital and few prospects. It is possible that the person could acquire the life skills and education to beat the odds, but rational calculation would suggest that the odds are overwhelmingly against success. In such circumstances, one can easily imagine that a life of intermittent "highs" or oblivion, for example, would be preferable to a clean, straight life, despite the threat of poverty, disease, and prison. Such a life would be limited but manageable, employing substances to help ignore or alleviate the misery of existence. Choosing such a life would be quite rational.⁵¹

⁵⁰ See Gary S. Becker, "A Theory of Rational Addiction", in Gary S. Becker, *Accounting for Tastes* (Cambridge: Harvard University Press, 1996), p. 50.

⁵¹ Although addicts may be largely responsible for becoming addicts and also responsible for much of their drug-related activity while addicted, our society should try to help change the odds for those in my not-hypothetical example. See section IV.C. *infra*.

Even if consciously risking or intentionally choosing to become an addict is not rational behavior, responsibility for conduct does not require that one acted for good, rational reasons. It is sufficient that the agent retain the general capacity for rationality. Until addiction occurs – and perhaps thereafter – there is little reason to believe that otherwise responsible agents do not retain this general capacity.

Finally, few people are compelled to become addicted. Peer pressure to experiment may be common in adolescence and early adulthood, but it seldom takes a form that would justify a compulsion excuse. First use is almost always intentional and in most cases rational, because virtually no-one is immediately hooked or harmed. The user tries the substance to please friends, for the thrill of experimenting or being on the edge, for the pleasure or arousal the substance produces, and for a host of other reasons that do not suggest irrationality that might excuse. Moreover, almost no one is literally forced to become an addict by the involuntary administration of substances.⁵²

B. *Being Addicted*

Let us assume that it is an open question whether being responsible for becoming an addict necessarily implies that the addict is therefore responsible for any and all consequences of being addicted. For many, this may be a strong assumption because they take the view that people should be strictly liable for all the consequences that may flow from responsibly causing oneself to become non-responsible. Indeed, the criminal law contains many doctrines that instantiate a similar view of strict liability, including those doctrines that do not allow evidence of intoxication to be used for defensive purposes.⁵³ Without making this assumption, however, the problem of responsibility for further consequences becomes uninteresting.⁵⁴

⁵² Infants born to addicted mothers might be an exception, but this exceptional case does not undermine the general argument.

⁵³ See, e.g., *Montana v. Egelhoff*, 518 U.S. 37 (1996) (upholding the constitutionality of a state statute excluding evidence of intoxication relevant to whether the defendant in fact had the subjective mens rea required by the definition of the crime).

⁵⁴ I discuss the assumption further in this section.

Once addicted, should addicts be responsible for use and further drug-related activity? By definition, addicts, or anyway most of them, experience subjective craving. In some cases, withdrawal might also be feared, but most addicts know that the physical symptoms are manageable and for some of the “hardest” drugs, such as cocaine, there is no physical withdrawal. Craving is what drives the addict. Does this complicated state compel the addict to seek and to use the addictive substance and how does it affect the addict’s rationality?

1. *The Internal Coercion Theory*

Although the disease model and related language imply that the addict’s symptomatic behaviors are mechanisms, we know that this is simply not true. Compulsive states are marked by allegedly overwhelming desires or cravings, but whether the cravings are produced by faulty biology, including brain disease, faulty psychology, faulty environment, or some combination of the three, a desire is just a desire and satisfaction of it by seeking and using is human action. The addict desires, broadly, either the pleasure of intoxication, the avoidance of the pain of withdrawal or inner tension, or both. The addict believes that using the substance will satisfy the desire and consequently forms the intention to seek and to use the substance.

An analogy is often used to attempt to demonstrate that people suffering from compulsive states are similar to mechanisms. We are asked to imagine that a person is hanging by the fingernails from a cliff over a very deep chasm. The hapless cliffhanger is strong enough to hold on for a while, but not strong enough to save her life by pulling herself up. As time passes and gravity and muscle physiology do their work, she inevitably weakens and it becomes harder and harder to hang on. Finally it becomes impossible and the cliffhanger falls to her death. We are asked to think that the operation of compulsive desires or cravings is like the combined effect of gravity and muscle physiology. At first the hapless addict can perhaps resist, but inevitably she weakens and satisfies the desire for drugs.

Brief reflection demonstrates that the analogy is flawed as an explanation of why compulsive states are “just like” mechanisms. Unlike action to satisfy a desire, the fall is a genuine mechanism. We

know that holding on indefinitely is physically impossible and that the ultimate failure of strength is not intentional. More important, imagine the following counterexample: a vicious gunslinger follows around the addict and threatens to kill her instantly if she seeks or uses drugs. Assume that the addict wants to live as much as the cliffhanger. Literally no addict will yield to the desire.⁵⁵ Conversely, no cliffhanger will fail to fall, despite having the best reason not to. Indeed, even if the same vicious gunslinger threatened to shoot the cliffhanger immediately if she started to fall, she will fall every time. Of course, our liberal society does not force or even permit addicts to employ such a self-management technique, but the counterexample indicates that the addict's behavior is not a mechanism.

An addict is not a cliffhanger, of course, so let us consider some closer analogies, such as a powerful, persistent itch, or an increasingly full bladder, or the motor and verbal tics of those suffering from Tourette's Disorder.⁵⁶ It can be damnably hard not to scratch an itch, even if it is contra-indicated. An increasingly full bladder can cause dreadful discomfort and an overwhelming feeling of the need to void. The premonitory build up of tension that precedes and is relieved by tic behavior among those suffering from Tourette's is usually intense and far more bothersome than the tics themselves. In all cases, the "pressure" to satisfy the desire, to end the discomfort, can be immense. But even in such cases the agent will be to some-degree reward-sensitive or reason responsive. The gun at the head will work again. If people with itches, full bladders, or pre-tic

⁵⁵ Addicts simply need sufficiently good reason not to yield. One might object that they only need sufficiently good inducement, rather than good reason, but in this case the inducement is in fact a good reason. Another possibility is that the variable that motivates abstinence is not a good reason, but simply one that is so salient that it creates motivational force. This is undoubtedly possible, but in most cases of genuine addiction, what induces abstinence will almost certainly be a good reason, rather than simply a salient rationale. I thank Geoffrey Sayre-McCord for helpful insight on these points.

