

# Addiction and Criminal Responsibility\*

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For more than a decade courts have debated the scope of the addict's criminal responsibility; today the issue remains unsettled. These debates were triggered by the Supreme Court's decision in *Robinson v. California*,<sup>1</sup> which recognized that narcotic addiction is a "disease," and held that criminal punishment of a person thus "afflicted" violates the Eighth Amendment's prohibition of cruel and unusual punishment.<sup>2</sup> Subsequent cases discussed the possible conflicting interpretations of *Robinson*.<sup>3</sup> All agreed that *Robinson* held, at the very least, that the Constitution precludes criminal punishment of the addict simply for a condition of body and mind manifesting a "bare desire"<sup>4</sup> or "mere propensity"<sup>5</sup> to use the drug. It is over the tendencies to go beyond this "minimalist" interpretation of *Robinson*, however, that controversy flourishes. While the major trend in the courts has been to interpret *Robinson* in the minimalist way,<sup>6</sup> some courts have argued for

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The present article is part of a comprehensive study in collaboration with Ann Fingarette Hasse, currently in progress; it covers all types of mental impairments that may affect criminal responsibility. See H. FINGARETTE, *THE MEANING OF CRIMINAL INSANITY* (1972); Fingarette, *The Diminished Mental Capacity Defence in [English] Criminal Law*, 37 *MOD. L. REV.* 264 (1974); Fingarette, *The Perils of Powell: In Search of a Factual Foundation for the "Disease Concept of Alcoholism,"* 83 *HARV. L. REV.* 793 (1970).

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1. 370 U.S. 660 (1962).
2. *Id.* at 666-67.
3. *Powell v. Texas*, 392 U.S. 514 (1968); *People v. Zapata*, 220 Cal. App. 2d 903, 34 Cal. Rptr. 171 (1963), *appeal dismissed for lack of juris.*, 377 U.S. 406 (1964); *State v. Margo*, 40 N.J. 188, 191 A.2d 43 (1963).
4. 370 U.S. at 679 (Harlan, J., concurring).
5. *Powell v. Texas*, 392 U.S. 514, 543 (1968) (Black, J., concurring).
6. *United States v. Rundle*, 429 F.2d 1316 (3d Cir. 1970) (per curiam) (conviction for unlawful use of drugs is not punishment for addiction); *Bailey v. United States*, 386 F.2d 1 (5th Cir. 1967) (no error in refusal to charge that addiction is disease creating compulsion under which defendant is not criminally responsible); *United States ex rel. Swanson v. Reincke*, 344 F.2d 260 (2d Cir.), *cert. denied*, 382 U.S. 869 (1965) (statute prohibiting self-administration of narcotic drugs held constitutional); *People v. Zapata*, 220 Cal. App. 2d 903, 34 Cal. Rptr. 171 (1963), *appeal dismissed for lack of juris.*, 377 U.S. 406 (1964) (imprisonment for possession of heroin for personal use not cruel and unusual punishment); *Nutter v. State*, 8 Md. App. 635, 262 A.2d 80 (1970) (addicts may be criminals because responsible for acts such as possession and control of a narcotic drug which are crimes even though they stem from the addiction); *People v. Borrero*, 19 N.Y.2d 332, 227 N.E.2d 18, 280 N.Y.S.2d 109 (1967) (penal sanction applied to addicts who committed crimes solely to procure money to purchase drugs not cruel and unusual punishment); *State v. Margo*, 40 N.J. 188, 191 A.2d 43 (1963) (punishment for being "under the influence" of

extension of exculpation<sup>7</sup> to crimes related to addiction.

