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AUTONOMY AND ADDICTION:
AN OVERVIEW OF RELEVANT AND CONFOUNDING FACTORS

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ABSTRACT

The accurate assessment of drug addiction is a widely debated issue across academic disciplines and a hotly contentious subject in society at large. While legal institutions largely recognize addicts as rational, moral agents, an emerging understanding of addictive cravings in the social and neurological sciences seems to challenge this view. In a complementary manner, medicine has traditionally viewed addiction as a disease, leading some addiction theorists to conceptualize addictive behavior as the product of a symptomatic physiological condition. Consistency on this issue has become of paramount importance, as disparities between punitive and rehabilitative programs create a confused and deleterious environment for addicts. It is the purpose of this paper to survey and critique the claims made by different groups about the questionable autonomy of those in a drug-addicted state, and to bring up through critical interpretation a strong base for understanding autonomy in both its particularly relevant and most general character. Through an examination of relevant concepts in mental health, physiology, medicine, sociology, law, and philosophy, tensions between competing explanations of the addictive experience will reveal gaps that demand mediation. Relating these different insights to a basic and non-normative definition of autonomy will show how explanations that deny or severely challenge the call for responsibility in addiction fail to address the vicissitudes of autonomy in its lived experience. I will argue that the practical, theoretical and therapeutic challenges of denying addicts status as autonomous agents compels us to retain a strong but nuanced notion of accountability in addiction, and structure our social response to chemical addictions around these lines of responsibility. In particular, I embrace a global and diachronous understanding of autonomy that places accountability on the chemically addicted to confront the challenges of addictive cravings, and plan their lives with insight into the very real compromises such cravings place on the exercise of self-rule. By debunking the popular and exaggerated representations of addiction, it is my goal to reinstitute addictive processes within the vagaries and allowances of autonomy as it is tenuously achieved by embodied agents. Situated as such, I argue that addicts be understood as autonomous in this very basic sense that protects their status as moral agents, with the rights, respects, and responsibilities due to such agents.

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PREFACE

So you realize most people don't agree with you and me on this one? They think often people know what's best for them and still don't want to do it, even though they could – they do something else instead. Now I've asked lots of people what on earth could be the explanation for this, and they all tell me that people who behave that way do it because they “can't resist the pleasure,” or “can't stand the pain,” or are “overpowered”...

Plato, *Protagoras* (352d-e)

In the arguments that follow this passage from the *Protagoras*, we receive the well-known and controversial discussion of *akrasia* where Socrates denies the possibility of weakness of the will. On the grounds that “nobody ever willingly goes towards things that are bad for them” (358c), he argues that all such phenomena can be explained by a lack of knowledge—that given adequate awareness of choices and their consequences, no one would ever knowingly pursue an inferior course of action when they judge another to be better. This argument, and the problem it addresses, has garnered a vast wealth of philosophical speculation and criticism in the millennia since its discussion, and likely long prior to its appearance in Plato's writing.

Weakness of the will is a bafflingly puzzle in both its theoretical difficulty and (in spite of Socrates' arguments) intuitive reality. Human beings are fallible, but to deliberately turn away from what one considers best seems to betray the most basic human sensibilities. For reasons I will discuss, I reject the arguments that follow this passage, but I believe the passage itself provides a framing thought that in no small way prompted this paper, a paper about that most popular and mythologized example of weakness of the will—addiction.

Any discussion of addiction is bound to be controversial. As a tragic and fatally ambiguous human condition, our society struggles with alternating fits of hostility and sympathy, blame and forgiveness, punishment and support. This ambiguity rests at the very heart of addiction in its lived experience; at one moment besetting the addict with impetuous cravings for

a drug and in the next ravaging them with regret and shame. The very definition of this condition – as a disease, as a disorder, as a failure of will or character – is still a matter of open debate and discussion. In our contemporary world, we get many different versions of the addiction story from many different sources, some describing moral monsters, others describing victims of illness or circumstance, and still others of hopelessness and despair.

It was the confusion between these different accounts that initially spurred my interests in writing this paper. Specifically, and with reference to Socrates' words shown above, it seems that in the golden age of neuroscience and novel advances in research technology we embrace ever more fully the medicalized view of addiction; that fatalistic account of addiction that seems to break down bit by bit any semblance of real human struggle, replacing it in step by descriptions of disease processes, disordered brains, and corrupted physiology—conditions that “overpower” the vulnerable agent. It seems addiction has become a problem of the body, and for that reason, no longer a problem of or for the person. While such views have done incredible work in pioneering new medications that relieve addictive suffering, bring humanitarian sympathies to addicts, promote coverage of addiction treatment by health insurers, and advance neuropsychological and medical understandings, it has been my guiding concern that such understandings obscure something crucial about the experience of addiction, and indeed, about the way people express their will in general. Why is it that people, and especially and most problematically in addiction, are willing to trade a short-term pleasure for what promises to be worse for them in the long run?

In the argument that the dramatic Socrates presents, he first claims that all instances of weakness of the will can be traced back to (a lack of) knowledge, and subsequently understands all judgments about the goodness or badness of a given choice by their relation to the pleasure or

pain such choices bring about. In what we would call now a utilitarian framework, Socrates claims that all situations can be broken down and calculated in terms of their current and projected pleasures and pains, the most pleasurable (on balance) taking precedence as the best option. In another passage that I find uniquely relevant to the debate about addiction, Socrates simulates a discussion that directly confronts how people end up making such lopsided evaluations about present and future goods:

Of course, somebody might say, “No, hold on Socrates; there’s a big difference between what’s pleasurable here and now, and what’s pleasurable or painful in the long term.” “Maybe so,” I’d say, “but surely no difference that isn’t itself a matter of pleasure and pain. The fact is, there’s no other way for them to differ. No, *you’ve just got to be a kind of expert at weighing things up...*” (356a-b; my emphasis)

For Socrates, such expertise amounts to knowledge, and the more knowledge you have of your situation, the better decisions you’ll make in it.

This seems intuitively true. But as an esteemed mentor once told me, it may be true as far as it goes, but it doesn’t go very far. In fact, I think a further inference from this passage reveals an essential fact about human judgment and agency that frames this paper. Insofar as executing our will successfully and effectively demands some measure of expertise, human beings are *not* experts. As thinking agents fraught with misconceptions, ignorances, fragile egos, more or less chronic self-deception, various lapses in competency and rationality, and conflicting desires of every variety, humans are notoriously bad at commanding their lives according to their stated ideals.

And yet we still get by. Moreover, we are able to surmount such vagaries and coordinate efficiently with one another. We are able to meet social and legal demands, and thus make expectations on one another. Whatever tentative command we have over ourselves, it seems sufficient for us to protect a respect for it—a respect for one’s right to conduct their life as they see fit, and in that way be robustly accountable for it.

This is generally what we call autonomy, and this is what is at stake in the addiction debate. In investigating the addicted condition, our fundamental suspicion is that this ubiquitous (albeit tenuous) capacity for self-rule has been severely compromised, and that we must view addicted agents, their behavior, and our response to them differently. And indeed, a growing body of psychological, physiological, and neuroscience data seems to reify the distinction we implicitly set between addicts and non-addicts in investigating the differences, widening the gap with each new claim made about what addiction definitively “is”. While I do not question the validity of asking such questions about addiction (the manifest problems we see in addiction seem to in fact demand such an inquiry), I do express concern about the – now widely accepted – account of addiction that mythologizes and distinguishes the addictive process as something wholly unnatural, deviant, and beyond the realm of normal human desires and experiences. True, for some the process of drug refinement and consumption might fairly be characterized as “unnatural” (although we might also identify many other habits and features of our world that are similarly unnatural), but as I will argue, the process of desire formation and response is not.

By resituating addiction within the vicissitudes and weaknesses of autonomy as it is demonstrated by the average embodied agent, it is my goal to build a bridge between our understanding of addicts and non-addicts, and bring up a base for understanding both classes on similar terms of rights and responsibilities. As Socrates mentions in the initial passage quoted here, many people may not agree with the portrait of addiction given here. It is my explicit intention, however, to highlight those lines of responsibility and those questionable aspects of autonomy that will combat the popularized view that addiction is about those who “can’t resist the pleasures” or “can’t resist the pain”. Rather, addiction is about those vulnerabilities and weaknesses present in all of us by virtue of our humanity.

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I. INTRODUCTION

The accurate assessment of drug addiction is a widely debated issue across academic disciplines and a hotly contentious subject in society at large. While legal institutions largely recognize addicts as rational, moral agents, an emerging understanding of addictive cravings in the social and neurological sciences seems to challenge this view. In a complementary manner, medicine has traditionally viewed addiction as a disease, leading some addiction theorists to conceptualize addictive behavior as the product of a symptomatic physiological condition. (Leshner, 1997). Consistency on this issue has become of paramount importance, as disparities between punitive and rehabilitative programs create a confused and deleterious environment for recovering addicts. It is the purpose of this paper to survey and critique the claims made by different groups about the questionable autonomy of those in a drug-addicted state, and to bring up through critical interpretation a strong base for understanding autonomy in both its particularly relevant and most general character. As a condition considered necessary for any robust determination of moral and legal responsibility (Wolff, 1970; Ripstein, 1999) and that warrants protection from unchecked paternalistic intervention (Feinberg, 1986), efforts to identify and assess autonomy have important practical consequences for drug addicts who often face austere legal and social repercussions for their behavior. Theoretically, addiction is recognized as a profound potential threat to autonomy (Christman, 1989), and an investigation of the psychological and physiological ramifications of drug dependence will illuminate if and how autonomy is maintained in the wake of strong drug-oriented desires.

It is my contention that the lived experience of addiction does not elude the basic sense of personal responsibility, nor the integrity of decision-making the autonomous agent possesses, and to this we may say its alternative—that is, finding addiction incommensurable with

autonomy—achieves no practical, theoretical, or therapeutic benefit in any proper response to addiction. As a problematic and multifaceted philosophical concept, autonomy is to be redefined in terms of its qualification for basic political and moral status—that is, those rights, respects, and responsibilities due to those considered full participants in a community.¹ This will be determined in part by exploring more demanding and narrow definitions in their suitability for autonomy in this generalized sense. Assessing what level of autonomy addicts command, then, will play an important role in defining how we as a society are to construct a punitive or rehabilitative response to the behavior of drug addicted individuals.

Indeed, it is the exceptional and often tragic nature of addiction-related behavior – behavior that often betrays social, legal, or even self-imposed rules – that prompts our concern with the integrity of the addict’s self-governance. The bare content of this behavior, however, cannot provide any solid ground for making judgments about autonomy. From the outset, I limit my investigation of autonomy to the process by which desires, reasons, preferences, rational deliberation and choices interact so as to legitimately identify core competencies that evidence a sense of reflective agency. It is my stated intention to suspend, to the greatest extent possible, any normative claims associated with judging the preferences or reasons an agent acts upon, and instead focus on those stable features and allowances which would define the autonomous decision-making process for the typical, healthy individual. Indeed, who counts as “typical” or “healthy” will explicitly be at stake here in this debate, and already invites questions of the normativity loaded in these concepts. However, our goal will be a careful concept-oriented analysis of autonomy that will allow us to render a judgment about the degree to which the

¹ For my purposes, I will leave the parameters of such a community open. In general, it implies both the legal obligations and prohibitions of an inhabited state or nation, and the moral evaluations and expectations of a given group. My argument is, again, that addicts not be viewed as compromised members of such groups.

addicted individual is robustly indicated in their choices as a reflective, competent agent, and in that way morally accountable for those choices.

To the extent that this demands some normative claims² about rationality, reflection or some other dimension of autonomy, I resist any claims concerning how the agent should choose to manage her autonomy at particular moments with reference to some “authentic” self to which the agent supposedly must be responsive. For reasons I will explain, such concepts create disastrous ambiguities that hinder potentially useful evaluations of agential responsibility in addiction. As a concept here used solely to determine one’s status as a political and moral agent (and thus ubiquitous enough to include most people), we must seek to define autonomy at a fundamental level that accommodates the vagaries in goals, plans, attitudes, and values—both between different individuals and over the course of particular individual lives. Agents can and do make choices and act on preferences which conflict with one another, and this does not invalidate a basic sense of autonomy that must accommodate such erratic behavior as basic human fallacies—addicted or otherwise.