⁵⁶ I owe the itch example to George Ainslee. The bladder example was first suggested by an anonymous participant at a conference. Jon Elster also uses it. On Tourette's Disorder, see Charles W. Popper & Ronald Steingard, *Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence*, in Robert E. Hales, Stuart C. Yudofsky & John A. Talbot, (eds.), *The American Psychiatric Press Textbook of Psychiatry* (Washington, D.C.: American Psychiatric Press, 2d ed. 1994), pp. 729, 795–798.

tension satisfy the desire to rid themselves of the itch, discomfort or tension, once again, surely their behavior will be action and not mechanism.⁵⁷

Still, although the addict's behavior is not mechanism, perhaps not seeking and using is as hard as not scratching an itch, voiding one's bladder, or engaging in tic behavior. Is it fair to expect the addict to self-regulate successfully in ordinary circumstances that do not permit brute techniques, such as threatening oneself with instant death, just in case one lapses? Is yielding to the desire apt grounds for blame and punishment, especially in extreme cases?

Perhaps, after all, drug-related activity is sufficiently like mechanistic movement to qualify for an excuse, but this requires an argument rather than an analogy. Too often we are seduced by medical metaphors that strongly suggest mechanism. Nevertheless, the disease model and ordinary language – the addict allegedly "can't help using", or is "impelled to use", or more bluntly, is "compelled to use" – suggest that addiction primarily produces a control or volitional problem.

Volition is clearly a vexing foundational problem for philosophy, psychology and law.⁵⁸ Even if "black box" models of control problems seem to explain the phenomena deemed addiction, the law's concept of the person as a conscious, intentional agent implies that such models cannot provide the law with adequate guidance either to decide if an excuse is warranted in general or in individual cases. Any model must translate into terms of human agency.

Consider some alternatives. If one adopts Michael Moore's contention that a volition is a functional mental state of executory intention,⁵⁹ the problem of volition disappears because virtually no addict has a volitional problem. Their wills translate their desires to have the drug into the necessary action quite effectively. Indeed, on this account of the will, almost no intentional conduct will raise

⁵⁷ If a full bladder finally simply "overflows" because the pressure prevents the agent from controlling the sphincter muscles, voiding is purely a mechanism.

⁵⁸ See, Bernard J. Baars, "Why Volition is a Foundation Problem for Psychology", *Consciousness and Cognition* 2 (1993); p. 281; Stephen J. Morse, "Culpability and Control", *University of Pennsylvania Law Review* 142 (1994), pp. 1587, 1595–1597.

⁵⁹ Michael S. Moore, *Act and Crime: The Theory of Action and Its Implications for Criminal Law* (Oxford: Clarendon Press, 1993), pp. 113–165.

a problem of volition.⁶⁰ Moore's account is persuasive to me, but like all accounts of the philosophical foundations of action, it is controversial. Some of the competitors that consider volition a species of desire, a view that Moore and others⁶¹ reject, may raise volitional problems in the case of addictions.⁶² Unless these alternatives can be reduced to ordinary language concepts that apply to human agency, however, it will be impossible for legislatures and courts to resolve disputes about the metaphysics of mind and action rationally.⁶³

I believe that the best explanation of a control or volitional excuse based on "disorders of desire" is a moralized, common sense approach that employs the defense of duress as a model and that requires no implausible, unverifiable empirical assumptions about how the mind works.⁶⁴ Because thinking about duress is so fundamental to this approach, let us first consider its criteria before turning to whether the model can be applied to addictions.

⁶⁰ When an agent has a duty to act and may be criminally liable for an omission rather than for an action, in rare cases a genuine volitional problem may arise that prevents the agent from acting intentionally to avert harm. See Morse, *supra* note 58, at 1597–1598.

⁶¹ E.g., Galen Strawson, *Freedom and Belief* (Oxford: Clarendon Press; New York: Oxford University Press, 1986), pp. 66–67 (citing Kant).

⁶² See, e.g., W. Charlton, *Weakness of the Will: A Philosophical Introduction* (Oxford and New York: B. Blackwell, 1988) (competing accounts of weakness of the will); Jay Wallace, "Addiction as Defect of the Will: Some Philosophical Reflections", *Law and Philosophy* 18 (1991), p. 621, especially sec. 2.

⁶³ A classic, well-known example of a theory of volition that can be understood in ordinary language terms and that has therefore received much attention in the legal as well as philosophical literatures, is Harry Frankfurt's hierarchical theory. Harry G. Frankfurt, *The Importance of What We Care About: Philosophical Essays* (Cambridge and New York: Cambridge University Press, 1988), pp. 11, 24. For reasons I have considered elsewhere, however, this seemingly attractive model does not succeed. Morse, *supra* note 58, at 1626–1628.

⁶⁴ The current discussion modifies and extends a previous treatment of this issue. See, e.g., Morse, *supra* note 58, at 1621–1634. The proposal has been enormously influenced by Alan Wertheimer's treatment of similar issues. See, Alan Wertheimer, *Coercion* (Princeton: Princeton University Press, 1987). I assume that duress can sometimes be an excusing condition. Jay Wallace believes that it is always a justification. See, Wallace, *supra* note 1, at 144–147. I discuss the differences in the text *infra*.