Arguments of this type appear in recent decisions in the District of Columbia, and in a number of powerfully argued dissents in cases decided by narrow majorities.<sup>8</sup> They claim either that the addict's use of the drug and some or all related offenses are inseparable from the addict's nonpunishable status or "disease,"<sup>9</sup> or that they are involuntary effects or symptoms of that status.<sup>10</sup> On the basis of such arguments some have urged that the *Robinson* immunity should be extended beyond the minimalist interpretation to include the addict's nontrafficking use, possession and purchase of his drug; others would go farther and include offenses motivated by addiction, such as theft.<sup>11</sup>

narcotic, as distinguished from act of using drug, not cruel and unusual punishment); *Rengel v. State*, 444 S.W.2d 924 (Tex. Crim. App. 1969) (no error to refuse to instruct jury to render verdict of not guilty of possession of narcotics merely because appellant was admitted and known addict). See *Powell v. Texas*, 392 U.S. 514 (1968); *United States v. Moore*, 486 F.2d 1139 (D.C. Cir.), *cert. denied*, 414 U.S. 980 (1973).

7. The term is used here to mean immunity from criminal liability either on the ground that *mens rea* is absent or on the ground that addiction functions as a defense. Whether exculpation takes the former or the latter form is undoubtedly significant both in terms of litigation strategy and in terms of the consequences of a finding of "not guilty." See Goldstein & Katz, *Abolish The "Insanity Defense"—Why Not?*, 72 YALE L.J. 853 (1963). Such discussion, however, is beyond the scope of this article.

8. *Powell v. Texas*, 392 U.S. 514, 554 (1968) (Fortas, J., dissenting); *United States v. Moore*, 486 F.2d 1139, 1236 (D.C. Cir.), *cert. denied*, 414 U.S. 980 (1973) (vacation of sentences, but not exculpation, for narcotics addict convicted under federal statute for possession of narcotics) (Wright, J., dissenting); *United States v. Carter*, 436 F.2d 200 (D.C. Cir. 1970) (conviction upheld where substantial testimony that defendant's alleged mental illness and narcotic addiction not causally connected with commission of robbery and assault) (Bazelon, C.J., concurring); *Watson v. United States*, 439 F.2d 442 (D.C. Cir. 1970) (insanity plea issue properly submitted to jury where plea made by narcotics addict); *Easter v. District of Columbia*, 361 F.2d 50 (D.C. Cir. 1966) (chronic alcoholism resulting in public intoxication not a crime; holding severely limited by *Powell v. Texas*, *supra*); *Driver v. Hinnant*, 356 F.2d 761 (4th Cir. 1966) (statute punishing public drunkenness could not be applied to chronic alcoholic; holding severely limited by *Powell v. Texas*, *supra*); *Hutcherson v. United States*, 345 F.2d 964, 971 (D.C. Cir.), *cert. denied*, 382 U.S. 894 (1965) (ten-year sentence for heroin addict convicted of narcotics trafficking not cruel and unusual punishment) (Bazelon, C.J., concurring in part and dissenting in part); *Lloyd v. United States*, 343 F.2d 242, 243 (D.C. Cir.), *cert. denied*, 381 U.S. 952 (1964) (denial of petition for rehearing for addict convicted for sale of narcotics) (Bazelon, C.J., dissenting); *United States v. Lindsey*, 324 F. Supp. 55, 59-60 (D.D.C. 1971) (defendant unable to show inability to abstain from narcotic drugs which would eliminate *mens rea* for nontrafficking possession of narcotic drug); *United States v. Ashton*, 317 F. Supp. 860 (D.D.C. 1970) (no liability for addict's nontrafficking possession of drugs); *People v. Malloy*, 58 Misc. 2d 538, 296 N.Y.S.2d 259 (Crim. Ct. 1968) (cruel and unusual punishment to charge certified addict with felony of escape when he is voluntarily incarcerated under valid civil commitment order for treatment).