More broadly, this paper will work to untangle some of the complicated and at times fallacious understandings which innervate and confuse this issue, with the hope that a nuanced and research-sensitive inquiry into addiction will bring the appropriate sympathies to what is unquestionably a troubled human condition. In practice, many of the apparent threats to the charge of autonomy in drug-addicted behavior are driven by tenuous interpretations of data from a variety of sources, which – while substantive contributions to the field in their own ways – fail

² See Gideon Yaffe (2001) for a discussion of how the question of responsibility in addiction begins with normatively defining how agents should be expected to manage their short- and long-term interests. For Yaffe, different normative judgments will bear different levels of responsibility. In the context of this paper, then, the choice to delimit the normative content in my assessment of autonomy will play a significant role in my final analysis of addiction. I defend my choice to define autonomy in such an ostensibly “loose” way with my intention of making autonomy a question of basic moral status, appropriate for social judgments about policy and treatment decisions.

to hold strong claims against autonomy and moral responsibility upon close scrutiny. It is the purpose of this paper to survey many of these sources, in disciplines ranging from neuroscience to law, psychology, sociology, history, and finally philosophy, in hopes of addressing the most prominent insights and challenges to autonomy given by these diverse sets of addiction literature. Each discourse offers evidence that can be used to explain addictive behavior in a way that will vitiate the charge of moral responsibility for the addicted. Whether out of pity or other motivations, these explanations offer confounding and spurious representations of addiction, which ultimately eclipse a more subtle understanding of addiction as an exaggeration of normal human tendencies and weaknesses. The force of my arguments will not be to levy additional shame and guilt on this often disastrous human situation, but to recover the moral status of agents vulnerable to the potentially paternalistic effects of academic and professional discourses.

From this platform, then, it seems appropriate to first evaluate some of the more concrete aspects of the addicted condition and then see how they may integrate with what may be determined the constitutive elements of “self-rule”. To introduce a non-interpretive assessment of addiction, to say what qualifies as a “concrete aspect” of this condition, will inevitably be contestable, as these are the tools which have traditionally been used to determine how addicted individuals are to be distinguished from the non-addicted. Arguments of this kind typically dissolve into a comparison between classes: as we talk about the addicted vs. the non-addicted, we implicitly set the precedent that there is a qualitative difference. To avoid any commitment to such a judgment, we may say that what we are responding to is a field of biomedical and psychological research that has found a certain set of behaviors and physiological mechanisms that indicate impaired functioning, and that such findings are consistently and amply more evident in a certain group of people.

Tremendous advances in technological and research sophistication have developed on a body of scientific and philosophical literature that has sought to explain the phenomena of embodied agency for centuries, and has brought us to an age that is able to take an informed gauge on the severity of addiction in a way no generation has before. For that same reason, the temptation to indulge in such discourses in triumphalist and uncritical ways has never been greater. The claims made by novel research methods demand careful and measured critique, particularly when adapted to address social issues which bare their own unique sociological and historical influences. Our response to chemical addictions, as I will argue, may in fact be motivated by a desire to control, justify, and explain deviance at a societal level, lumping together under the title of “disease” a diverse set of phenomena incongruent with a prevailing social order.

My aim here will be to provide an authentic recognition and engagement with the undeniable challenges and compromises that chemical addiction bring about, while focusing special attention on those areas in the research where agential responsibility is obscured but open for recovery. I attempt such a recovery by relating these questionable aspects of addiction to a non-normative definition of autonomy that will serve to justify the addict’s status as a political and moral agent. It is with due deference to such research findings, then, that we include some of the more relevant psychological and neurological reports which best represent the empirical differences that help define addiction as a problematic human condition. To this end, it may serve best to take on a general definition of addiction as it is employed by those who work specifically in its treatment in mental health institutions—that even as we must not ignore the relative value of one definition over another, we can start on the solid ground which dictates how addicted sufferers are currently to be understood and treated.

II. SCIENTIFIC AND TREATMENT CONCEPTS IN ADDICTION

DSM-IV-TR DEFINITION OF ADDICTION

The American Psychiatric Association's *Diagnostic and Statistical Manual*, fourth edition, text revision (DSM-IV-TR), defines substance dependence (hereafter described with the more common term "addiction"³) as a "maladaptive pattern of substance abuse, leading to clinically significant impairment or distress" (American Psychiatric Association, 2000,). An abbreviated list of criteria identifies seven dimensions for diagnosis, three of which constitute substance dependence; they include:

1. Tolerance, marked by increased dosage necessary for former levels of intoxication
2. Withdrawal, marked by adverse symptoms in the absence of a substance and alleviation of said symptoms by continued use
3. Consumption which exceeds intention
4. Unsuccessful attempts at consumption control, marked by persistent desire
5. Excessive time commitment to substance acquisition
6. Important social, occupational or recreational activities given up or reduced because of substance abuse
7. Continued substance abuse in spite of persistent physical or psychological problems likely caused or at least exacerbated by the substance

The breadth of the features recognized here are to some extent historically novel. Previous DSMs have (we must expect) observed behaviors in addicted individuals similar to those listed above, but as theories of drug addiction began in the medical and rehabilitative setting, it is unsurprising that treatment-oriented physicians and specialists first seized on addiction solely in terms of its physiological dimensions. Doing so gives addiction the more approachable status as

³ In some ways, we must take more issue with DSM language than with the term addiction. Substance dependence, at its broadest levels, encompasses a range of phenomena that are of little interest in the addiction debate discussed here. One can certainly be dependent on a substance (e.g., broncho-dilating inhalants for asthmatics, insulin for those with diabetes) while not displaying the particularly problematic behavioral patterns integral to what we understand as addiction. For this reason, I will resist the term "substance dependence" in favor of "addiction" or, more specifically, "chemical addiction". Behavioral addictions will not be within the focus of the arguments given here, and it is perhaps significant that the DSM has yet to recognize these as full disorders. Gambling addiction, however, has been proposed as a diagnosable condition for the new DSM-V awaiting release (Holden, 2010).

a problem of the body, as a disease. Before our contemporary understanding, addiction was understood exclusively in terms of dependence and withdrawal; any deviant behavioral changes that followed were explained in relation to the avoidance of the latter. This position was quickly dismissed as a woefully narrow and inadequate understanding. Under this model, as soon as withdrawal was mounted, sobriety and abstinence from drugs would be simple. However, rates of relapse and the overwhelming evidence of drug-related desires and the difficulty of quitting long past detoxification run contrary to this notion (Hyman, 2005).

All the same, it is important to note that criteria 1) and 2) still hold priority as the only clinical precedents for physiological dependence (American Psychiatric Association, 2000), and hence, are in their own way distinguishable from other forms of psychological addiction. However, as I will attempt to show, it is reasonable to assume that all activities concerning the addictive substance have chemical precursors that mark the subject's cognitive preoccupation with use, which themselves have an indirect physiological base. While it is not the purpose here to have all points draw back to brain biology as a kind of triumphalist argument towards science, it is important to understand that drug addiction distinguishes itself as a complex network of chemical responses that extends well beyond the scope of tolerance and withdrawal.

CHEMICAL ELEMENTS AND CRAVING

Extensive scientific research undertakings that have sought to explain the phenomenon of addiction regularly point out the potent effects such addictive drugs have on the physiology of the brain, specifically in areas which regulate reward-response and motivational control. The neurological response most relevant here involves the release of dopamine in the brain, which

regulates (among other things) reward-related learning, maintenance of desires, and goal-oriented behaviors (Berridge and Robinson, 1998). It is simple enough to assume that there is some feeling of reward that comes with the “high” that addictive drugs offer the user, but as one addiction neuroscience researcher explains it, “unlike natural rewards... all addictive drugs exert pharmacologic effects that cause release of dopamine. Moreover, the effects of addictive drugs on dopamine release are quantitatively greater than that produced by natural rewards under almost all circumstances.” (Hyman, 2007, 10) The excessive signaling of dopamine in the brain gives rise to a system where addictive drugs become grossly over-valued, while the importance of other typical self-interests (occupational responsibilities, relationship maintenance, personal care, etc.) become simultaneously devalued.

Neuronal connections of the mesotelencephalic dopamine circuitry emanate from the more primitive regions of the mid-brain and brainstem and terminate in the prefrontal cortex (the acclaimed “executive” region of the brain in part responsible for advanced cognition and planning), which over time become reinforced and more greatly sensitized to dopamine signaling through habitual substance use (Gardner and David, 1999). Eventually, addicts create many more dopamine receptors in the brain to accommodate the overabundance of dopamine signaling characteristic of habitual drug use. This wealth of receptors remains long after drug cessation, making normal reward responses to natural rewards seem comparatively weak. Addiction researchers speculate that this whole process creates a graded weakening of cognitive control; even if the addicted person wishes to cut back on her rate of consumption, a learned response to drug-seeking behaviors (as they relate to the expectation of rewards and chemical cues/precursors in the brain) makes this very hard to suppress.

Such a “learned response” is commonly referred to as a drug craving, which is an integral experience in drug addiction relapse behavior that has garnered a wealth of research interest. More than just a general preference or appetite for a substance, craving is a discrete event that happens in the process of drug cessation and relapse prevention when a desire to use is recognized but not acted upon (Tiffany, 1990). The memory centers that underlie habitual drug use (i.e., the overabundance of dopaminergic receptors mentioned above) are physiologically set in synapses that not only change the way other rewards are felt but also remain potentially active, which leads some researchers to believe they have some relation to craving (Gardner and David, 1999). This is unlike withdrawal, which can be cured of the body through detoxification in a matter of days. Cues and triggers associated with and conditioned by drug use instigate cravings, and will often beset addicts years into their sobriety, if not for the rest of their lives. Addiction specialists widely agree that controlling craving is a chief therapeutic obstacle (see Hyman, 2005).

A brief overview of the literature suggests that the experience of craving in drug cessation compromises an individual’s ability to accurately assess the benefits and costs of relapse, and acts as a predictor of relapse among addicts who are attempting to quit (Killen & Fortmann, 1997). As an emotional and cognitive state reflecting the activation of motivational, drug acquisitive systems (Baker, Morse and Sherman, 1987), craving has been shown to bring about an attentional bias for drug-related cues (Juliano & Brandon, 1998). Craving also generates positive affect in the memory and anticipation of the drug’s reinforcing qualities (Marlatt, 1985); can cause intense dysphoria with the expectation of not satisfying the addictive desire (Tiffany, 1990); initiates biased and motivational reasoning for drug acquisition, predicting more positive and less negative consequences for relapse (Kunda, 1987); and isolates

the opportunity for relapse as a “special circumstance” consistent with a broader desire to quit (Ainslie, 1999a). What’s more, such changes in drug-related thinking are exaggerated by an experience of time-dilation (Klein et al., 2003), whereby addicts overestimate the amount of time passed while acutely craving a substance. Such increased time perception has been shown to diminish one’s capacity for self-regulation (Vohs and Schmeichel, 2009), and thus increases the likelihood of momentary relapse behavior.

As mentioned previously, craving is a discrete episode experienced (sometimes frequently) in drug addiction recovery, and is typically felt as a “pulsatile” and short-lived distress (on the order of 15-30 minutes of acute anxiety) rather than as an enduring feature of drug abstinence in addiction recovery (Gawin, 1991). Such an experience typically cashes itself out in the subtle shifts described above, with distinct differences in information processing evident in “hot” states of craving that are absent in “cold” states when one is not experiencing an acute craving. Aside from the difficulties of successfully managing such a “hot” state, this gap poses a unique challenge in itself. Addicts assessing their ability to resist relapse while in “cold” states tend to be overconfident in their ability to succeed (Gwaltney et al., 2001), which may result in confrontations with temptation that promotes drug craving. The related underconfidence in one’s ability to resist relapses associated with the “hot” state of craving will then undermine one’s ability to navigate potential relapse situations effectively. Michael Sayette (2006), in his review of the many cognitive changes demonstrated in states of craving, describes how this experience can shock and intimidate an addict into a fatalistic attitude: “Without recognizing the powerful shifts in information processing occurring while craving, the smoker may conclude that the relapse reflects an immutable dispositional weakness.” (12) He goes on to describe how such craving-states, which essentially begin as bottom-up, somatic phenomena, can

influence our reflective, top-down, planning-oriented cognitive resources, and thus interfere at multiple registers with our ability to make decisions.