Duress obtains if the agent is coerced to commit a criminal offense by the threat or use of unlawful force of death or grievous bodily harm against the defendant or another and a person of reasonable firmness would have been "unable to resist."⁶⁵ In other words, an agent faced with a particularly "hard choice" – commit a crime or be killed or grievously injured – is excused if the choice is too hard to expect the agent to buck up and obey the law. The defense is not based on empirical assumptions about the capacity of individual agents to resist threats, however; it is moralized. For example, the defense is not available to a defendant allegedly "unable" to resist if the threats were less than death or grievous bodily harm or if a person of reasonable firmness would have been able to resist.

The "person of reasonable firmness" standard is the primary moral criterion, but how should it be understood? One interpretation is that if a person of reasonable firmness would have yielded, doing so is the right thing to do, or at least permissible.⁶⁶ After all, reasonable conduct ordinarily is justifiable. But this interpretation is questionable if the balance of evils is negative. When yielding produces a positive balance of evils, the residual, choice of evils/necessity justification obtains and there is no need to resort to notions of "resistibility."⁶⁷ Indeed, justified behavior is usually "easy" to choose.

If the balance of evils is negative, duress as a justification seems odd. Imagine a person threatened with death unless she kills three equally innocent people. At this level of negative balance of evils, the defense might still be permitted, but few would deny that it would have been socially better for the victim of the threat to sacrifice herself. Agent-relative restrictions on what morality generally demands will surely yield to the greater good under some circumstances in which duress will still obtain. Indeed, most people unfortunately placed in such a position might agree that it is their duty to resist. Faced with such a hard choice, however, even a generally moral person might have yielded and should be excused, but the agent still should have resisted and we hope that she does. This

⁶⁵ Model Penal Code, § 2.09 (1962).

⁶⁶ Michael Moore refers to these as the strong and weak theories of duress as a justification.

⁶⁷ Model Penal Code, § 3.02(1) (1962).

is quite different from standard justifications, such as self-defense. Although the harm caused is regrettable in self-defense cases, we do not hope that she sacrifices herself rather than defend against a wrongful aggressor, but excuse the defender nonetheless.

The better moralized interpretation, I believe, is that the standard does not indicate that yielding is reasonable and thus justified. Reasonableness is a proxy for asking when the choice is too hard to require the agent to resist or face criminal penalties, even if yielding is wrong. If the person of reasonable firmness would resist, the choice is not too hard. If the choice is too hard, an excuse should obtain.

Both the moralized excuse and justification interpretations of duress appear to risk unfairness in cases in which yielding is either unjustified or not excused because a person of reasonable firmness would have resisted. Suppose a person is genuinely unable to resist under such conditions. Criminal penalties would be retributively unjust because a person does not deserve punishment for conduct that is impossible to avoid. Moreover, specific deterrence is bootless in such cases. A purely consequential view might justify punishment to buck up the marginal people, but only at the cost of injustice to those unable to resist. Because fault is a necessary condition for blame and punishment in our system, denying the defense would be unjust. The justification interpretation of duress implies in such cases that the conduct is not justified because it is unreasonable. Nevertheless, those committed to the justification interpretation could properly propose that another, independent excuse should apply based purely on an assessment of the defendant's empirical capacity to resist. This standard would be a nightmare to adjudicate, but worth the effort if it were necessary to avoid injustice.

I believe, however, that neither interpretation is subject to the risk of unfairness. If a person is threatened with death, for example, the defense should be potentially available unless the balance of evils is so remarkably negative that every person would be expected to resist. In all other cases, the question would at least "go to the jury." Thus, there will be few cases involving sufficiently serious threats in which the person incapable of resisting would lose the potential defense. The person genuinely incapable – if any there be – of resisting even when the threats are relatively mild, say, kill or be

touched, will almost certainly be a person with irrational fears that will qualify for some type of irrationality defense. Duress might not obtain, but exculpation will be available on other grounds.

Before turning to the analogy of duress to addiction, consider the formulation, "unable to resist", which has the unmistakable implication of mechanism. Unless force majeure or genuine mechanism is at work, we virtually never know whether the agent is in some sense genuinely unable or is simply unwilling to resist, and if the latter, how hard it is for the agent to resist. Research evidence exists concerning the characteristics that help people maintain control when faced with temptation or experiencing impulses.⁶⁸ But in the present state of knowledge, such research is no more than a general guide. No metric and no instrumentation can accurately resolve questions about the strength of craving and the ability to resist. This was in large part the reason that both the American Psychiatric Association and the American Bar Association recommended the abolition of the control or volitional test for legal insanity in the wake of the ferment following the Hinckley verdict.⁶⁹ If strength of craving or resistance are to be the touchstones, legal decisionmakers will have to act with little scientific guidance and lots of common sense.⁷⁰

The analogy often used to demonstrate that craving is like duress is to think of the intense cravings or desires of "compulsive" states as an "internal" gun to the head. The sufferer's fear of physical or

⁶⁸ Baumeister et al., *supra* note 45, pp. 242–256 (considering self-regulation techniques and distinguishing underregulation, in which the agent often actively participates, and misregulation, in which the agent seldom actively participates).

⁶⁹ See, American Bar Association, *ABA Criminal Justice Mental Health Standards* (Washington, D.C.: American Bar Association, 1984), pp. 330, 339–342; American Psychiatric Association, *Statement on the Insanity Defense* (Washington, D.C.: American Psychiatric Association, 1982), p. 11.

⁷⁰ For example, one writer explains that, "The strength of the craving may be gauged by how willing the person is to sacrifice other sources of reward or well-being in life to continue to engage in the addictive behavior." Dennis M. Donovan, "Assessment of Addictive Behaviors: Implications of an Emerging Biopsychosocial Model", in Dennis M. Donovan & G. Alan Marlatt (eds.), *Assessment of Addictive Behaviors* (New York: Guilford Press, 1988), pp. 3, 6. Although written by an estimable researcher, it is no more than an operationalized, common sense measure.

psychological withdrawal symptoms and of other dysphoric states⁷¹ is allegedly so great that it is like the "do-it-or-else" fear of death or grievous bodily injury that is necessary for a duress defense. Yielding to a compulsive desire, a craving, is therefore like yielding to a threat of death or grievous bodily harm.⁷² The argument is that we cannot expect a person of reasonable firmness not to yield in the face of such an internally-generated hard choice, much as we cannot expect such a person not to yield in the face of an external threat of death or grievous bodily harm.