9. See *Watson v. United States*, 439 F.2d 442, 475 (D.C. Cir. 1970) (McGowan, J.).

10. See *Powell v. Texas*, 392 U.S. 514, 567 (1965) (Fortas, J., dissenting); *Easter v. District of Columbia*, 361 F.2d 50 (D.C. Cir. 1966) (holding severely limited by *Powell v. Texas*, *supra*); *Driver v. Hinnant*, 356 F.2d 761, 764-65 (4th Cir. 1966) (holding severely limited by *Powell v. Texas*, *supra*).

11. Most of the debate has focused on nontrafficking use, purchase and possession. At one end of the spectrum a state court held that *Robinson v. California*, 370 U.S. 660 (1962), did not even cover an addict's "being under the influence" of the drug. *State v. Margo*, 40 N.J. 188, 191 A.2d 431 (1963). At the other end, Judge Bazelon has argued for immunity on the broadest grounds. *United States v. Carter*, 436 F.2d 200, 202 (D.C. Cir. 1970) (Bazelon, C.J., concurring). For a direct expression of disagreement among those

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In *Powell v. Texas*,<sup>12</sup> decided six years after *Robinson*, the Court again addressed these issues in four separate opinions. Four dissenting Justices argued that *Robinson* and common law principles rendered an alcoholic immune from criminal punishment for public drunkenness by virtue of his addiction.<sup>13</sup> Four Justices in the majority rejected this reasoning in affirming the appellant's conviction.<sup>14</sup> The fifth, Justice White, in his concurring opinion, seemed to support immunity from criminal punishment for the chronic alcoholic's drinking or being drunk, but he found that the factual record in the case could not support exculpation based on that principle.<sup>15</sup> In 1970 the Circuit Court of Appeals for the District of Columbia seemed close to a consensus that would clear up this confusion. In *Watson v. United States*<sup>16</sup> that court announced that a nontrafficking addict presenting a better factual record than appeared in the case before it ought to be able to invoke *Robinson* to win immunity from punishment for possession. But when the issue arose again in 1973 the same court rejected, in a five-to-four

who would extend the scope of *Robinson v. California*, *supra*, compare *United States v. Moore*, 486 F.2d 1139, 1260 (D.C. Cir. 1973) (Bazelon, C.J., concurring in part and dissenting in part), with 486 F.2d at 1236 (Wright, J., dissenting).

The extensive case law debates over *Robinson* are paralleled by extensive discussion in journal literature. Amsterdam, *Federal Constitutional Restrictions on the Punishment of Crimes of Status, Crimes of General Obnoxiousness, Crimes of Displeasing Police Officers, and the Like*, 3 CRIM. L. BULL. 205 (1967); Cuomo, *Mens Rea and Status Criminality*, 40 S. CAL. L. REV. 463 (1967); Dubin, *Mens Rea Reconsidered: A Plea for a Due Process Concept of Criminal Responsibility*, 18 STAN. L. REV. 322 (1966); McKevitt, *The "Untouchable" Acts of Addiction*, 55 A.B.A.J. 454 (1969); McMorris, *Can We Punish For the Acts of Addiction?*, 54 A.B.A.J. 1081 (1968); Note, *Criminal Law: Demise of "Status"—"Act" Distinction in Symptomatic Crimes of Narcotic Addiction*, 1970 DUKE L.J. 1053; Note, *The Cruel and Unusual Punishment Clause and the Substantive Criminal Law*, 79 HARV. L. REV. 635 (1966); Note, *Punishment of Narcotics Addicts for Possession: A Cruel But Usual Punishment*, 56 IOWA L. REV. 578 (1971). Legal commentators generally approve extension beyond the minimalist reading of *Robinson* to provide immunity from criminal punishment at least for the addict's nontrafficking use, possession, and purchase of the drug.

12. 392 U.S. 514 (1968).

13. *Id.* at 584 (Fortas, J., dissenting, joined by Douglas, Brennan, & Stewart, JJ.).

14. *Id.* at 514 (Marshall, J., joined by Warren, C.J., and Black & Harlan, JJ.).

15. *Id.* at 552-54 (White, J., concurring).