At base, then, we may say that addicts are responding to an exaggerated form of desire that scientists, in various ways, have measured as a threat to healthy decision-making. While this is at best a cursory sketch of but one aspect of the question, the implications we can take from this need to be understood in their wider context. Human beings are clearly open to a world of desires, many of which guide our lives in more or less subtle ways. While it would be inappropriate for our purposes to try and map out some elaborate correspondence between our drives and goals, their satisfaction, and the chemicals they elicit in the brain that give biological grounding to such feelings of satisfaction, and to say *this* is the key to understanding the impetus of all human action, we may say that brain chemistry provides a suitable backdrop for making a distinction. Although the exact mechanism for drug craving is (in our contemporary understanding) still unclear and likely unique to each drug of addiction (Gardner and David, 1999), craving and relapse universalize across different substances and reflect some general structural and functional similarities, specifically in their relation to dopaminergic activity in the brain. Dopamine, however, is an endogenous chemical to the body, built in through evolution, active in all healthy people, and even uniquely responsive to a person's particular tastes and motivations. For all of the shifts and changes described in the psychology literature above, while addict's display these changes more dramatically, it is appropriate to assume that our dopamine system adjusts in a similar way (Foddy and Savulescu, 2006). What is at stake with addictive drugs is that they have the ability to affect the systems of reward and satisfaction in a direct and explicit way—a way decidedly unnatural to the human system. Dr. Avram Goldstein (2001), in writing through an explanation of the physiology of addiction, explains that addictive drugs

“activate the pathways artificially—short-circuiting the natural process one might say—and thus they disturb the mechanisms that keep people on an even keel” (68). It is this level of artifice, and indeed, a closer investigation of how autonomy might be reconcilable with people who are not on an “even keel” (if this is a granted, albeit colloquial description of the addicted condition) that may illuminate this question of personal responsibility.

Not being on an even keel, however, is hardly a condition unique to addiction, and much less a well-defined criterion for judgment. The way certain addiction theorists interpret this condition, however, lends itself to a specious and exaggerated representation of addiction that demands our attention. Specifically, many treatment-oriented clinicians seize these subtle changes in biology and perception as evidence of a discrete medical condition. In looking at the discussions surrounding the disease model of addiction, with the addiction-as-compulsion model as its most common extension, it is my suspicion that a careful dissection of the claims and motivations behind these concepts will let us draw out any erroneous conclusions, and perhaps out of these models all together. I begin with claims made towards addiction as compulsion, and from this pull back into the disease model in its wider historical and sociological dimensions.

ADDICTION-AS-COMPULSION

The craving for drink in real dipsomaniacs, or for opium or chloral in those subjugated, is of a strength of which normal persons form no conception. ‘Were a keg of rum in one corner of a room and were a cannon constantly discharging balls between me and it, I could not refrain from passing before that cannon in order to get the rum’; ‘If a bottle of brandy stood at one hand and the pit of hell yawned at the other, and I were convinced that I should be pushed in as sure as I took one glass, I could not refrain’: such statements abound in the dipsomaniacs’ mouth. (James, 1890, 543; cited in Levy, 2006, 431)

Such accounts as those from quoted above from philosopher and psychologist William James – rather unexceptional in his time and still, I would contend, popular in ours – attest to the

power and influence this idea of an irresistible compulsion has had in the history of addiction. In many cases, we see addicts act in ways that breach common sensibility, betray occupational and interpersonal duties, and lapse into the kind akratic behavior that often demands the most dramatic social intervention. It is, for many, a baffling situation, so incommensurable with what we know about the behavior of normal, healthy human beings that we are led to believe this condition is significantly beyond the range of normal experience, that there is some severe impairment at work that demands our sensitivity. Such sensitivities come through the therapeutic community in many ways, but all too often they come by making a leap, and elevating the severity of addiction to this level of irresistible compulsion. In one of the strongest stances on this issue, Alan Leshner writes that addicts have an "uncontrollable compulsion to seek and use the drugs"; that their drug taking is a "direct physiological consequence" of the neurological and psychological changes we have discussed; and that these impulses "nullify any semblance of voluntary choice". Most boldly, he is famous for his bottom line, that "quite literally, the addict's brain has been hijacked by the drug" (Leshner, 1997; cited in Perring, 2001, 50).

Appeals to these types are arguments abound, both anecdotally and even within the DSM diagnostic criteria we have already examined. To see that individuals in the addicted condition have open desires to stop or temper their use of substances, but find themselves unable to do so (criteria 4 and 5, respectively), we assume that there is some level of desire that seems disordered. However, to say that drug-seeking behavior should be considered a physiological consequent to a complex psychological and bodily condition is logically inconsistent with the behavior itself. As an opposing voice in the bioethics community, Christian Perring (2002) holds

that the use of such simple medical descriptions cannot be grafted over the drug acquisition process:

Even in the most extreme cases of addiction ... no form of complex behavior such as seeking and taking drugs could simply be a "direct physiological consequence" of a change in the brain, since a great deal of planning and thought is required for such behavior, especially when it requires finding ways to get the money to buy the drugs and evasion of the police is required in the process of buying and using the drugs. (50)

From this, we take that the line of events between the desire to use drugs and the satisfaction of that desire are by their greatest organization linear, but almost always the combination of several different decisions and consequences, all of which bear time for reflection and recourse. This takes us far away from the idea that the craving and pursuit of drugs is an autonomic bodily response.

All the same, however, we cannot rule out that what overlays all of these decisions is the chemical incentive towards a reward that operates far outside the way a healthy mind values rewards. In many cases, it seems that the addict has abundant reasons to stop using addictive substances, that the potential or certainty of certain harms far outweighs the actual benefits (even by the addict's own analysis). And even in spite of this, we still often see addicts continue to pursue drug use in ways that draw into question their very ability to make reasons-responsive choices. As one theorist summarizes quite well, "[t]hey [addicts] engage in illegal, dangerous or degrading activities in order to procure their drug, they lose their jobs, their partners and their homes. If it was *purely* a matter of autonomous choice, we should not expect their lives to spiral out of control so dramatically" (Levy, 2006, 433).

There are, however, many examples of population research which do not play neatly into the idea of the indiscriminate user. By demographics, we observe that mothers with dependent children show a disproportionate rate of drug addiction recovery (Watson, 1999), and even self-reports among heroin users evidence a reflective attitude towards a changing drug market and a

basic budgeting of pros and cons that can lead to decreased usage (Neale, 2002). It does not seem that drug use for most people can be integrated into the idea of an irresistible compulsion if it is given to a matter of population- and attitude-relevance, at least when considered in relation to a community of Obsessive-Compulsive Disorder or Tourette's Syndrome sufferers who do not demonstrate the same distinctions in their maladies.

Even if we remove the component of an invincible irresistibility from the discussion, we must still take on the problematic use of the word "compulsive" in a weaker sense. That is, even if we distinguish the addicted from the obsessive-compulsive, bioethicists and treatment communities may still use a kind of terminology that implies drug-oriented desires in the addicted are qualitatively different than normal, appetitive desires. As determining this point may serve to put the addicted under a distinct moral and medical lens, it is important to examine if there is any such *qualitative* difference.

In writing on this topic, Foddy and Savulescu (2006) worked to consolidate research concerning the neural mechanisms involved in appetitive desires (those based on palatable foods) as they relate to the way drug-oriented desires are developed in those experiencing full, clinically diagnosable addiction. The results of many experiments tracking dopaminergic sensitivities to sugar and conditioned stimuli (foods deemed palatable by subjects) have shown that these kinds of desires operate and develop by the same mechanisms as those in drug-oriented desires, and that the two *bear no functional distinction* (even to the point of withdrawal observed in animal subjects cut off from certain palatable foods). At most, the research at play here does respect a methodological distinction: "The only relevant difference... is the fact that drugs operate directly on the motivational system without using only endogenous chemicals, so that their

motivational power is directly dose-dependent (and may thus be very strong).” (Foddy and Savulescu, 2006, 10)

From this, we are compelled to conclude that the experience of addictive desires lies in fundamental continuity with the experience of other strong desires. Even in humbling and down-playing the exceptional nature of the addicted condition, however, Foddy and Savulescu concede to one point that may continue to drive our discussion: that drug-oriented desires, although admittedly indistinguishable by neural mechanism, are distinct in their ability to toxify reward systems in an artificial and determined way. While we are all able to elicit feelings of pleasure by engaging in activities we enjoy, addictive drugs allow a user to quantitatively manipulate their bodily response to such pleasure by simply dosing themselves to the desired level. Even while sexual stimulation can be a compulsive and habituated desire, the sex-addict can only increase the frequency, not the strength of the chemical reaction, to sexual gratification. In this sense, drug dependence becomes unique in eliciting symptoms potentially more severe and physiologically more toxic than those generated in other forms of dependence, and thus may be legitimately treated as a separate diagnosable condition. How this physiologically potent dependence presents in the addict’s life, however, does not engulf every moment of that life and in fact varies quite widely between different stages of addiction, with different people generally, and with different drugs of addiction. Thus, the potential severity of the corporeal elements does not *prima facie* imply any full claims about the experience of autonomous decision-making in addiction, and this must remain an open question at this point (to be taken up later).

In general, the most physiologically potent effects of any drug addiction are experienced in the periods of active tolerance and withdrawal, which may place active users in a different moral or legal category than those recovering users who have been weaned of the aversive

effects of withdrawal for some period of time. But as our previous discussion of craving reveals, even long into sobriety an addict can face psychologically compelling desires that often predict relapse behavior better than the strong physiological reactions associated with tolerance and withdrawal. This disrupts the notion that these more heavily corporeal elements characterize the bulk of addictive experiences, but opens up a broader concern about the long-term neurological effects of habitual drug use. Indeed, researchers have already discovered that the small changes in patterns of dopaminergic activity that determine a proclivity toward addiction in children of addicted parents can be generated by a history of habitual drug use within one's life (Nestle, 1993). From this, some theorists go on to privilege the experience of drug craving as the lynchpin for most addictive phenomena, and conceptualize it a "visceral factor" akin to the need of survival-related necessities like food and sleep (Loewenstein, 1999). Given that dopamine's evolutionary function in most animals (including humans) is to motivate behavior towards survival-related goals, such a theory is intuitively compelling, and serves again to "normalize" drug addiction as an experience consonant with the body's species-typical motivational mechanism. Craving, then, would be retained as an exceptional body-state (which helps explain the characteristic corruptions of behavior), but one at least in principle relatable to the experience of other body-states.

Proponents of this "visceral" account, however, trade on the idea that at sufficiently high levels of craving, the scope of volition narrows to a place where choice itself seems to disappear. While this may be true, experiences like hunger and sleepiness should be accommodated in our definition of autonomy, and how agents manage their lives around these foreseeable needs is not insignificant. Likewise, the different degrees of such experiences create a wide field where some appreciable level of decision-making can be recognized and appreciated. Although it is simple

enough to manage needs like sleep and hunger by the regular role they play in our lives and the lives of others, the exotic and artificial nature of chemical dependency on illicit substances is not a substitute for its strength. In spite of the explicit physiological manipulation implied in drug-taking, if we do take drug-oriented desires to be in continuity with other forms of desire, the need to pathologize this condition becomes less apparent. Indeed, although it seems appropriate to address drug addiction needs as a disorder (i.e., a discrete condition inviting specific research and therapeutic strategies), whether addiction constitutes a *disease* because of its physiological components becomes a difficult question—not by definition, but by the heavy social and historical implications that such a title carries.

DISEASE MODEL OF ADDICTION

Addiction, in spite of its many confounding and troubling aspects, is largely understood as a disease in our contemporary society.⁴ Medical students are taught about it, medications are researched and prescribed, most health insurances now cover treatment, and whole hospital settings are created and devoted to the care of the chemically addicted. And indeed, from what has been said so far, addiction might fairly be characterized, without too much concession, as a disorder of function that produces consistent physiological signs and symptoms. It is human tragedy that involves – at least in part – a corruption of the body. Of course, in having shown that any sufficiently strong appetitive desire might also produce the same symptoms, this makes this argument problematic, but not altogether invalid. Treatment communities already exist for those with disordered desires involving food and sex, and we may speculate that if the disease

⁴ Specifically endorsed as a chronic disease by both the *National Institute on Drug Abuse* and the *National Institutes of Health*, the two largest research institutions concerned with addiction.

criterion is acceptable for drug addiction, this must also be the case with overeating and sex addiction. But if we are resistant to affirming a disease-status for these similarly affected groups, we must reevaluate the reasons we have for relating this title to the drug addicted. Our reasons for doing so are, in fact, unique to the relationship between society and the ill, and more generally, how we treat such people who deviate from accepted social norms.

From the outset, it seems odd to characterize the sick as social deviants. In spite of the accusatory sentiments in this title, the concept of deviance addresses a general conflict within social systems. If a society thrives on a population of citizens actively participating in socially sanctioned roles (e.g., working, taking care of children, providing goods and services), then how do we treat those who fail to perform in any of these prescribed roles? Much worse, what if their behavior actively disrupts social stability? Responses will obviously vary between different excusing conditions, but a historical and sociological analysis of the manifestations of deviance in Western cultures reveals several distinct concepts that are commonly levied against deviants by the hegemony they offend. Such concepts can help organize our contemporary opinions about chemical addiction and the different understandings that lay claim to this phenomenon.