The analogy is attractive, but theoretically and practically problematic. Notice, first, that the analogy suggests no problem with the defender's will, which operates effectively to execute the intention to block or remove the dysphoria.⁷³ Further, it is entirely rational, at least in the short-term, to wish to terminate ghastly dysphoria, even if there are competing reasons not to, such as criminal sanctions, moral degradation or whatever. And it is simply not the case that addicts always act to satisfy their cravings because they fear dysphoria. Many just really want to yield and it's unpleasant not to – who does not like getting what one really wants? – but they don't substantially fear the dysphoria. I suggest that the phenomenology of the sufferer's response to craving, unlike the phenomenology of the victim of a threat of death, is often not, and perhaps never, clear or the product of unitary, simple causes. Suppose, for example, that the primary motive is the pleasure or satisfaction of yielding or that such pleasure is an important additional motive. The possibility of pleasure seems more like an offer than a threat and offers expand rather than contract freedom. The strong desire for pleasure is not a hard choice excusing condition in law or morals.

Assuming that fear of dysphoria is a sufficient motive and that the analogy to the fear of death or grievous bodily harm is initially plausible, two problems remain: Assessing the strength of the fear and deciding what degree of fear of dysphoria is sufficient to excuse what types of conduct. Based on ordinary experience and common

⁷¹ See, *DSM-IV*, supra note 8, at 609 (essential features of "impulse-control disorders" include a build up of tension and arousal).

⁷² *Id.* (essential feature of "impulse-control disorders" is an experience of pleasure, satisfaction or relief after committing the impulsive act).

⁷³ Herbert Fingarette and Anne F. Hasse, *Mental Disabilities and Criminal Responsibility* (Berkeley: University of California Press, 1979), p. 61.

sense, the criminal law uses threats of death or grievous bodily harms as objective indicators of the type of stimulus that would in ordinary people create sufficient fear to create an excuse. Of course, people subjected to such threats will differ markedly in their subjective fear responses and in their desires to live or to remain uninjured, but ordinary average people will have very substantial fear.⁷⁴ We have all experienced dysphoric states, and many have experienced intense dysphoria, but dysphoria as a source of present and potential pain is more purely subjective than death or grievous bodily injury. Consequently, assessing the average or ordinary intensity of craving or inner tension, including seemingly strong states, is simply more difficult than assessing the fear of death or grievous bodily injury. Focussing on more objective markers of compulsive states, such as physical withdrawal symptoms, will surely help, but fear of such symptoms, I shall argue, is unlikely to support an excuse.

Death and grievous bodily harm are dreadful consequences for virtually any rational person. Other threatened consequences, such as lesser physical, emotional or economic harms, may also be extremely unpleasant, but if the balance of evils is negative, threat of such harms will not warrant an excuse. Committing crimes is itself considered so wrong that we require people to buck up and obey the law, even if they are very fearful. How do the consequences facing addicts compare?

Fear of the physical symptoms of withdrawal from most drugs is not likely to be as intense as the fear of death or grievous bodily harm because in most cases withdrawal is not terribly painful – withdrawal from heroin is often likened to a bad flu – and can be medically managed to reduce the discomfort.⁷⁵ Withdrawal from alcohol dependence can be extremely severe, but it, too, can be medically managed. And because ethanol is freely and inexpen-

⁷⁴ The analysis could apply to moral dilemmas that the criminal law does not address. Imagine a person who possesses a monetarily worthless locket that contains an equally financially worthless but emotionally priceless memento, say, a strand of a sainted parent's hair. One could easily imagine that a threat to destroy the locket might morally excuse quite serious property crime and perhaps crimes against the person, although the criminal law would recognize no excuse in this case.

⁷⁵ See John Kaplan, *The Hardest Drug: Heroin and Public Policy* (Chicago: University of Chicago Press, 1983), pp. 35–36.

sively available for adults, those who fear withdrawal and don't want treatment seldom need to commit crimes or other wrongs to obtain ethanol to avoid withdrawal. Consequently, fear of the physical symptoms does not appear to rise to the category of fear of death or grievous bodily harm and the reasonable alternative of medical management exists.

Dysphoric mental or emotional states are surely undesirable, but does their threat produce a sufficiently hard choice to warrant an excuse? I do not know the answer to this question, but perhaps at the extreme they do. People suffering from severe depressive disorders, for example, report subjective pain that is apparently as great and enduring as the reported pain from many forms of grievous bodily harm and sometimes depressed people kill themselves to avoid the psychological pain. But people don't consciously commit crimes to ward off the feared onslaught of severe depression. For another example, some people addicted to ethanol who are being treated with a drug that makes them dreadfully sick if they ingest any alcohol, including trace amounts, will "drink through" the miserable sickness.⁷⁶ Common sense suggests that such willingness to endure physical dysphoria implies that the craving produced by the fear of psychological dysphoria is very strong, indeed,⁷⁷ but is it as strong as the fear of death?

Assuming that the feared dysphoria of unconsummated cravings can be substantial, I suspect that it will seldom be as severe as the fear of death or grievous bodily harm. If this is right and assuming, too, that we could reliably assess the fear of dysphoria, few addicts would succeed with a hard choice excuse. On the other hand, if the drug-related activities were simple possession for personal use and use itself, then perhaps the justification of necessity should obtain. But even if we concluded that the harm of such activity is less than the harm of dysphoria, most addicts would be responsible for becoming addicted and thus for placing themselves in the situation that created the need for the defense. The law disallows the justifica-

⁷⁶ Ludwig, *supra* note 29, at 58–59. Such cases are surely rare, however, and most alcoholics who wish to drink either discontinue their aversive therapy or find ways to disable its effect.