See *In re Foss*, 10 Cal. 3d 910, 519 P.2d 1073, 112 Cal. Rptr. 649 (1974) (cruel and unusual punishment to prohibit consideration of parole for a minimum period of ten years where addict convicted of furnishing heroin had a record of a prior heroin possession conviction). The court noted that, although statutes providing for increased penalties for habitual offenders are generally justified, in the case of the addict one must take into account the fact that the repetition of drug offenses may be "attributable solely to a psychological and/or physiological compulsion arising from an addiction." *Id.* at 916, 519 P.2d at 1079, 112 Cal. Rptr. at 656. The court notes that the penalty it strikes down falls somewhere between sanctions for status prohibited under *Robinson*, and the sanctions for overt acts that result from addiction, permissible under *Powell v. Texas*, 392 U.S. 514 (1968). *Foss*, apparently, can be punished for his second offense, since it was an "overt act," but not for the fact that it is a second offense, since that was a result of a "compulsion" due to nonpunishable addict status! The distinctions generated by *Robinson* and *Powell* are thus so strained as to substitute metaphysics for matter in order to reach exculpatory ends.

16. 439 F.2d 442, 452-53 (D.C. Cir. 1970).

vote, immunity for possession by an addict.<sup>17</sup> Some of those opposing exculpation for the addict, however, rested their arguments more on the current state of legislation than on a square and self-sufficient rejection of the legal reasoning and factual assumptions of those favoring exculpation.<sup>18</sup>

The present study seeks to dispel the confusion that arises in the case law. The discussion begins with an analysis of the typical exculpatory arguments that are based on *Robinson*. It will be seen that, insofar as these arguments attempt to extend the immunity of the addict beyond the minimalist interpretation of *Robinson*, they ultimately rely on the assumption that behavior motivated by addiction is involuntary. The discussion then reviews the factual background of addiction<sup>19</sup> as it relates to the legal concept of involuntariness. It demonstrates that the assumption of involuntariness is plainly unsound. Finally, this study explores nonlegal theories of drug addiction in an attempt to show that these cannot function as exculpatory vehicles in the criminal law. All the exculpatory arguments, whether they originate within or without the legal arena, lead to oversimplified "solutions" to complex and ill-understood problems, thus injudiciously preempting the legislature's role. Though they are intended to be humane, they actually reflect a less humane, less realistic, and less helpful attitude toward the addict himself than would their rejection.

## I. The Legal Arguments

The principal lines of constitutional and common law argument designed to preclude criminal liability where addiction is at issue are often interwoven in the leading opinions. For clarity of analysis, however, the following sections of this article will distinguish them carefully and examine them successively. They resolve into three distin-

17. *United States v. Moore*, 486 F.2d 1139 (D.C. Cir.), *cert. denied*, 414 U.S. 980 (1973).

18. *Id.* at 1159 (Leventhal, J., concurring, joined by McGowan, J.).

19. Unless otherwise indicated, I will be discussing narcotic addiction as an example of the most acute addiction problem from the standpoint of the power of the craving and the consequent intensity and persistence of the quest to obtain and use the drug. For a discussion with similar conclusions in relation to alcohol, see Fingarette, *The Perils of Powell: In Search of A Factual Foundation for the "Disease Concept of Alcoholism,"* 83 HARV. L. REV. 793 (1970). I shall only occasionally comment specifically on other forms of addiction (e.g., those involving barbiturates, amphetamines, tobacco, and tranquilizers), although I maintain that, so far as the criminal law is concerned, the principal theses of this article and of the 1970 article, *id.*, apply to all forms of conduct generally collected under the rubric "addiction." For concise and authoritative standard descriptions of the various types of addictions, see Eddy, Halbach, Isbell & Scevers, *Drug Dependence: Its Significance and Characteristics*, 32 BULL. WORLD HEALTH ORG. 721 (1965); DeLong, *The Drugs and Their Effects*, in DEALING WITH DRUG ABUSE: A REPORT TO THE FORD FOUNDATION 62 (Staff Paper No. 1) (1972) [hereinafter cited as DEALING].