Indeed, the very idea of “laying claim” characterizes an important feature of how deviance has been understood historically. When social aberrations appear in a population – be it through counter-normative behavior, ideas, or illness (mental or physical) – different institutions are called to address the situation. Legal systems punish and incarcerate criminals, medical clinicians treat the ill, and religious figures render judgments about spiritual subjects. Significantly, sociologists have recognized that the varying definitions of deviance arising in history are in no small part a result of these institutions and the norms they engender in society (Buckner, 1971). Although eminent sociologist and theorist Emile Durkheim has helped us

understand that deviance definitions are in some ways universal, endemic to the very notion that society has something like social norms (1895), these institutions create the sanctions that speak to their interests, and buttress specific social norms and deviance definitions in concrete ways. In that sense, then, an etiology of certain deviant conditions can be understood through their trajectory within different institutions that participate in defining that condition. Moreover, important work has been done in understanding that deviance definitions often have an etiology which is separate from the deviant behavior itself, and that the *meaning* of the deviant behavior (i.e., its social reception, moral status, mode of treatment, and potential for revision) changes closer in step with these politicized and arbitrated definitions (Freidson, 1970).

To that end, we might understand the rise of the disease concept of addiction, a definition which places addiction under the auspices of medical treatment, at least in part as a sociological event independent of the reality of addictive behavior. Certainly, as long as addictive substances have been available to humans, there have been those who have fallen prey to chemical dependency and addictive use. And while there can be no doubt that a dramatic rise in research and technological sophistication has allowed us to understand the robust physiological components of addiction with greater attunement, there are certain social realities to different institutional definitions of deviance that bear our attention. That is, we might understand the relatively recent designation of disease-status as motivated by a desire to change the meaning of this phenomenon. This is not to be taken in some clandestine or conspiratorial way, but that a generally changing and more sensitive attitude about drug addiction was marked by a shift in institutional dominance. This shift, however, radically altered our understanding of addiction in a way that has more to do with what the changing institutions represent. Even as we understand

more about chemical addictions, it is the institutions that lay claim to their treatment that may speak the loudest about our moral assessment of those afflicted.

In particular, Peter Conrad and Joseph Shneider (1980) have cited three main paradigms that have significantly shaped our understanding and the institutionalized treatment of deviant behavior: deviance as sin, deviance as crime, and deviance as illness. The authors make the argument that a Kuhnian shift across these paradigms has variously influenced how the “facts” of deviant behavior are interpreted, in a way that generally demonstrates a trajectory from moral blame to medical therapy for many ambiguous deviant social phenomena (e.g., opiate addiction, alcoholism, mental illness, child hyperactivity). Although all three of these paradigms still exist with more or less prominence today, it has been the unprecedented rise and expansion of the medical paradigm in the past century that has defined an ascending model of medical description, explanation, and authority over many forms of deviance: “In a world that views science as the ultimate arbiter of reality, deviance designations that can be supported by scientific research are more likely to gain credence... When medical designations of deviant reality are in competition with other designations, we may well witness a *hegemony* of medical definitions; that is, a preponderant influence or acceptance of medical authority as the ‘final’ reality and a diminishing of other potential realities.” (Conrad and Schneider, 1980, 28; their emphasis) They describe this process as “the medicalization of deviance,” and suggest that it represents a fundamental transformation of deviance from *badness* to *sickness*.

Looking at the definitions of deviance apart from illness, it is clear that some form of “badness” or social/moral blame accompanies the accusation of sin or crime. Any behavior defined as such implies that the only appropriate response must involve punishment of some social or spiritual force, and some charge of responsibility and repentance for one’s conduct.

The ill, however, are relieved of this responsibility. Thus, the move from badness to sickness represents one of excuse and assumed moral neutrality. Someone's illness is not generally considered a proper object of moral assessment, and so the ethical responsibilities of the sufferer in these cases becomes greatly diminished or entirely absent, at least with regard to that illness. Absolving the deviant offender in this way demonstrates a potential benefit of the medical paradigm, which I contend operates as a motivation in its own right. Such motivations are understandably humanitarian in nature, but it is the added social consequences of this disease status which may provide a misleading representation of the condition they mean to exculpate.

To return to the most salient feature of disease-status, to be sick effectively means to be beset by limitations which are considered to be more or less beyond your control, and for that reason social expectations are adjusted to meet our understanding of the disease. From this, it is fair to say a *social judgment* accompanies the biophysiological phenomenon of disease and creates a social reality of "illness" which can be distinguished from the disease's physical sequelae. As Freidson (1970) summarizes eloquently: "When a veterinarian diagnosis a cow's condition as an illness, he does not merely by diagnosis change the cow's behavior: to the cow, illness remains an experienced biophysical state, no more. But when a physician diagnoses a human's condition as illness, he changes the man's behavior by diagnosis: a social state is added to a biophysical state by assigning the meaning of illness to disease." (223; cited in Conrad and Schneider, 1980, 31)

This social state, as I've mentioned, variously removes certain social expectations from the person experiencing the constructed concept of illness, but also adds other expectations. As Talcott Parsons (1951) explains in his landmark sociological definition of the "sick role," the ill are excused from many social duties, but additionally required (by a social obligation inherent to

the “social state” of illness described) to recognize their illness as undesirable, want to recover, demonstrate some deference to an appropriate health agent for recovery. Perhaps most provocative in our discussion of chemical addiction, this sick role (for Parsons definition and, I would argue, for its social legitimacy and acceptance) must also trade on the fundamental assumption that the illness has a natural course and recovery in and by the body; that is, disease occurs *outside* of a willful act, and is not, in its internal biophysical development, amenable by a sheer act of will. Parsons was keenly aware that the sick role operated as another sociological avenue for understanding deviance, and argued that the distinction between willful and unwillful deviance is what hung at the crux between deviance as crime and deviance as illness.

Thus, insofar as we understand the movement through these paradigms as a change in the way we conceptualize deviance, these changes bring with them heavy normative assumptions which need to be crucially scrutinized before being accepted wholesale. While I have dwelled on the emergence of a medical hegemony in defining certain forms of deviance and the social realities they entail, we should keep in mind that the inclusion of chemical addiction into the realm of illness comes from a flight from purely criminal designations. To be sure, most illicit drug use can and will continue to be criminalized in the United States, but our nuanced medical and scientific understanding of chemical addictions seems to radicalize and bifurcate our treatment of addicts. Again, under the system of legal penalty, they are considered largely responsible for their behavior (some subtleties of which have yet to be discussed), while under medical definitions, this responsibility rapidly diminishes. While our sympathies and frustrations with addiction drift us somewhere between these two – full moral blame and medical excuse – the reality of these institutions forces us push the addicted in one way or another, each side of the fence (which we might literally understand as the choice of two systems of paternalistic

control—the jail or the hospital) making bold claims about the addicted condition that ultimately obscure its understanding.

In an important way, then, any step into an institutionalized definition of deviance will carry heavy implications. As mentioned previously, from a sociological standpoint all institutions formalize and enforce social norms, regardless of the different, and in this case contradictory claims they make about the deviant offenders. With respect to Parsons's definition of the sick role, the key unifying concept in disease is that it is explicitly recognized as something undesirable, demanding intervention, and ultimately correction. By couching this need in terms of "health" (in all its ambiguity), the medical paradigm of sickness makes powerful claims that even supersede (at least in our contemporary society) the claims of religious and legal bodies. Consider that in 1851, an American doctor 'discovered' drapetomania – a disease that caused slaves to run away – conspicuously concurrent with a changing political climate that threatened slave-holding practices (Cartwright 1851, cited in Ranger, 1989). By appealing to medicalization, slave-holders were able to bolster (however absurdly) a normative conception of Southern chattel slavery that was under political duress. By conferring disease status onto this form of social deviance (deviant in its slave-holding context), the hope was to de-politicize what was clearly a matter of social justice, and preserve the notion that a slave seeking freedom was taboo—and what's more, "unhealthy". The attempted shift between institutional dominance meant very little social change in this case, except that a new justification was used to take the *idea* of change off the table. If drapetomania is a disease, it is inscribed within the potential health and pathology of the body (or, more ambiguously, the mind), and our duty will always be to treat the offender as sick; i.e., as an unwillful victim that needs to be brought back to "health". Likewise, if chemical addiction gets uncritically ushered under the title of disease, it runs the

threat of being instilled with a social reality that wrongly dismisses the free will of addicted sufferer to affect their recovery.

In general, to equate addiction with drapetomania would be a mistake, as there are many valid physical and social consequences of drug addiction that at least grant it status as a disorder with physiological components. But what underwrites both of these examples is the force of medicalization in levying a powerful social judgment that is largely independent and perhaps disturbingly inconsistent with the condition they overlay. Even without passing judgment on the legitimacy of the disease status of addiction, we can readily appreciate that holding to such a claim allows us to both morally vindicate and profoundly change (and I would argue, obscure) our understanding of chemical addiction. Now bolstered by the advent of new neuroimaging technologies that promise to visualize and pin down the biological bases for many mental disorders, many writers in ethics literature are becoming keenly aware of the power research scientists wield in confirming their own paradigm about health, deviance, and the medical “reality” of certain ambiguous mental health issues (Boyce, 2009). In spite of the precarious and generally unappreciated (but severe) limitations to modern neuroimaging (see Logothetis, 2008), neuroanatomical imagery, simply by virtue of its novelty and independent of its content, has been empirically proven to have a markedly influential effect on people’s evaluation of scientific evidence (McCabe and Castel, 2008).

While many bioethicists are now clambering for a new and rigorous ethics of neurointerpretation to follow in step with the unprecedented celebration and profusion of neuroimagery in popular magazines and newspapers (see Illes and Racine, 2005), the influence and expansion of these new technologies represent another manifestation of the push towards medicalization I have just outlined. With regard to this addiction, many recent neuroimaging

studies have focused directly on understanding addiction as a disease (see Lubman et al., 2004; Kalivas and Volkow, 2005), but in general they pose the same potential threat of distortion for many other ambiguous mental health issues, issues that simply more approachable as diseases than as more complex biopsychosocial and moral issues. Society is comforted by the idea that certain patterns of behavior are not normal, and by creating diagnoses, institutions and prescription medications for people who exhibit deviant behavior, society effectively and humanely diverts the suffering into treatment (although just how “humane” and different this type of paternalistic intervention really is from criminal punishment might still be up for debate).

What is effective for the self-esteem maintenance of society, however, may actually sabotage an addict’s road to recovery. One of the most prominent addiction theorists and researchers, George Ainslie warns us that supporting an image of addiction as some disease of impulse control allows addicts to defer responsibility for their harmful behavior, and leads to an increased incidence of relapse (1999). In spite of this, Narcotics Anonymous (along with its mother program, Alcoholics Anonymous, widely the most popular non-clinic drug rehabilitative systems in this country) espouses a similar rhetoric of submission.⁵ It is no less than the first step of the popularized twelve steps that addicts admit that substances have rendered them “powerless,” and that their lives had become utterly “unmanageable” (*Narcotics Anonymous*, 1988). Addicts are responsive to these motivations, and to promote the notion that an individual suffers from a condition that does not allow them to control their drug-oriented desires carries denigrating emotional and practical consequences for rehabilitation. For an addict to lapse into a

⁵ It should be noted that Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are organizations that share an understanding of addiction and, more importantly, recovery from addiction as a spiritual condition; that is, addicts only recover from their affliction through an appeal to a “higher power” – variously defined by the individual addicts themselves – and the community of shared experience and support that AA and NA provide. While I genuinely respect and admire the critical aid such communities can provide for recovering addicts, I take issue with the problematic understanding of addiction this organization embraces.

kind of fatalism about her condition opens a place for relapse: it creates a self-fulfilling prophecy in which temptations towards drug-use become uncontrollable because they are convinced to be so.

Of course, the medical model would not be adopted if it was found to be entirely detrimental to society by exacerbating the addict's self-efficacy in recovery. To consider addiction as a disease has the benefit of driving scientific research into a better understanding of the exact science behind addictive desires, and in turn creating medications which can effectively curb those desires (or at least eliminate their satisfaction by blocking certain neurotransmitters sites which allow addictive drugs to give pleasure, as is the case with popular opiate addiction medications). It elicits sympathy for ailing drug-addict; to imagine that the addict faces pathologically severe desires makes us more inclined to believe she cannot command adequate control of such desires and the consequences they will incur. The natural extension of this sympathy becomes the kind of paternalistic intervention often brought into the addict's life. Despite the fact such interventions may at times seem necessary, the problem comes when these practices are driven by the concept of addiction as a totally unmanageable disease. At bottom, these beliefs come at the implicit expense of that individual's integrity to make meaningful decisions for herself. Weighing our duty as a society to take responsibility for an individual's self-destructive behavior against that individual's right to autonomy is one of the basic concerns in the drug addiction debate, and of central importance in this work.