⁷⁷ See, Donovan, *supra* note 78.

tion in such cases.⁷⁸ Finally, even if we were to conclude that addicts were not responsible for placing themselves in the situation, all legislatures on policy grounds would resist permitting a justification for possession and use and would surely reject the defense for other possibly related crimes, such as theft or robbery to pay for drugs. The disease model is powerful, but the moral failure model is resilient.

In sum, the internal coercion or duress approach uses understandable terms and has a moral basis derived from a defense the criminal law and ordinary morality already accept. Nevertheless, currently insurmountable practical problems beset attempting to assess the appropriateness of an excuse in individual cases. What is more, thinking about excuse in terms of control difficulties will inevitably invite misleading metaphorical thinking about mechanism and expert testimony that is little more than moral judgment wrapped in the white coat of allegedly scientific or clinical understanding. The law should not adopt an internal coercion excuse.

2. *The Irrationality Theory*

I believe that irrationality is the most straightforward, persuasive explanation of why some addicts should perhaps be excused. Moreover, irrationality will excuse any addict who may apparently qualify under the internal coercion theory. If the craving sufficiently interferes with the addict's ability to grasp and be guided by reason, then a classic irrationality problem arises and there is no need to resort to compulsion as the ground for excuse. Finally, it is simply more practicable to assess rationality than to assess the strength of compulsive desires.

How does it feel to crave intensely? The subjective experience of addicts is diverse, but I shall attempt a modal tale produced from experience with and wide reading in anecdotal and research literature about people addicted to various substances, including both licit and illicit drugs. Despite different historical pathways to addiction, the descriptions of the subjective experience are broadly of a

⁷⁸ See, e.g., NY Penal Law, §35.05 (Consol. 1999) (allowing the defense as an emergency measure to avoid an imminent harm if the situation occurred "through no fault of the actor").

piece,⁷⁹ although different descriptors and metaphors are and could be used. The story is not meant to include all the features of the addictive process; rather, it is an approximation of the subjective experience preceding use that may bear on responsibility.

Between episodes of use of the substance, the addict commonly experiences a build up of tension, irritation, anxiety, boredom, depression, or other dysphoric states. As time passes since the last use, these dysphoric states typically become stronger, more persistent, more intense, and more demanding. In some cases, the build up is described as sheer desire, sheer wanting. As the wanting remains unsatisfied, increased dysphoric states or, in some cases, excitement, accompany the wanting. For illicit-drug addicts, anxiety or fear about obtaining the substance often adds to the dysphoria.

At some point, the addict metaphorically, and in some cases perhaps literally, can think of nothing else but the desire to use the substance. One informant described the desire like "a buzzing in my ears that prevents me from focusing." It is like an extreme version of being dehydrated or starved: The addict can ordinarily think of nothing else except getting and using the stuff. It is like the moment just before orgasm during an episode of exceptional excitement, but usually without the pleasurable feeling of sexual excitement. There is only one tune or story in the addict's head and nothing can drive it out.⁸⁰ When the addict can't get the tune out of his head, it's very difficult to concentrate the mind on the good reasons not to use, especially because, in almost all instances, there is no police officer at the elbow or other available "self-management technique" sufficiently powerful to motivate the addict to think clearly about drug-related activity. Fundamental components of rationality – the capacities to think clearly and self-consciously to evaluate one's conduct – are compromised. The agent may not recognize the various options at all or may not be able coherently to weigh and assess those that are recognized. For moral and legal purposes, the precise

⁷⁹ See, e.g., Donovan, *supra* note 78, at 5–11 (describing "commonalities across addictive behaviors").

⁸⁰ See, e.g., Michael B. Ross, "It's Time for Me to Die: An Inside Look at Death Row", *The Journal of Psychiatry and Law* 26 (1998), pp. 482–483 (first person account by death row inmate with persistent, allegedly overwhelming urges to degrade, rape and kill, who describes the urges as a song one cannot get out of one's head).

mechanisms by which addiction can compromise rationality are less important, however, than the clear evidence that it can.⁸¹ On the other hand, the addict's characteristic ambivalence about addiction suggests that addicts recognize that they have good reason to stop, at least during lucid or inter-use intervals.⁸²

The degree to which the general capacity for rationality is compromised can vary widely among addicts. The modal tale is told as an extreme case and is only an approximation. Still, addiction can compromise rationality and therefore can potentially excuse drug-related activity, especially for those most severely affected. Thus, the question remains whether the law should consider addiction as a potential excuse. This is an important question for social and legal policy because drugs are a factor in much criminal conduct. Possession and use offenses are rampant. In most big cities, well over half of all people arrested for felonies test positive for addictive substances.⁸³ Many of these are surely addicts. We believe that it is fair to blame and punish them, but is it?

I previously addressed whether addicts are responsible for becoming addicted and concluded that most were, because prior to addiction they retain general normative capacity and knowingly, albeit with imperfect information, placed themselves at risk for becoming addicted. Moreover, some people become addicted intentionally. Of course, because the majority of users of any substance do not become addicts, when future addicts use substances prior to addiction, virtually none was practically certain to become addicted. At most, they were consciously aware of the risk,⁸⁴ but conscious awareness of substantial risk is sufficient to support ascriptions of responsibility. At the very least, an addict becomes so negligently. Some addicts surely are not responsible for their condition because

⁸¹ See Elster, *supra* note 23, at 169–179 (reviewing the potential mechanisms).

⁸² I owe this point to George Ainslee.

⁸³ Bureau of Justice Statistics, *Sourcebook of Criminal Justice Statistics* (Washington, D.C.: U.S. Dept. of Justice, Bureau of Justice Statistics, 1997), p. 364. These data are for marijuana, opiates, cocaine and methamphetamines, and do not include alcohol, which would raise the percentages substantially. In all twenty-three cities reported, the rates for males exceeded fifty percent; in all but three the rates for females also exceeded fifty percent.