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guishable lines of argument here labelled, for the sake of convenience, the "status argument," the "disease argument," and the "involuntariness argument."

### A. *The Status Argument: A Minimalist Reading of Robinson v. California*

The issue of "status" is central in *Robinson*. Referring to the statute under which the defendant had been found guilty, the majority wrote:

This statute, therefore, is not one which punishes a person for the use of narcotics, for their purchase, sale or possession, or for anti-social or disorderly behavior resulting from their administration. . . . Rather, we deal with a statute that makes the 'status' of narcotic addiction a criminal offense . . . .<sup>20</sup>

The Court found that the statute violated the Eighth and Fourteenth Amendments: "We hold that a state law which imprisons a person *thus afflicted* as a criminal, even though he has *never touched* any narcotic drug within the State or been guilty of any irregular *behavior* there, inflicts a cruel and unusual punishment in violation of the Fourteenth Amendment."<sup>21</sup> In arriving at this holding the Court analogized punishment for the status of narcotic addiction to punishment for affliction with a disease.<sup>22</sup> The analogy suggests that the term "disease" carries an exculpatory force independent of that of "status"; alternatively, it suggests that disease is a species of status and is nonculpable simply because it can be so classified. This section of the discussion adopts the latter view; the former is discussed elsewhere.<sup>23</sup>

What, then, is the scope of exculpation for the status of addiction in *Robinson*? Certainly the case cannot be read to do away with all crimes of status. These have a long history in the common law and in statutory law; they have not been fundamentally challenged by the Court.<sup>24</sup> It

20. 370 U.S. 660, 666 (1972). The trial judge made a similar distinction in instructing the jury: He noted that addiction, which the statute made a criminal offense, was a "condition" or "status" while the "use" of the narcotic was an "act." Unlike the act of using a narcotic, said the judge, the status of being an addict is a "chronic" offense that "continue[s] after it is complete." *Id.* at 662.

21. *Id.* at 667.

22. *Id.* at 666-67.

23. See pp. 419-25 *infra*.

24. See generally Amsterdam, *supra* note 11; Cuomo, *supra* note 11; Lacey, *Vagrancy and Other Crimes of Personal Condition*, 66 HARV. L. REV. 1203 (1953).

Vagrancy, for example, is often characterized as a crime of status. Although a number of vagrancy statutes have been struck down for vagueness in defining the status, nowhere has the claim been accepted that vagrancy is immune simply because it is a status. See *Papachristou v. City of Jacksonville*, 405 U.S. 156 (1972); *Edelman v. California*, 344 U.S. 357 (1953).

is implausible to read *Robinson* to announce a new constitutional doctrine declaring crimes of status generally to be outside the scope of the criminal law.<sup>25</sup> The text and context of *Robinson* carry no such implication, nor has any court proposed such a reading of the case. It is therefore more accurate to read the case to bar punishment for status only insofar as, and just for the reason that, the status excludes any act at all. Indeed, a criminal offense, even though it may not itself be conduct, must generally be defined with some essential reference to conduct.<sup>26</sup> In *Robinson* the majority emphasizes the absence from the statute at issue of any requirement to prove that there was any drug use, purchase, possession, or sale, or any antisocial or disorderly behavior resulting from drug use.<sup>27</sup> In *Powell v. Texas* Justice Marshall reads *Robinson* to stand for the proposition that punishment may not be inflicted in the absence of proof of any *actus reus*.<sup>28</sup> Many lower courts have focused on the distinction between status and act in making this, the minimalist argument.<sup>29</sup>

Does this concept of pure status as distinct from acts make sense in

25. Amsterdam's exhaustive 1967 survey notes that the questions as to how to construe *Robinson* with regard to status crimes have not even yet been structured. Amsterdam, *supra* note 11, at 240.