The disease status of addiction is undeniably more conducive to exercising certain social duties, but the issue here is whether it additionally confounds and artificially constructs an understanding of the addict's autonomy (or lack thereof) that is not only unfounded, but also deleterious to an addict's recovery. I contend that taken uncritically, the disease status of

addiction carries with it heavy normative claims that severely threaten our understanding of the central role that appeals to and support of autonomy plays in chemical addiction and its recovery. Moreover, failing to retain a respect for the addict's autonomy in favor of treating the "disease" could lead to problematic paternalistic interventions. As more medications become available for addiction treatment, there are already worries that these medical regimens could become a standard policy for drug offenders on parole (see Bonnie, Chen, and O'Brien, 2008). Such cases clearly evidence how the conceptualization of addiction as a disease could have potentially disastrous consequences for the addict's status as an autonomous moral and political agent, in a way that demands a critical reevaluation before we step forward with such plans.

In spite of the emphasis placed on an addict's autonomy in the recovery process, there can be no doubt that this is also profoundly compromised by the addiction process itself. The task is then upon us to consider how individuals execute their autonomy (under various conceptions of the word) in terms of decision making, and how they balance certain short- and long-term desires into effectively free choices, both in states of addiction and in states of relative "health". After comparing these two, the issue of moral responsibility will be addressed to see if and how addicts maintain responsibility for their addiction-related behavior, and how this might inform our expectations for treatment and recovery.

III. CONCEPTS OF AUTONOMY AND RESPONSIBILITY IN ADDICTION

BASIC AUTONOMY

As mentioned previously, it is my intention here to relate addiction to autonomy under threshold conditions; that is, to determine solid criteria for autonomy and understand whether the addicted condition fails to meet such criteria. From the outset, however, it seems that any assessment of autonomy must be conducted through a balance of different paradigms and arrive at something like a normative definition. That is, it seems difficult to propose any definition of autonomy useful for making judgments without answering the normative question of what we should expect autonomy to look like for morally accountable agents.

As I stated in my introduction, however, I limit such normativity to just those qualifications deemed necessary for recognition as a moral and political agent, with the ensuing rights, respects, and responsibilities due. Determining the scope and features of such a status will be a matter of restricting our focus to only those elements deemed essential for moral agency and responsibility. Although it might be argued that autonomy is not a necessary condition for moral responsibility, and that addiction may fit better with some state of freedom short of full autonomy, I believe such an argument retains a fundamental distinction of the addicted vs. the non-addicted that I wish to challenge. By examining the different understandings that autonomy can fall under, we will arrive at a definition that embraces embodied self-authority in both its complexity and weaknesses.

As a philosophical topic, we understand that there exists a rich array of issues in autonomy; e.g., how self-law might reflect a broader and perhaps universalizable state of reason

(Kant, 1993); how preferences are formed, judged against one another, and acted upon in spite of external influences (Christman, 1989); and how determining one's actions is responsive to a coherent and practical "self", and how the nature of reason-giving implies a certain moral structure (Korsgaard, 2008). While these are some of the in-roads to our discussion, we must round out these inquiries in a way that identifies the most salient characteristics of autonomy as they are judged in the more common social and legal spheres: What physical and mental conditions might absolve someone of personal responsibility? How do we identify and respond to those who seem to lack such a basic ability? What rights and respects are due to such vulnerable demographics, and conversely, to those considered fully autonomous agents?

The difference between these question sets may reflect different notions of autonomy altogether, what John Christman (2003) describes alternatively as *basic* and *ideal* autonomy. Ideal autonomy, which denotes a state of maximal authenticity unencumbered by manipulative or self-distorting influences, exists as a goal rather than a real and achievable human state. Basic autonomy, on the other hand, is understood as a question of status: it is the fundamental condition presupposed of most healthy adults who have the ability to make decisions, absorb the costs and benefits of their choices, and generally control their lives unfettered by excessively oppressive and constricting conditions.

While this is a fair and general characterization of the kind of autonomy we can readily appreciate, the worry looms that this paints autonomy with such a broad brush so as to be insubstantial for making distinctions. But even to be incisive on this matter, to understand exactly what autonomy means as a basic status, is to understand what it means to exercise autonomy from the position of the average, embodied person, which we will find is necessarily general and in fact rather loose. It is only on the assumption that autonomy is a relatively

universal quality that we are able to honor a protected respect for it across our legal and social systems. We will therefore abandon the concern that addiction creates a serious obstruction to the enjoyment of full, ideal autonomy. Even as this might be a relevant and obvious argument to drive at, it does not strike at the heart of addiction as a social issue. What is at stake in the debate over the questionable autonomy of those in the addicted state is their basic status as an agent who should be considered morally and legally responsible for their actions—as most people are. If the conditions of decision-making and agency in addiction are suitably divorced from those of average person, then a new legal and medical status must be clarified and instituted.

With this in mind, then, we must reorient the rigors and conditions of self-authority that we are to place on those in the addicted state to be conditions we would expect any non-addicted individual to readily fulfill. While this seems to be a trivial point to belabor, it will serve as a constant point of comparison that will determine if and how the addicted individual is to be distinguished in her ability to exercise her autonomy. What will emerge is a picture of autonomy that is duly responsive to the imperfect way most people exercise authority over their motivations and desires, and how a practical assessment of autonomy may resist the strictures commonly confronted in an idealized definition of the word. Even as we must be wary of instituting a theoretically “thin” conception of autonomy, our main concern rests in establishing a definition which is not disproportionately “thick” and irreconcilable with the vicissitudes of real, lived experience.

OVERVIEW OF TERMS

Etymologically, autonomy is understood as *autos* ('self') + *nomos* ("law"), and was first used to denote the self-sufficiency and power of ancient Greek states. To describe even in brief review all of the relevant moral, political and metaphysical implications that have been drawn from this word is not only well beyond the scope of this paper, but needlessly confounding. As noted theorist on autonomy Gerald Dworkin (1988) summarizes: "About the only features held constant from one author to another are that autonomy is a feature of persons that is a desirable quality to have... it is very unlikely that there is a core meaning which underlies all these various uses of the term." In reviewing various sets of literature, it has been my experience that to invest any faith in having found a concrete aspect of this elusive concept is to be flabbergasted by its inevitable exceptions and undeniable subtleties. To this end, I will keep to the spirit of basic autonomy that I have delineated above in identifying certain trends and features of autonomy that integrate most suitably with its lived experience, and eliminate those which reach too far or demand too much of the average person.

As mentioned previously, we are tackling a definition of autonomy in its minimal designation; which is to say, we are taking on just those features that allow a person to make relatively un-coerced and self-generated choices. Some concepts to consider in this investigation will be an agent's ability to act on preferences and execute decisions; to alter conditions which surround decision making; to identify with her decision and endorse such a decision as her own; to make decisions which relate to personal convictions; and to rationally reflect and respond to reasons for and against certain choices. A brief description of each of these conditions will be substantiated by relevant examples and then related to any relative impairments the addicted condition might bring to the situation. Two conditions related to the legal assessment of

autonomy (or rather, the potential lack thereof) also bear some scrutiny, as legal institutions trade on some assumption of an offender's minimal command of autonomy that relates well to the definition sought here. If chemical addiction convincingly falls into either of the traditional nullifying conditions for responsibility – when crimes are committed involuntarily or by insanity – then some minimal conception of autonomy would not seem to obtain. We begin with a discussion of these legal categories.

LEGAL CONCEPTIONS OF NON-RESPONSIBILITY

A simple understanding of legal responsibility suggests that all agents subject to the laws of a governing body are accountable for their actions. While this is by and large the case, the law is able to accommodate differences in the degree of an agent's responsibility that can substantially mitigate or absolve sentencing. The difference between first and second degree murder demonstrates the way these kinds of distinctions are built into the letter of the law. Among the more robust defenses available to an alleged offender is the assertion that the illegal act was committed "involuntarily", that is, without the offender's force of intentional will, or that an agent was acting irrationally and without a sound state of mind. I will explore these two excuses in this order.

Two conditions excuse an illegal act as involuntary: the absence of an act or duress. By the absence of an act, this means simply that one's conscious, willful intentions do not accompany the harmful acts. Cases of bodily reflexes or certain disease-states (e.g., epilepsy or Tourette's syndrome) provide the most common examples of such excusing conditions. While restitution or punishment for damages may follow in the instance that these conditions produce

harm, the legal system recognizes an absence of responsibility which is morally and socially relevant to the interests of this paper. This level of involuntariness, however, does not obtain in the case of drug addiction. Those acting on drug-related desires, regardless of how severe, are all able to express conscious knowledge of the behavior they themselves produced, without recourse to the notion that they had no awareness of what they were doing or why they were doing it. In light of this, this paper makes the modest assumption that the drug-acquiring behavior of an addicted individual is an act worthy of moral and legal analysis, and prompts a more subtle understanding.

From this fundamental assumption, any final recognition of non-responsibility will thus be more of a qualification than a literal description. Generally, in both cases of “involuntary” action, the agent is not considered responsible for their behavior because we deem that it would be unreasonable to have expected them to do otherwise. In the case of compulsion or duress, the situation is that of a “hard choice” between the offensive act and some other course of action seen as overwhelmingly harmful by the agent. The paradigm example given involves a person threatened with bodily harm by a third party if they do not commit an act beneficial for this third party. In this case, the agent will willfully and knowingly perform an action she understands as illegal or wrong, but feels compelled to perform under the narrowed conditions given to her—a “lesser of two evils” choice, however selfishly oriented it may be.

In the case of addiction, this paradigm needs to be adapted around an “inner duress”: a perceived hard choice between the dysphoria of not acting on drug-related desires or cravings, and the costs of perpetuating their use patterns through illegal or harmful means. From the bodily dimensions of chemical addictions previously mentioned, the aspect most relevant here is that drug-oriented cravings, at the very least, produce feelings of frustration, anxiety and tension

comparable to some form of psychological or even physical pain. This feature of addiction could likewise be exaggerated by the presence of active withdrawal symptoms and their associated dysphoric sequelae. The question at stake in the duress excuse is whether this pain is sufficiently threatening to narrow an addicted agent's scope of meaningful choices (i.e., to either engage in unlawful behavior or feel pain), and whether this pain (or the expectation of it) is intense enough to expect that another person in the same conditions could not reasonably be expected to bear it.

This last point bears on an interesting phenomenon common to chemical addictions. While it is difficult for us to quantify exactly how severe the experience of dysphoria is for the embodied addict, researchers have shown that the expectation of dysphoria in periods of withdrawal is disproportionate to the actual feelings reported by the same subjects in withdrawal (Sayette, 2006). Put into another context, we understand that this expectation is just as legally significant as the act itself. In the former example, if the third party coerces a decision under threat of bodily harm, acting on the expectation of the harm is what drives the action, whether or not the third party is willing to inflict such harm (or does so to the extent promised). Even insofar as the research has shown that the addict's expectations are markedly skewed, they may represent a salient moral and legal feature of the "duress" produced by addiction.

More broadly, however, although self-reports from addict's speak to the level of distress cravings cause, this limits non-responsibility for addiction down to the avoidance of such feelings, and does not accommodate the positive choice for pleasure constitutive of appetitive drug use (although it might be admitted that the negative escape from dysphoria and the positive pursuit of pleasure are inextricably entwined). The point is that this line of defense fixates on a narrow feature of addiction, one not representative of the majority of addiction-related decisions, and again one not objectifiable or quantifiable across peoples and contexts. Even as we discuss

how the force this threat (expected or otherwise) might be experienced by the addicted sufferer, we lack the ability to make substantive, legally-forceful judgments about the strength of such desires. Mental health expert and lawyer Stephen Morse relates this fact to the false analogy between strong desires and a bladder: although a bladder will necessarily relieve itself when sufficient pressure is applied to the urethral sphincter (which in effect shows an absence of willful action, as described above), there is no threshold understanding of craving such that a certain discrete amount of desire will overwhelm the brain's self-control mechanisms (Morse, 2006).