⁸⁴ In the case of licit substances, such as alcohol and nicotine, the risk may not be legally *unjustified*, however. Cf., Model Penal Code, §2.02(2)(c)&(d) (1962).

they became addicted when they were younger or they were involuntarily addicted or for some other responsibility-diminishing reason, but such addicts are surely a minority.⁸⁵

Note, first, that whether or not addicts are responsible for becoming addicted, they will not lack mens rea for their substance-related criminal activity.⁸⁶ Virtually all potential addicts are consciously aware of the risk that if addicted they will persistently and intentionally seek and use substances. This information about addiction is well-known and, indeed, seeking and using is part of what it means to be actively addicted. Nevertheless, the previous conscious awareness of this risk is distinguishable from forming the pre-addiction intention to seek and use after becoming addicted. For most addicts, however, there will be no mens rea problem when they seek and use. They are not automatons and do form the intent to buy, possess and use. In most cases of serious criminal wrongdoing, the potential addict may be unaware of the risk of committing such offenses after becoming addicted. Even if this is true, however, there will still be no mens rea problem. An addict who robs or kills surely will form the intent to do so. In the narrow legal sense, most addicts have the true purpose to engage in their drug-related conduct. If they deserve mitigation and excuse, it is because they are not fully rational, not because they lack the mental state, the mens rea, required by the definition of the offense.

As a result of addiction, some addicts surely are sufficiently irrational to warrant mitigation or an excuse at the time they commit their substance-related crimes. Should they be held responsible nonetheless? Two theories suggest in general that virtually all should be. The first is that by experimenting, the addict knowingly

⁸⁵ Assuming that addicts are responsible for their condition, an interesting question is whether addiction is just a status, as *Robinson* held, or whether it necessarily includes seeking and using behavior, as the definition I considered above requires. See, *Robinson v. California*, 370 U.S. 660 (1962); notes 5–29 and accompanying text, *supra*. Because the law is unconcerned with status per se, I will not address the criminality or immorality of simply being an addict, although many views of morality might reasonably do so.

⁸⁶ The major exception will be cases in which the addict offends while in a state of "unconsciousness" or blackout induced by substance use. Most jurisdictions would permit only limited use of such evidence to negate mens rea and some would not permit it at all.

took the risk that he or she would become irrational, including the possibility that the irrationality would operate specifically in contexts involving substance-related behavior. The second is that almost all addicts have lucid, rational intervals between episodes of use during which they could act on the good reasons to seek help quitting. Again, the ambivalence about addiction that characterizes addicts implies that they are capable of and do recognize these good reasons during their lucid intervals.

Both theories are potentially subject to the same objection, however. Addiction can become an entire lifestyle and prolonged use of substances can so debilitate addicts physically and psychosocially that some addicts have exceptional difficulty exercising substantial rationality concerning their status and behavior. Although potential addicts may be aware of the risk of irrationality, they may not be fully aware of the risk of such extreme irrationality that can arise in some cases. In such cases, perhaps one cannot find responsibility for extreme rationality by referring back to pre-addiction, knowing conduct. Furthermore, in cases of extreme debilitation, the intervals between episodes of use may not be (fully) rational.

The foregoing objection does not seem decisive. First, in those few cases in which prolonged drug use produces a permanent major mental disorder that compromises rationality at the time of criminal conduct, the addict will have available a traditional insanity defense based on "settled insanity" resulting from the use of intoxicants.⁸⁷ But except in such rare cases, addicts' rational intervals are probably sufficiently rational to hold addicts largely or fully responsible for diminishing their own rationality at the time of use or other drug-related crimes. In addition, as a result of both street wisdom and personal history, experienced addicts typically know during the intervals both what treatment alternatives are available and the type of criminal behavior beyond the seeking and use that they are likely to engage in. Indeed, much of the further activity probably takes place during the rational intervals and involves harm to others, which carries greater criminal penalties and thus gives the

⁸⁷ I assume that almost all jurisdictions would permit this defense for cases in which the settled insanity resulted from illicit drugs. See, Wayne R. LaFare & Austin Scott, Jr., *Criminal Law* (St. Paul: West Publishing, 2d Ed. 1986), p. 395, n. 61.

addict even stronger self- and other-regarding reasons not to offend than in the case of personal possession and use.

Finally, suppose one concludes that some addicts deserve mitigation or excuse for at least some criminal conduct. In the previous subsection on the internal coercion theory, I suggested that irrationality would excuse any addict that the internal coercion theory might fairly excuse. The argument, in brief, is this. A person driven crazy by fear is crazy. Or, in the alternative, people so fearful of mild dysphoric states that they appear incapable of bucking up when reasonable people would be irrationally fearful. Any plausible story about allegedly compulsive cravings driving the criminal conduct, especially in cases of serious crime, will also be a story in which the addict is less than fully rational or not rational at all. In such cases, irrationality would be the appropriate excusing claim; there would be no need to resort to problematic internal coercion.

My conclusion is that most addicts are responsible for seeking and use and almost none should be excused for further criminal activity, and especially not for serious wrongdoing. There are simply too many periods of rationality and simply too much awareness of alternative possibilities to permit excuse in more than a small number of cases.⁸⁸

C. "Social Responsibility"

Socioeconomic arrangements, culture, life stories, legal regulation, and other "external" causal variables can appear to bear much of the blame for addiction and its consequences. Even if most addicts are responsible for becoming addicted and for their behavior while addicted, whether one becomes an addict and how one lives as an addict are not solely "up to" the intentional conduct of the agent who becomes an addict.