26. *Powell v. Texas*, 392 U.S. 514, 543 (1973) (Black, J., concurring). Justice Black notes that this requirement applies even for "offenses most heavily based on propensity, such as attempt, conspiracy, and recidivist crimes." See G. WILLIAMS, CRIMINAL LAW: THE GENERAL PART 1 (1961). In *Papachristou v. City of Jacksonville*, 405 U.S. 156, 170 (1972), Justice Douglas's majority opinion quotes with approval an English opinion, Frederick Dean, 18 Crim. App. 133, 134 (1924), that disapproves prosecution and conviction under the Vagrancy Act where there would not be enough evidence to charge the prisoner with an attempt to commit a crime. Lacey, *supra* note 24, at 1204, finds that many statutes defining status crimes contain no reference to acts. But he acknowledges that in cases such as "common thief" status, one can argue that "evidence of past conduct is necessary." In analyzing these statutes it would seem clearer to distinguish between the *status* (admittedly not itself conduct) and an *implicit reference* to conduct necessarily made because proof of conduct is essential to prove the existence of the status.

27. 370 U.S. at 666.

28. 392 U.S. at 533.

29. In these cases "status" includes no more than the mere physical and mental state associated with desire. *United States v. Rundle*, 429 F.2d 1316 (3d Cir. 1970); *Bailey v. United States*, 386 F.2d 1 (5th Cir. 1967); *United States ex rel. Swanson v. Reincke*, 344 F.2d 260 (2d Cir.), *cert. denied*, 382 U.S. 869 (1965); *People v. Zapata*, 220 Cal. App. 2d 903, 34 Cal. Rptr. 171 (1963), *appeal dismissed for lack of juris.*, 377 U.S. 406 (1964); *Nutter v. State*, 8 Md. App. 635, 262 A.2d 80 (1970); *State v. Margo*, 40 N.J. 188, 191 A.2d 43 (1963); *People v. Borrero*, 19 N.Y.2d 332, 227 N.E.2d 18, 280 N.Y.S.2d 109 (1967); *Rengel v. State*, 444 S.W.2d 924 (Tex. Crim. App. 1969). But see the following cases and opinions which challenge this use of "status" by arguing either that certain addictive conduct inevitably and involuntarily flows from this immune addictive status or is indeed a part of the status itself: *Powell v. Texas*, 392 U.S. 514, 554 (1968) (Fortas, J., dissenting); *Watson v. United States*, 439 F.2d 442 (D.C. Cir. 1970); *United States v. Carter*, 436 F.2d 200, 243 (D.C. Cir. 1970) (Bazelon, C.J., concurring); *Easter v. District of Columbia*, 361 F.2d 50 (D.C. Cir. 1966); *Driver v. Hinnant*, 356 F.2d 761 (4th Cir. 1966); *Hutcherson v. United States*, 345 F.2d 964, 971 (D.C. Cir.) (Bazelon, C.J., concurring in part, dissenting in part), *cert. denied*, 382 U.S. 894 (1965); *Lloyd v. United States*, 343 F.2d 242, 243 (D.C. Cir.) (Bazelon, C.J., dissenting), *cert. denied*, 381 U.S. 952 (1964); *United States v. Lindsey*, 324 F. Supp. 55 (D.D.C. 1971); *United States v. Ashton*, 317 F. Supp. 860 (D.D.C. 1970); *People v. Malloy*, 58 Misc. 2d 538, 296 N.Y.S.2d 259 (Crim. Ct. 1968).

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the context of addiction? Of course one may separate addiction status (some distinctive bodily state or mental desire) from the actual use of the drug by mere definition; the California trial court did so in *Robinson* in construing its statutory crime of "addiction."<sup>30</sup> But some would insist that the addict's purchase, possession, and use of the drug are "realistically inseparable from the status of addiction."<sup>31</sup> In this view California's definition of addiction is unduly arbitrary and unrealistic; regardless of our verbal freedom to define "addiction" only in terms of desire, the possession and use of the drug—and perhaps other acts—are seen as *factually* inseparable from the physiological and psychological status of addiction.