Such a mechanistic understanding of the mind plagues the addiction debate, and leads to an untenable model of mental causation that doesn't demonstrate any real distinction between addicts and non-addicts. Even if we hold that there are significant physiological forces underpinning the experience of addictive cravings (a position soundly reinforced by the literature), the same can be said for any decision weighed and generated in the brain, addicted or otherwise. As the research previously provided suggests, the experience of craving is not qualitatively different than that of other strong desires (Foddy and Savulescu, 2006), and some theorists (Loewenstein, 1999) embrace the identification of drug-related desires to other survival-related "visceral" factors (e.g., drives for food, sex, and sleep).⁶ If we take these assessments to be accurate, it would be difficult to excuse drug-related craving as some exceptional form of duress when it presents as a body-state within the range of other healthy, endogenous (albeit strongly motivated) bodily desires. Taken in this way, we cannot maintain a skepticism about our

⁶ While this brings up an interesting discussion of whether a court would convict someone of, say, stealing food while under the duress of hunger, a caveat in the duress defense stipulates that individuals responsible for putting themselves in situations which invite such conditions of duress are still culpable for the crime they commit under duress. This points to a broader notion of autonomy and responsibility which includes avoiding foreseeable consequences. Whether we can levy this same judgment against addicts, who should have been forewarned about the dangers of habitual drug use, is an interesting argument that I leave open. In general, I take the reasoned expectation and management of extreme, transient body-states to be within the purview of a more global assessment of autonomy and responsibility, to be discussed more later.

ability to manage bodily desires without also putting our whole deep-seated experience of embodied freedom and a deterministic understanding of the brain sciences also on trial (a challenge put forth by some authors to the future of the legal system as a whole; see Greene and Cohen, 2004). Without entering into a detailed discussion of this philosophical impasse, it may suffice to say that the duress argument makes claims about the experience of dysphoria in addiction that are not sufficiently verifiable to warrant a call for non-responsibility wholesale. Because the duress model works within threshold concepts and represents a very robust form of legal defense, its use here seems inappropriate.

Although we may appreciate the duress addictive cravings place on addicts, making legally forceful judgments about the strength of one's internal desires at a given moment of weakness ultimately seems dubious. A plea of insanity, however, is likely taken as more plausible, given that it describes a more subtle defect in reasoning that addicts seem to demonstrate, at least with respect to their drugs of addiction and under the pressure of craving. Indeed, with respect to our earlier discussion of craving, it is perhaps the most characteristic feature of addiction that people mobilize poor reasoning in their decision to use substances, rationalizing plans that more often than not lead to regrettable, excessive use or relapse during periods of stated drug-abstinence. Exercise of an insanity defense from a legal standpoint, however, goes far beyond the faulty reasoning that leads to self-sabotage in the ways described. Although the insanity plea has experienced many interesting redefinitions and repeals throughout its career, legal analysts claim that the current definition still hovers around a famous mid-19th Century English court decision (see Matthews, 2004).

In the case cited, an accused murderer, Daniel McNaughton (who killed a man he believed to be the Prime Minister and under threat of delusional persecution), was absolved of

traditional sentencing based the court's unanimous judgment about the defendant's mental instability. This led to the still often cited McNaughton Rule, first articulated by Judge Tindall in the aforementioned case in such a way that reveals the exceptional nature of this decision (Regina v. McNaughton, 1843):

the jurors ought to be told that in all cases every man is presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfaction; and that to establish a defence on the ground of insanity, it must be clearly proved that, at the time of committing the act, the party accused was labouring under a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong.

Under this definition, then, nothing short of severe cognitive disorientation will suffice in obtaining such a defense. Indeed, to know nothing of “the nature and quality of the act” one is engaged in implies an almost complete corruption of cognition, intention, planning, or even minimal self-consciousness. Even certain states that might fall under this (e.g., somnambulism, epilepsy) would likely fall into the more basic register of lacking an “act,” under the definition of involuntariness already described. Likewise, although the second caveat offers a little more room for interpretation, this definition still seems to fall short within the context of chemical addiction. While some might debate that addiction has a corrosive effect on an individual's sense of morality (a topic still to be discussed), the bald fact that addicted users recognize that they need to obtain their drug illegally or discretely (given that they must often hide their addictions from friends, family, and often the law) speaks to the fact that they recognize the potential consequences for their behavior, and thus command a sense of right and wrong sufficient for the legal assumption of sanity.

While some have argued for a more robust and complex notion of human agency that would incorporate other faculties of the mind outside of the cognitive (Matthews, 2004), a long and controversial legal history with the insanity defense has convinced most courts to adhere to a conservative model of the defense that sets a very high threshold for recognizing insanity. For

these reasons, although other aspects of “sanity” remain pertinent to our discussion of autonomy (e.g., reasoning, insight, identification/endorsement of actions), insanity in a legal register does not seem to offer a stable excuse for chemical addictions. Other mitigating strategies do exist for drug offenders – specifically in the form of specialized drug courts⁷ – but I do not believe these strategies make any substantive comment about addicts or addictive experiences directly.

Explorations outside of the legal arena will, however, prove more fruitful in describing on more general terms the subtle claims we commonly make about autonomy. Beginning with the most modest and working up in complexity, we may examine if and how chemical addiction fits or fails these concepts.

EXECUTION AND CONDITIONS OF ALTERABILITY

Very simply, the ability to execute decisions demonstrates that the agent is in a condition of minimal freedom—an obvious but altogether necessary condition for any discussion of autonomy. By minimal freedom, we mean very simply whether the agent lives under circumstances that include and indeed require valid choices; that is, situations in which the agent could have acted otherwise.

While it seems absurd to argue that any embodied person lives outside of these conditions, it could be questioned under this particular aspect of autonomy whether those

⁷ Such programs propose treatment and intensive drug-abstinence monitoring over and against more punitive measures, with a heavier emphasis on rehabilitation as a measure of protecting social welfare and reducing recidivism. A growing body of independent and government-conducted research supports this approach (Marlowe, 2006; Finigan et al., 2006; Rhodes et al., 2006; Finigan et al., 2007). While I do believe this points to a changing perception of the legal status of addictive behaviors, I also believe a more subtle shift in attitude about the severity of drug enforcement laws and penalties is at work here. Importantly, I do not believe this gives addicts a compromised legal status, but more sensitively responds to the nature of the crime in a way that our response to other types of crime (violence, sexual misconduct, etc.) could benefit from. Addicts are not considered less responsible, but the approach is augmented to more effectively prevent relapse and recidivism.

suffering Tourette's Syndrome or epilepsy should be precluded from autonomy for this reason. Certainly, these disorders share a pathological severity that surpasses drug addiction in terms of how directly and irresistibly behavior is corrupted, but it is important to note that it only obviates the charge of autonomy when viewed locally around the moment of dysfunction. From this lens, any healthy bodily reflex may serve as an argument against an agent's autonomy. This is an erroneous charge to place against any general assessment of autonomy, as it creates conditions that eliminate virtually any embodied agent, and becomes the kind of strong and pedantic definition that is not useful for our purposes of understanding basic responsibilities.

Moreover, this leads us towards putting any questionable or restricted conditions for any given choice on trial, and under this depth of scrutiny we are bound to find our lives filled with more or less autonomous conditions. To avoid analyzing autonomy at such unmanageably subtle degrees, it is important to recognize that in matters of autonomy (as we are considering it) the whole is more than the sum of its parts. Coming to terms with autonomy under more global and less local conditions puts us in a position to realize its efficacy as a basic status. Even if someone is put under strong duress to make a particular decision, we may say that the real threat to autonomy only emerges when that person is unable to change conditions which produce such duress.

In terms of addiction, we can imagine an experimental setting in which an individual in recovery from an addiction is placed in a closed room with free access to his her drug of choice, and see whether an express and authentic commitment to sobriety can sustain itself in the wake of overwhelming desires. Even despite the obvious ethical barriers and countless confounding factors that might invalidate any findings this study has to offer an understanding of the addict's autonomy, what is more important is the very nature of the situation. Although it is not

inconceivable for a recovering addict to be in open confrontation with an opportunity to use her drug of choice, such a situation still has much to do with her autonomy in a global sense. Even if we concede that an addict's craving in this case was reasonably irresistibly (that is, most people in the same situation would not have the fortitude to resist that level of duress—a position I've already denied but include here for argument's sake), it does not obviate the addict's responsibility to exercise their autonomy so as to avoid situations in which irresponsible behavior is more likely. As Stephen Morse (2005) describes it:

Agents can be responsible for placing themselves in a non-responsible state, a form of responsibility that we may term diachronous... Although the agent's conduct may seem excusable when the desire is intense and creates a threat of dysphoria or disables the agent's rationality, during those periods when the desire is more quiescent and the agent can think straight, the agent will almost always be aware that periods of non-responsibility will arise. (453-454)

This “diachronous responsibility” evidences the kind of global autonomy we assume of most people. Although chemical addictions bring about compromised and stressful periods of craving, we recall former arguments in the addiction literature which explicitly relate such cravings to other “visceral” experiences like hunger, sexual desire, and the need for sleep. To the extent that such experiences are universally recognized as potentially severe compromises to our autonomy, but are nonetheless readily accounted for in our everyday exercise of autonomy, we have no substantive reasons to isolate drug craving as an exceptional circumstance by virtue of its exoticism. While we may view autonomy as a capacity that variably performs or fails in the local moments of our lives, it is more broadly that which allows us to organize our world such that where and what we find ourselves doing is to some degree a substantive reflection of who we are.

Far from simply excusing the addict because we can appreciate the intensity of her cravings, we understand that, in most cases, open access to illegal drugs is not only a relatively uncommon and preventable circumstance, but also a situation that has been fairly cautioned

against as a road to relapse. Likewise, an epileptic faces similar situations of non-responsibility that have the potential to cause harm not only to themselves but to others under the right conditions (e.g., if the epileptic happens to be driving). What distinguishes moral responsibilities in this case is whether or not the person in question was diagnosed at the time of the seizure, and if so, whether or not said person complied with her prescribed treatment plan, which may include protective headwear (to insure personal safety) and a prohibition against driving (to insure the safety of others).

Awareness of a potentially dangerous affliction, and failure to adhere to a prescribed program of treatment serves to characterize the afflicted as morally negligent to the external consequences of her disorder, and subsequently responsible to the problems she may cause in a way that legitimately points to her autonomy. Although treatment plans for addiction do not always follow the same trajectory or enjoy the recovery rates of many other (particularly physical) disorders, we do not take the prescription as inconsequential. Peter Cohen (2007), a critic in the bioethics literature on addiction, is keen to point out:

[T]he addicted individual must accept and continue appropriate therapy once the illness has been diagnosed. And, as with any disease, if failure to do so harms others, legal action is justified... the possibility that even the best therapy may not succeed should not argue against the proposal that acceptance of diagnosis and treatment is a useful bright line for assigning responsibility. (22)

Having access to some variety of a treatment plan, or at the very least, being aware of situations that are potentially disastrous for one's sobriety are features of the addicted condition for most any addict making an honest attempt at recovery. For that reason, it satisfies conditions of global autonomy that involve making choices that let one continue to enjoy an un-coerced sense of freedom and responsibility. Although the addict may have questionable decision-making abilities and perhaps "irresistible" urges when confronted with craving and temptation (although we have contested this point earlier), we may say that she is able to alter the conditions that

might mitigate the force of such coercive influences. The alternative to this—the conception of an addict who lacks the ability to change environmental or personal factors that guide that individual towards open access to drugs—might prove to be a valid counter to the charge of autonomy, but it is overwhelmingly the case that any free individual can take responsibility for her proximity to drug use.

Even for those whom the sociological conditions of their environment are such that the sale and use of drugs is a consistent feature (and the availability of effective treatments relatively low), health policy analysts have recognized that appeals to the freedoms of agents within that environment remains as an important point of intervention (Dougherty, 1993). Broader political and social forces might ultimately take precedence in certain vulnerable communities, but programs that attract and aid individual addicts continue to receive a great deal of funding and support. These types of efforts evidence a fundamental belief in the ability of individuals to affect changes that will make a substantive difference in their recovery. This presupposes that at least some addicts will be motivated to utilize these resources and discontinue drug use. How addicts generally respond to motivations and reasons to quit, however, might be considerably different from the normal autonomous agent, and may prompt us to consider their autonomy as compromised or absent. An investigation of the way addicts use reasons and reasoning thus follows here.

REASONS AND REASONING

One of the main obstacles in any account of personal autonomy stands in how we are to understand the dynamic between motivations and choices. For our purposes, the main impasse

we face comes in determining if and how certain motives or motivational processes can be subversive to our autonomy. As it is impossible to argue against the bald fact that we and we alone have the capacity to initiate our actions as bodily agents, we must consider the internal arena in which motives are encountered, considered, and acted upon. Without a lengthy discourse as to the external or internal origins of such motivations, what remains important is our ability to govern and express our various desires in a way that gives status to our self-authority—not as a mere formality, but as a legitimate and functioning capacity. The distinction that we mean to make will come through recognizing the process that goes into authorizing our motivations and reasons for acting, and whether such a process has the inherent integrity to be deemed self-government.

One useful way of determining the validity of autonomously-based decision-making is to demonstrate that an agent's choices are responsive to a process of reasoning that involves rational reflection. Having the ability to appreciate a sufficiently wide range of reasons for acting and the consequences a particular course of action will incur insures a state of mindfulness that seems vital to self-authority. To lack a basic ability to evaluate the ways in which the motivations I enact can effectively express my goals creates a significant impediment to being the kind of person I wish to be—perhaps to the extent that it may call into question my very ability to govern and express any sense of “self”.