Consider the following examples. It is entirely understandable that people living in communities of deprivation, with few life chances, may find a life of addiction preferable to the misery of an impoverished straight life. Some subcultures particularly encourage and celebrate the use of potentially addictive substances, increasing the risk of addiction among members of that subculture. For those who have lived lives of abuse or who suffer from psycholo-

⁸⁸ Section V, *infra*, considers the case for mitigation in more detail.

gical miseries for any reason, substances can be a welcome escape. Finally, legal regulation can affect the probability of addiction, the life styles of addicts, and the further behavioral consequences of addiction. It is more difficult to bum a dime bag than to bum a smoke or to cadge a free drink, even from friends, and the addict can never be sure that a dealer isn't a narc, an informant, or cutting the dope. Lawful availability and price affect rates of consumption, the development of informal customs and conventions for controlled use, the health, safety and legal dangers of seeking and using drugs, and the probability that other criminal behavior beyond possession and use will occur as a result of addiction. Explanations such as these, especially when considered in the context of a sympathy-arousing life history, can tug at our hearts and influence our responsibility attributions. As Gary Watson concluded in his discussion of the case of a murderer, in many cases our reaction will be, "No wonder."⁸⁹

How should we respond to powerful social explanations? Social variables account undeniably for a great deal of the variance in addictions and related behavior and many of these variables are potentially modifiable by sound social policy. For example, resolution of the current debates concerning decriminalization of illicit drugs, differential penalties for essentially similar substances such as crack and powdered cocaine, the propriety of needle exchanges, and whether nicotine should be regulated by the Food and Drug Administration will affect millions of lives. A just society should try to minimize the inevitable ill effects of its policies. Nonetheless, crimes and moral wrongs are ultimately committed by individual agents and social causal variables, or any other kind of causal variables, cannot excuse addicts who are individually responsible without threatening all individual responsibility.

⁸⁹ Gary Watson, "Responsibility and the limits of evil: Variations on a Strawsonian theme", in Ferdinand Schoeman, Ed., *Responsibility, Character, and the Emotions: New Essays in Moral Psychology* (Cambridge and New York: Cambridge University Press, 1987), pp. 256, 275. Watson's description was of the life of Robert Alton Harris, a notorious multiple murderer who seemed to have no empathy for other people. Indeed, his cellblock mates on death row detested him. Yet if one reads his life history, it is difficult not to have at least a modicum of sympathy for Harris and to think that a dreadful outcome was entirely understandable for reasons in no way Harris' fault.

All behavior is caused by variables over which we have no control. Some causal stories surely arouse more sympathy than others, but sympathy and an unfortunate life history are not excusing conditions per se.⁹⁰ One may wish to consider such variables for disposition on consequential grounds or as an expression of mercy, but they do not excuse unless they produce sufficient irrationality or a sufficiently hard choice. Focusing on individual responsibility should not blind us to the remediable causes of wrongdoing and should not diminish justifiable sympathy for wrongdoers, but neither should explanations and sympathy undermine our view that most wrongdoers are responsible agents.

V. A PROPOSAL: "GUILTY BUT PARTIALLY RESPONSIBLE"

My discussion has suggested that perhaps some addicts might not be responsible for seeking and use or for further drug-related or drug-affected activity because they are not rational or not fully rational, or perhaps, because they faced a sufficiently hard choice. This would certainly be true if morality and the law held a less demanding set of criteria for responsibility than now obtains. How could the law respond to such claims in appropriate cases?

According to almost any definition, rationality and hard choice are continuum concepts.⁹¹ There are infinite degrees. Consequently, responsibility must be a matter of infinite variation. But even if rationality is easier to assess than irresistibility, it is beyond human ability to measure it precisely enough to ascribe infinite degrees of responsibility. As a result, the law adopts bright-line tests, such as legal insanity, and does not include a generic partial responsibility doctrine.⁹² I suggest that the law should consider a limited, generic partial excuse of "partial responsibility."

⁹⁰ See, Stephen J. Morse, "Deprivation and Desert", in William Heffernan & John Kleinig, eds., *From Criminal Justice to Social Justice* (forthcoming) (considering and rejecting the various theories proposed to excuse on the basis of an unfortunate life history).

⁹¹ For ease of exposition, I shall discuss only rationality. I believe, however, that the argument applies equally well to an internal coercion or a so-called volitional theory of excuse.

⁹² The major exceptions are the mitigating doctrines of homicide that reduce murder to manslaughter and sentencing practices.

I should confess that in previous writing I have rejected the adoption of a generic partial responsibility defense on the grounds that morality did not require it and that the practical costs of adopting it would be unacceptably large.⁹³ For reasons I discuss in detail elsewhere, however, neither current doctrines nor sentencing practices can guarantee generally principled consideration of mitigating factors in most cases.⁹⁴ Thus, upon further reflection, I now believe that the moral claim for a partial excuse is sufficiently weighty to justify bearing the potential practical costs.

As the extant mitigating doctrines of homicide imply, some legally responsible defendants suffer from impaired rationality that warrants mitigation and triers of fact can fairly make this relatively gross culpability judgment. The underlying theory of excuse that supports these doctrines – impaired capacity for rationality – and the doctrines themselves are perfectly generalizable to all crimes. There is no reason that juries could not reasonably make the same judgments about mitigation for other crimes that they routinely make to determine if murder should be reduced to manslaughter.

Justice would be better served if the criminal law adopted a generic partial excuse, reflected in another possible verdict, "Guilty but Partially Responsible [GPR]." Many crimes are committed when the defendant's rationality may be substantially impaired by a wide variety of factors, including the cognitive and affective changes that addiction may produce. Fairness may demand mitigation in such cases, but except within homicide or at sentencing, the criminal law has no means to do justice, and the existing means suffer from various deficiencies. A verdict such as GPR would provide a remedy. Because GPR would be a partial affirmative defense, the Constitution would permit the state to place the burden of persuasion on either the prosecution or the defense.⁹⁵

⁹³ Stephen J. Morse, "Undiminished Confusion in Diminished Capacity", *Journal of Criminal Law and Criminology* 75 (1984), pp. 28–36.