Two arguments have suggested the forms this alleged inseparability takes: (1) The addict's drug use is a symptom of disease. (2) The addict's use of drugs is an involuntary result of a status which is physiological or psychological, or perhaps both. If the status argument is pushed beyond the minimalist reading to exculpate other behavior associated with the status, it thus resolves into arguments based on disease or involuntariness. These arguments will lead us into complex factual issues about drug addiction that will be explored later in the article; we turn now to a closer examination of the arguments themselves.

### B. *The Disease Argument*

*Robinson* opens the door to the argument that "disease" may preclude criminal liability. Justice Stewart's majority opinion acknowledges that persons addicted to narcotics are diseased or ill;<sup>32</sup> the emphasis on disease is central to his argument. Justice Douglas's concurring opinion asserts that the addict is sick, and that addiction is a disease.<sup>33</sup> Justice Clark's dissent speaks of "cure" and justifies confinement in a penal institution as "treatment."<sup>34</sup>

Although the theme of disease has remained pervasive in case law on the topic, its exculpatory force remains as ambiguous as it is in the *Robinson* opinions.<sup>35</sup> In applying that theme to the case of addiction, however, the skeleton of the argument is discernible in at least a

30. *Robinson v. California*, 370 U.S. 660, 662 (1962).

31. *Watson v. United States*, 439 F.2d 442, 475 (D.C. Cir. 1970) (McGowan, J.). See *Robinson v. California*, 370 U.S. 660, 686 (1962) (White, J., dissenting).

32. 370 U.S. 660, 667 & n.8, citing *Linder v. United States*, 268 U.S. 5, 18 (1925).

33. 370 U.S. at 674, 676.

34. *Id.* at 681, 683, 680. However, Justice Clark insists that the issue which ought to be central is the voluntary quality of the addiction.

35. *But see United States v. Brawner*, 471 F.2d 969, 1010 (D.C. Cir. 1972) (Bazelon, C.J., dissenting).

generalized form. Its proponents would claim that it cannot be a crime to be afflicted with a disease, that addiction is a disease, and hence unpunishable. Others would argue further that some or all addictive conduct is either part of the disease,<sup>36</sup> "a compulsion symptomatic of the disease,"<sup>37</sup> or an "invariable"<sup>38</sup> symptom of the disease; as a result such conduct is unpunishable. Two questions must be explored in order to evaluate these arguments: Can the claim that addiction is a disease be usefully adapted to the context of a legal argument? Which, if any, of the phenomena associated with disease are inappropriate as grounds for punishment under the criminal law?

The first question is problematic because the term "disease" is vaguely defined within the medical profession.<sup>39</sup> The term suggests generally that a person manifests some distinguishable complex of abnormal conditions having, or surmised to have, a biological basis.<sup>40</sup>

36. *Watson v. United States*, 439 F.2d 442, 470 (D.C. Cir. 1970) (Bazelon, C.J.) (appendix to rehearing en banc).

37. *Powell v. Texas*, 392 U.S. 514, 569 (1968) (Fortas, J., dissenting) (quoting findings of the trial judge with approval). Compare *Marshall v. United States*, 414 U.S. 417, 433 (1974) (Marshall, J.) with *Powell v. Texas*, 392 U.S. 514, 526 (1968) (Marshall, J.).

38. *Watson v. United States*, 439 F.2d 442, 470 (D.C. Cir. 1970) (Bazelon, C.J.) (appendix to rehearing en banc).