Ignorance and inefficacy in action, however, do not preclude the designation of autonomy. There are many instances in which we unknowingly commit acts of great significance or come to make decisions on issues we know little about, but we still retain a sense of responsibility for executing a particular choice we sanction.⁸ What is important, again, is the

⁸ This may be contrasted with autonomy as it is appreciated in the bioethics literature. In matters of healthcare, the gap in knowledge between physician and patient is such that a patient's ability to make effectively autonomous

integrity of reasoning employed in making such a decision; not in the sense that our reasoning coincides with normative evaluations of what is practical and beneficial, but that it is not undermined by mental states or conditions which render our judgments corrupt. To this, we may say that what we require is a procedurally sound budgeting of desires, preferences, goals, and expectations that logically agree with one another, and that the agent demonstrate a reflective appreciation for competing reasons, preferences and goals. To observe someone in the depths of addiction supply valid reasons toward continued drug use, but display a relative inability to accept reasons against use, seems to evidence a reasoning process that produces faulty judgments. The issue is not that one makes fallacious judgments (as misguided people must still be considered to have made real choices that they identify with), but that these judgments may in a significant way be immune to a rational deliberation between competing reasons.

Although we have already demonstrated that rates of relapse and addiction do change with rational disincentives like having dependent children and rising drug prices (which points to at least some integrity in the reasoning process), we must still question whether the type of reasoning employed by addicts is sufficiently similar to that of the unaddicted agent. Research on craving shows that it can produce a motivational bias in reflecting on the pros and cons of drug use, and may give the addict different preferences than she would have in normal, “cold” states of non-craving. However, if we take the procedural reasoning employed in this case as sound (given the agent can, in fact, supply a list of reasons for and against use), how exactly are we able to invalidate the agent’s preferences implicated at the moment of judgment? In the absence

decisions relies to a great extent on the physician’s ability to explain the implications of various choices, usually through a process of informed consent. In the context of addiction, such a knowledge gap does not appear for addicts making drug-related decisions, about which we may actually consider them relative experts. In general, we reserve this nuance in the bioethics definition for the specialized healthcare setting it was designed for.

of any conception of what these reasons represent for the self-authorizing agent, i.e., *who* they should or should not be motivational for, such a question will not find grounding.

With this in mind, we defer our attention away from establishing what appropriate reasons or evaluations must look like, as this draws us into making arguably normative claims about which reasons must be the most compelling in any given situation. While we have already committed ourselves to the normative statement that autonomous agents must rationally deliberate over competing motivations and goals, we may suspend an additional debate over what reasons deserve recognition and which do not. Such a claim, I believe, ultimately rests upon the identity of the individual agent, and particular reasons or choices cannot be considered irrational or incompatible with autonomy in abstraction. Indeed, we cannot claim that the decision to use substances, even self-destructively, is an invalid motivation for behavior, as this would eliminate the question of addiction altogether. Under this model, one could freely make such a decision even before establishing a habit of addictive drug use, and we would be forced to question the integrity of her decision-making in the same way as we would the addicted, although we know these two situations intuitively bear important differences.

What might link these two cases, however, is that in both cases the agent may be making an evaluative judgment about drug use that does not agree with her decision to use; i.e., the agent deems such a decision to be, all things considered, worse for them than abstaining, but still follow through with the decision to use. Such cases are described in the philosophical literature as weakness of the will, and the theoretical difficulties behind the possibility of such a choice have garnered many disparate opinions (cf. Davidson, 1970; Mele, 1987 and 1995; Charlton, 1988). I resist engaging in the nuances of this particular argument (if only because many of the authors explicitly reject addiction as an instance of weakness of the will) again by recourse to the

guiding principle of this discussion: namely, that even if an agent does have the capacity for weak-willed action, the mere choice of an inferior course of action doesn't necessarily imply an absent capacity for self-authority, but may in fact reify it (that is, the agent has sufficient autonomy to even go against her own judgments). Exercising one's autonomy in this particular way, however, I concede may be difficult to justify, as it may point to a kind of incoherence that fails to meet standards of minimal rationality accepted as necessary for a basic sense of autonomy needed here. More relevant in this debate is whether such a betrayal of one's own evaluative judgments is a habitual and self-alienating feature of that individual's use of autonomy, and in what ways particular, local evaluations cohere (or fail to cohere) with more stable, self-stated evaluations that better characterize the agent's attitudes. Such attitudes, again, imply an enduring sense of self that is implicated in the motivations and choices endorsed, giving "self-rule" its very grounding.

IDENTIFICATION/ENDORSEMENT AND PLANNING

Because personal autonomy is based on the agent's ability to organize and act upon desires as an individual, our concern is chiefly in determining how motives move through our authorization as a choice we have produced. While determining whether one has or has not made a choice that emanates from their truly "authentic self" (whoever in their history we might identify as such) would be a difficult and perhaps impractical judgment, at least one measure of a healthy autonomy might be the agent's identification with and endorsement of the motives she acts upon. If one cannot identify with her motives to act it may be hard to fairly claim that she was, in fact, the author of them.

For one to expressly identify with every motivation she acts on, however, proves to be somewhat problematic, on the grounds that many of us simply cannot be rigorously honest with ourselves. While we might expect addicts to display excessive or pathological self-deception, numerous studies have shown that all healthy individuals display self-deception and poor self-characterization when confronted with aspects of themselves which threaten their self-esteem (Johnson, Vincent and Ross, 1997). As a matter of degree, we cannot pathologize or condemn addicts for defending their egos in a way most of do to a greater or lesser extent, especially given the shameful stigma surrounding drug addiction and the very rational motivation to downplay one's association with or dependence on psychoactive substances. The point is that we must be suspect of anyone's claims to have accurate self-knowledge about which motives are truly theirs, as there proves to be aspects of our mental health which work to defer threats to our personality by distorting the facts.⁹ Indeed, in debates concerning autonomy, we run into the difficult snafu with endorsement such that if we only include those actions we identify with as expressions of our ideal self, we are bound to deny or cut away those aspects that don't cohere with this image and thus claim less responsibility for them. "I just wasn't myself last night," is a colloquial and common excuse we give and accept from one another, but not in a way that robustly challenges our status as self-ruling agents. Conversely, however, if we take self-identification to be a mere acknowledgment of one's role enacting those questionable behaviors, it's unclear to what extent my powers of self-rule had anything to do with them.

⁹ To this extent, addiction might be more accurately described on existential terms as a project of bad faith. Jean-Paul Sartre (1943) characterizes such projects as the denial of one's own inherent freedom and the responsibilities such freedom entails. In the case of addiction, we see two potential projects of bad faith: the denial of any problematic relationship with or dependency on chemicals, or the flight from responsibility implied by claiming that the "disease" of addiction is what compels the addict to action. I believe such analyses are helpful in this discussion, as they describe the self-deceptive patterns of addicts on terms that Sartre himself claims are "essential to human reality" (87), and thus inherent to all existential agents vulnerable to certain infirmities and weaknesses.

The issue most at stake with drug addiction is whether one's seemingly asymmetrical trade-off of a short-term high at the expense of some long-term stated goal (most often sobriety) sufficiently calls into question her ability to express a sense of self in her actions. Anecdotally, we recognize that most people fall short of their ideals for themselves, which leads us to ask just how costly or how severe our self-disappointment has to be before we recognize a genuine threat to autonomy—this autonomy which by its very human nature seems to motivate us to expect or hope for more than we will really achieve. How many self-made promises to improve one's diet, exercise more, or change occupational or relationship habits go unfulfilled every day? And how do they differ from addiction in ways outside their different social ramifications? While studies have shown that addicts display a disposition towards valuing short-term goals over long-term goals (Levy, 2006) and a somewhat impaired sense of temptation-resistance (Baumeister, 1998), this does not clarify the issue of whether such costly preference-reversals invalidate a sense of autonomy. And although the ability to retain long-term goals in the wake of short-term whims seems relevant as a question of self-government, our status as autonomous agents does not seem to hinge upon it. Sarah Buss (2002), a writer on philosophical issues in autonomy, helps explain the dynamic role planning has within our different exercises of self-government:

Such plans often enable a person to exercise some measure of control over her life as a whole; they are her way of governing her more local exercises of self-government. But a person can govern herself at a particular time even while defying her earlier attempts to place constraints on how she will govern herself at this time. She can take it upon herself to abandon her plans, or to modify them in ways she did not anticipate when she first made them. She can even reject the counsel of her long-term values.

It seems hard to deny that people can and will dynamically engage themselves with their commitments in a way that is not necessarily rigid, and that holding people to some standard which discredits their autonomy for adapting to new situations, desires, and ideas seems generally inappropriate.

Still, certain addiction theorists claim that addicts suffer from an exaggerated form of myopic thinking that demands our attention. Gray Becker and Kevin Murphy (1988) and George Ainslie (1992) have proposed influential economic models of reward-related behavior that sees our current choices to be a rational budgeting of short- and long-term rewards, in which rewards closer to us in time are valued more heavily than rewards expected at a longer delay. Even if there is a considerable disparity in the amount of each reward, smaller rewards (as they have soundly demonstrated with empirical research and mathematical modeling) will tend to dominate agent preferences over larger rewards as a function of temporal proximity. An intuitive example of this phenomenon can be appreciated if hypothetically one were to offer you \$100 today, or \$150 a year from today. Although most people will tend to take the \$100 today, if the same offer is made, but instead the \$100 is offered five years from today, and the \$150 six years, people tend to budget differently, and take the larger sum, in spite of the fact that the same temporal gap (1 year) separates the two. Moreover, such delayed rewards are discounted at a characteristic rate, defined in large part by individual temperament—addicts exhibiting much heavier rates of discounting. Thus, in terms of addiction, craving can be modeled as the acute perception of the imminence of drug-related reward, which eclipse long-term goals and plans (sobriety, relationships, occupation) in a predictable, time-dependent way.

An important limitation of this research, however, concerns what relationship we perceive between such rates of discounting and addiction (does the latter explain the former, or vice versa?¹⁰), and what we make of this preference at all. If we maintain our commitment to

¹⁰ It is interesting to note how questions of causal priority emerge with other questionable aspects of addictive behavior, particularly criminal behavior. Consider that in the Final Report of the Joint Committee of the American Bar Association and the American Medical Association on Narcotic Drugs (in a review of studies tracking the behavior of drug addicts in Chicago and New York City), they conclude that "it is inescapable that delinquency both preceded and followed addiction... there was little evidence of a consistent sequence from drug use without delinquency to drug use with delinquency" (Lawson, 2007). Such findings call into question the popular notion that

withhold normative judgments about reasons and motivations, what is to say that one person's preference for the future is inherently more reasonable than a preference for the present? In fact, the inclusion of most healthy people under this economic model of discounting future rewards seems to argue that, in general, rational agents seem to bias the present more than the future. As Ainslie describes it, our proximity to an expected reward can cause a preference-reversal in which previous evaluative judgments about goods change. Moreover, such changes cannot be strictly considered irrational or an instance of a weak will, but that these instances have the legitimate force of a rational reevaluation of present and future goods that favor present goods.

And indeed, such reevaluations need not be inconsistent or mutually exclusive with long-term goals. As Michael Bratman has argued (1999), an agent need not experience any rational pressure to see her current behavior as dictating any way of acting in the future. Thus, for our purposes of identifying minimal rationality in autonomous decision-making, we must concede that it is at least somewhat reasonable for an addict to view current drug use as consistent with a future desire to quit. From what we have said about craving so far, it seems clear that addicts utilize such reasoning in their local judgments about drug use. Addiction and unhealthy patterns of behavior occur only because we fail to act on personal insights which would counsel us on the limits of our rationality and how our judgments tend to change characteristically over time. Were we to know how we would act in the wake of an imminent desire, and more importantly, how we would feel about acting on such desires at a later time, we would take steps to prevent such a reversal from taking place so easily.

But, as I have argued across this paper, in issues of addiction we *should* be aware of such changes across time, and plan accordingly. Although I consider such changes to be minimally

addiction causes moral degradation and corruption in what were otherwise innocent people. At the very least, it would be more appropriate to say that addiction exaggerates these tendencies, rather than causing them wholesale.

autonomous in their reasoning and execution, if we appeal to a more robust notion of autonomy that sees such preference-reversals as inconsistent with other, more “authentic” stated attitudes, addicts are still in a position to change the nature of these temptations and make relapse less likely. Among the other techniques that might be helpful for such an enterprise, many writers in the medical ethics literature propose some model of a “Ulysses contract” that would pre-commit an mentally-compromised agent to certain decisions by adding costs to any deviance from them.¹¹ For example, an recovering addict leaving a rehabilitation center could financially hold a sum of money in escrow to be deprived of the agent in the instance of any relapse (verified by urinalysis), or similarly keep a letter written by the addict with a third-party, to be sent out to employers or close contacts admitting drug use if a relapse is confirmed.