⁹⁴ Stephen J. Morse, "Excusing and the New Excuse Defenses: A Legal and Conceptual Review", in M. Tonry (ed.), *Crime and Justice* 23 (1998), pp. 301–303.

⁹⁵ *Patterson v. New York*, 423 U.S. 197 (1977). It is important to distinguish GPR from "Guilty But Mentally Ill [GBMI]", a verdict adopted by a substantial minority of the states. GBMI reflects a jury finding that the defendant was mentally ill at the time of the crime, but that the defendant was fully responsible for

Any formula that expressed the central excusing notion would work. I rather like the Model Penal Code's formula: "extreme mental or emotional disturbance for which there is reasonable explanation or excuse."⁹⁶ It addresses the underlying normative excusing condition, uses common sense terms, and is not tied to any limiting model of why a defendant suffered from the requisite disturbance. As studies of the insanity defense have shown, however, the words of the test are not crucial.⁹⁷ Juries just need some formulation roughly to guide their normative judgment.

Sentencing partially responsible defendants is a critical issue. Although such defendants may be less culpable, in many cases the defendant's impaired rationality may present a continuing, substantial danger. Ex-addicts often relapse and return to addictive life-styles that may involve related, dangerous criminal conduct, especially if they return to the setting in which the addictive activity previously occurred. Unless a purely retributivist theory governs punishment – in which case, punishment must be strictly proportional only to desert – a sensible, legislatively-mandated sentencing scheme must try to balance culpability and public safety interests. The legislature should set a fixed reduction in sentence for GPR. However the reduction is characterized, applying it would be no different in principle from the penalty reduction from murder to manslaughter or from the reduction for mitigation that a sentencing judge might order. Moreover, if the reduction were legislatively-mandated, and holding plea bargaining constant, its application

her conduct. A GBMI defendant receives no necessary reduction in sentence – indeed, in some jurisdictions capital punishment may be imposed – nor does it guarantee treatment for the defendant that otherwise would not have been available. Thus, *unlike* GPR, it is *not* a mitigating (or excusing) "defense." Indeed, it is not a defense at all. In my opinion, GBMI is a useless, confusing alternative that impermissibly allows juries to avoid finding a defendant not guilty by reason of insanity in cases in which legal insanity appears justified. GBMI is like "Guilty But Hepatitis." For a more complete critique, see, Stephen J. Morse, "Excusing the Crazy: The Insanity Defense Reconsidered", *Southern California Law Review* 58 (1985), pp. 803–804.

⁹⁶ Model Penal Code, §210.3(1)(b) (1962) (reducing homicides that would otherwise constitute murder to the lesser crime of manslaughter).

⁹⁷ Rita J. Simon, *The Jury and the Defense of Insanity* (Boston: Little Brown, 1967); Henry J. Steadman et al., *Before and After Hinckley: Evaluating Insanity Defense Reform* (New York: Guilford Press, 1993).

would be more consistent than if it were left to pure judicial discretion. Again, any reasonable scheme would do.

This proposal would lump together for the same degree of mitigation defendants of disparately impaired rationality, and consequently, different responsibility. This may seem to be a denial of equal justice, but it results inevitably from the epistemological difficulties confronting more fine-grained assessments. To permit many degrees of partial excuse and corresponding degrees of punishment reduction would require juries and judges to make judgments with a precision that is beyond both our moral theories and our ability to understand the necessary facts. Confusion and arbitrary decisions, rather than more justice, would follow from attempts at greater exactitude. If GPR were adopted, defendants in general would have the potential to obtain just mitigation that is not currently available for most. The failure to provide perfect justice in this imperfect world is not a decisive, or even weighty, objection in this instance.

A major objection to this proposal is that it could potentially excuse a wide array of unsavory defendants, such as pugnacious people or racists, because they might claim that their characteristics impaired their capacity for rationality. I have no doubt that some defense attorneys would attempt to make such claims, but in most cases they would be entirely unjustifiable and the courts would routinely exclude them. Variables such as temperament and preferences rarely will operate to cloud reason sufficiently to mitigate or excuse. Most people retain the general capacity for rationality, even if their temperaments or preferences put the capacity under pressure. Moreover, even if people are not responsible for their temperaments and preferences, they are aware that they have them, are aware of the dangers they present, and are aware of society's response to those dangers. Thus, it is the duty of such people to tie themselves to the mast. If they do not and if they intentionally offend, a mitigating condition should not obtain. Much as I think most addicts will not be able to mitigate or evade responsibility, I believe the same is true of offending occasioned by temperament and preferences, even if these are extreme.⁹⁸

⁹⁸ For a more complete discussion of the potential problems a verdict of GPR might create, see, Morse, *supra* note 94, at 305–306.

In sum, GPR might be the fairest way to respond to the diminished rationality claims that some addicts and others present as a partial excuse to crime. If adopted, the law might have more flexibility in responding than under the current all-or-none approach, in which few addicts could claim complete non-responsibility. Nothing in this scheme would prevent the law from imposing treatment on addicted and partially excused criminals as a sentencing condition for partially excused defendants, much as hospitalization now follows acquittal by reason of insanity.

VI. CONCLUSION

Despite the exciting, undoubted advances in the biological understanding of addiction and despite the plausibility of considering addictions as diseases, the disease model does not and cannot fully explain addiction or inform social and legal policy concerning addiction. Addiction inevitably involves human action and is therefore subject to moral evaluation. Although addiction potentially might cause a condition that warrants mitigation or excuse, primarily by compromising rationality, there is good reason to believe that most addicts are responsible for seeking and using behavior and for other immoral or criminal activity related to addiction. Although non-criminal, non-judgmental interventions should play a substantial role in effective social responses to addictions, the criminal justice system, too, might play a useful role. But modification of the existing doctrines of mitigation and excuse would be necessary to respond fairly to the claims of diminished responsibility that addicts might present.

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