Such contracts do not literally force the addict to adhere under threat of force, but operate as an appeal to the addict’s (admittedly hampered) sense of rational deliberation; the only reason such contracts work is because they provide rational disincentives that the addict can appreciate, which shows clear regard for her capacities as an autonomous agent. Although some controversy surrounds the use of such advance-directive type agreements in other areas of mental illness or neurodegenerative diseases, their use in cases of drug addiction has received support (Andreaou, 2008). Specifically, such contracts can be viewed as an extension of the addict’s autonomy, in that the agent is able to express her stable preferences and support such preferences diachronously over time by shaping (not dictating) future situations in a way she herself endorses. Any threat of paternalism in this case is mitigated by deference to the addict’s own explicit and self-written guidelines, representing considered and thoughtful judgments, only modest use of disincentives, and only carried out by others as reflection of their respect for her

¹¹ The name derives from the well-known account of Ulysses encounter with the Sirens, where Ulysses prepared for his potential seduction by having his crew tie him to the mast before their approach. See Puran (2005) for a good discussion of the ideal dynamics and potential ethical dangers of such an arrangement.

autonomously designed plans. While we should be wary of the adoption of Ulysses contracts as a policy for addicts attempting treatment (even devoid of specific content, such a policy would still be coercive in nature), such contracts generally provide a viable and legitimate prophylactic against undesirable behavior consistent with a respect for an addict's autonomy. Moreover, such contracts provide an opportunity for social coordination and support between the addicted individual and different actors in her life of recovery, which could only provide a potential benefit in treatment. At the broadest level, we may understand

In review, then, there are manifold challenges that beset using an agent's endorsement as a condition of autonomy, most of them stemming from the inherent self-deception and bias for immediate goods economists and mental health experts have identified in most healthy people. How people dynamically engage with their present moment and accept or reject the counsel of their long-term plans seems to be a constitutive feature of autonomy, and not one we can easily problematize for the addict alone. Although addicts often demonstrate a severe inconsistency in their stated preferences at different times, we must accept their minimally rational decision-making process as sufficient for a basic sense of autonomy. Such inconsistencies are, however, open to change by an addict's own potential use of Ulysses contracts or other pre-commitment strategies, which could potentially strengthen the addict's autonomy by working to shape future situations that support a stated preference for sobriety. The addict's command of basic and potentially more robust forms of autonomy through judicious and informed planning allow us to appreciate her accountability and open up new lines of responsibility in treatment. All the same, we may still worry that what addicts lack is a basic stability in preferences required for any recognition of authentic values that could operate as a base for such planning. A discussion of the role of values in exercising one's autonomy thus follows here.

VALUES

If we reach beyond the scope of specific short- and long-term goals that we allow people to set, betray, and reorient at their will, we may say that what brings coherence to these various shifts is an overarching relationship to stable values. As noted autonomy theorist Harry Frankfurt (1971) describes it, in an internal world of immediate impulses and motivations (first-order desires), we organize ourselves into patterns of behavior by relating to a higher order of beliefs (second-order desires) that determine what motivations are desirable to act upon. Whatever designation you give them (values, higher-order desires, personal convictions), we must consider that most people hold a set of stable beliefs that generally guide their behavior. Much less than the demand that we identify with every motive to act, we may say that we do endorse and identify certain values that define and give shape to our status as holistic agents. To lack this fundamental base for acting or reflecting on what actions best represent who we are might be thought of as a state of severe self-alienation, which could threaten our ability to organize ourselves in a way that reflects basic autonomy.

To this end, there have been some that have argued that the autonomy of addicted individuals is compromised because they are only exhibiting “minimally stable values” (Charland, 2002); that is, to the extent that addicts make free choices, they cannot sustain the strong base of values which allows our agency to work itself out on a level we have exclusively deemed autonomous. Where we must make our distinction, however, is how we define our relationship to our values, as it has been alternatively argued that acting on strong desires which contradict our values does not eliminate them: “Even if an addict is self-deceived about her motivation for taking the drugs, she may still have insight into her own values. It's certainly a

mistake to conflate a person's overriding desires with her values.” (Perring, 2002, 50-51) The cash value of our core beliefs rests in their ability to generally organize and coordinate our desires to fit into a broader definition of self, and that it is this holistic self that is constitutive of autonomy.

Tracking the development of this self, determining what qualities are vital to its maintenance, what patterns of behavior might evidence its absence, however, becomes so abstract so as to be an impractical domain for judgment. To say whether or not an addict or any person is sustaining her values and acting against them, or simply losing her values altogether, either claim is inherently variable and in a deeply troubling way unfalsifiable (Freckleton, 2002). Moreover, the ability to change our values, adapt to new spiritual and moral outlooks, might be a more fundamental quality of autonomy than the ability to merely retain a certain stability. Indeed, we may wonder just how much dissonance an addict really has with their lifestyle; while much of this discussion seems to trade on the idea that the addict’s behavior is not in line with her values, it is not inconceivable that an agent develops a pattern of habitual drug use that does not conflict with her other goals, duties, or self-concept.

We can accept such cases as the exception and not the rule, however, and simply ask what relevance such values have to determining a basic sense of moral and political autonomy. For our purposes, it doesn’t seem clear that we would use such values as a prerequisite to our respect for another’s choices and the expectation of accountability. For a non-normative conception of autonomy, we do not pass judgment on what values people have or lack, but only that they enjoy some integrity in their decision-making process and have some say in how they shape their world. From this position, even “minimally stable values” would suffice to let an addict develop attitudes, ideas, and beliefs we can appreciate. Moreover, it is hard to ascribe to

the drug addiction process itself some destabilization of values that works beyond the discrete episode of craving that promotes a temporary preference-reversal and different evaluative judgments of goods. The experiences addicts endure may be traumatic or disorienting, but we do not therefore think they have lost their ability to maintain a minimal conception of what they value. All the same, whatever trials and vacillations one experiences in defining and developing her beliefs, we cannot develop strong guidelines for assessing what changes are so dramatic so as to be deemed disordered—much less say that those with trifling values are unable to govern themselves. Addicts, like most people, will undergo a lifetime of different ideas, social patterns, and personal transformations that will variably inform and change what beliefs they live by. Such matters are deeply personal and unique, and for that reason inappropriate content by which we can judge or dismiss their status as a self-authorizing agent.

IV. CONCLUSION

It seems, then, that in full review basic moral and political autonomy is something very different than the more idealized versions that are commonly considered. While discussions of personal values, identification, and reasoning inform our assessment of autonomy, their abstract and often ill-defined character leave much room for valid exceptions, and less room for identifying real threats to autonomy in its basic sense. Although an addict's hold on any of these qualities may be precarious at best, she still retains an ability to make valid evaluative judgments that reflect a minimal rational reasoning process. Moreover, we realize that the global and diachronous nature of their autonomy allows addicts to prepare for foreseeable changes in judgment and plan accordingly. I have argued that as such globally responsible planning agents, addicts have the duty to appreciate the influence drug craving will have on them, and either change aspects of their environment or consider pre-commitment strategies that could bolster their resolve.

In general, however, the addict represents the familiar failures and vicissitudes that a basic sense of autonomy can accommodate. Those who give in to unhealthy short-term pleasures or discount the value of future rewards, those who make misguided or ill-informed decisions, the self-deceived person who does not accept certain aspects of themselves, and those with fluctuating values and goals all represent familiar dimensions in life that admittedly fall short of the kind of ideal autonomy we strive for, but do not invalidate one's integrity as autonomous agents wholesale. Likewise, even if we consider addicts as those who consistently display these problematic characteristics (often concurrently), we cannot discount their role as agents who produce choices worthy of moral and legal evaluation. Although we may concede that drug addiction can toxify the motivational centers of the brain in a way that tends to be more

potent than other rewards, we must assume that the experience of drug-oriented desires is inherently comparable to any other strong desire. It is for that reason that addiction is somewhat unexceptional as a physiological condition, and should be accommodated as any other compelling “visceral” experience like hunger or the need for sleep that embodied agents are responsible to plan their lives around.

Finally, a critically review of the historical and social pressures that surround the disease status of addiction exposes how our treatment of this complex issue can be obscured by certain motivations to excuse, institutionalize and rectify deviant behavior. The medicalization of addiction, while bringing certain moral and practical benefits in treating addicts humanely and driving forward research, has the potential to corrupt our understanding of addiction-related behavior in a way that closes off therapeutic appeals to responsibility and self-efficacy in recovery. In the wake of new neuroimaging technologies that continue to make powerfully influential claims about chemical addictions, it is more important now than ever to retain a strong but nuanced belief in an addict’s autonomy, and to remain critical of any attempt to essentialize addiction as strictly a problem of the body and medical treatment. While such findings bring potentially useful insight into this issue, they threaten to close off other lines of insight, and thereby vitiate the therapeutic project.

It is only by closing the vast but artificial gap we assume stands between the addicted and the non-addicted that we get a better sense of the struggles people face in addiction, and the resources we can bring to this problem. As I have tried to argue, addicts make decisions and face weaknesses and failures in much the same way that the non-addicted do: weighing short- and long-term goods, rationalizing indulgent behavior, self-deceiving, and vacillating in commitments. But these instances, whether they arrive from addiction or elsewhere, do not fully

divorce us from a sense of autonomy. As one bioethicist elegantly puts it: “We are not so different from one another. Addiction thus becomes a poignant, even tragic, metaphor for the general human condition—as well as being a more severe instantiation of the same.” (Madeume, 2007, 27)

The addicted condition is not to be dismissed. It has been the purpose of this paper to clarify some of the confounding and outright misleading conceptions that surround this issue in the hope that a better understanding promotes better care and treatment of those afflicted. Addicts have been the popular target for myths, misconceptions, and hostility perhaps for as long as we have understood drugs of abuse, and the disparities between competing definitions of this condition leave addicts in a difficult world to recover in. Now, as potentially paternalistic interventions emerge from the research on the psychopharmacology of opiate maintenance (Bonnie, Chen, and O’Brien, 2008), it is more important than ever to affirm the integrity and status of addicts as autonomous agents that demand the rights, respects, and responsibilities that others possess as basic moral and political agents. Although I have shown consistent appreciation for the empirical differences that demarcate the addicted condition in its different difficulties and compromises, nothing in the addiction literature provides solid justification for denying their status as autonomous agents. Moreover, the alternative – considering addicts less than autonomous – threatens to give an understanding which runs counter to therapeutic efficacy by removing useful lines of responsibility we can appeal to in designing treatment plans. The next step, utilizing this insight, comes through reorienting our social duties—both for those who offer help and those who need it.

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- Assisting patient movement throughout the hospital
- Cleaned rooms, changed bed linens and restocked nurse-staff supply

08/08-01/09 **Global Medical Brigades** State College, PA and Tegucigalpa, Honduras

International Medical Relief Volunteer

- Provided ambulatory medical relief to rural and underserved populations
- Interacted with Spanish-speaking patients, dispensed and explained prescriptions
- Coordinated mass donations of medical supplies directly from pharmaceutical companies
- Fundraised through group efforts and individual solicitations

01/08-10/08 **Central Pennsylvania Institute of Science and Technology** Pleasant Gap, PA

PA Literacy Corps Tutor

- Helped tutor a diverse group of high-school, mentally disabled, and ESL students (Ages 18-55)
- Preparation for SAT, life-skills training, and English language and grammar
- Experience with both one-on-one and group sessions, with and without lesson plans

PROSPECTIVE PROJECTS AND ACADEMIC GOALS

06/10-07/10 **A Broader View Volunteering** Ladyville, Belize

International Volunteer

- Working as active staff and educator at a local orphanage
- Providing care and tutoring to abused or neglected children, ages 1-6 years
- Working with other staff and volunteers to create or sustain long-term education programs

08/10-05/14 **New York University School of Medicine** Manhattan, NY

M.D. Candidate, Class of 2014

- Primary clinical rotations in Bellevue, Tisch and Langone Medical Center
- Preparation and completion of USMLE Phase I and II before applying to residencies
- Prospective interest in Internal Medicine, Primary Care, Neurology, and Psychiatry

INTERESTS/HOBBIES:

Reading (Philosophy and Classic Literature), Writing, Travel (experience across the United States , Canada, Europe, Australia, New Zealand, the Caribbean and the Middle East), Running, Weightlifting, Hiking, Camping, Music, Snowboarding