39. Although Jellinek, one of the greatest authorities on alcoholism, defends the claim that "alcoholism is a disease," he admits that the proposition reflects a labelling decision rather than a discovery of fact: "[A] disease is what the medical profession recognizes as such." The term "disease" is a highly general, handy rubric, not itself the direct subject of any scientific demonstration. E. JELLINEK, *THE DISEASE CONCEPT OF ALCOHOLISM* 12 (1960). For a discussion of "disease" as it has been used in relation to alcohol addiction, see Fingarette, *supra* note 19.

Meehl stresses that even in neurology and internal medicine, "there is actually no clearly formulable disease-entity model." Meehl, *Specific Genetic Etiology: Psychodynamic and Therapeutic Nihilism*, INT'L J. MENTAL HEALTH, Spring-Summer 1972, at 10, 20. Typical of innumerable medical texts as well as lists of nomenclature is E. THOMPSON & A. HAYDEN, *STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS* (5th ed. 1961), which uses the word "disease" as a general rubric but nowhere defines or explains it. The terminological difficulty is not overcome by shifting to the phrase "mental disease." Challenges to the use of this term are widespread both within and without the medical profession. See generally H. FINGARETTE, *THE MEANING OF CRIMINAL INSANITY 19-52* (1972).

40. *STEDMAN'S MEDICAL DICTIONARY* (22d ed. 1972) defines "disease" as: "illness, sickness; an interruption, cessation or disorder of body functions, systems, or organs," or "[a] disease entity, characterized usually by at least two of these criteria: a recognized etiologic agent (or agents); an identifiable group of signs and symptoms; consistent anatomical alterations, caused by specific micro-organismic alterations." McHugh, *Psychologic Illness in Medical Practice*, in *TEXTBOOK OF MEDICINE* 107 (P. Beeson & W. McDermott eds. 3d ed. 1971) states: "The term 'disease' is difficult to define.... It is intended to convey the idea that among all the morbid changes in physical and mental health it is possible to recognize groups of abnormalities as distinct entities or syndromes separable from one another and from the normal and that these separations will prove to have some biologic explanation when the entities have been thoroughly investigated" (emphasis added). *TABER'S CYCLOPEDIA OF MEDICAL DICTIONARY* D-47 (12th ed. 1973) defines "disease" as: "a pathological condition of the body that presents a group of symptoms peculiar to it and which sets the condition apart as an abnormal entity differing from other normal or pathological body states." Those in the medical profession tend to use the word "disease" even where they do not yet know the biological basis (if any) of the "disease entity"; they will do so because they assume that one exists. Similar usage of the term in relation to addiction avoids some crucial legal questions. See pp. 433-39 *infra*.



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If one seeks to derive a relevant meaning of disease by analysis of the term "addiction," one confronts a plurality of concepts and definitions describing addiction.<sup>41</sup> Moreover, these are used in varying ways by various authorities within the health professions, sometimes overlapping and sometimes differing significantly in meaning.<sup>42</sup> Unresolved questions, problems, speculation and controversy abound in this field.<sup>43</sup>

41. Jaffe, *Drug Addiction and Drug Abuse*, in PHARMACOLOGICAL BASIS OF THERAPEUTICS 285, 286 (L. Goodman & A. Gilman eds. 3d ed. 1965).

42. Experts in the field now avoid the term "addiction." DeLong, *supra* note 19, at 82. For a brief review of these definitional inadequacies, see Lewis, *Introduction: Definitions and Perspectives*, in SCIENTIFIC BASIS OF DRUG DEPENDENCE 5-11 (H. Steinberg ed. 1969) [hereinafter cited as BASIS OF DEPENDENCE]. For a fuller review, see NATIONAL COMM'N ON MARIJUANA AND DRUG-ABUSE, DRUG USE IN AMERICA: PROBLEM IN PERSPECTIVE 120-40 (2d Rep. 1973) [hereinafter cited as DRUG AMERICA]. See generally Eddy, Halbach, Isbell & Seevers, *supra* note 19, at 721.

In 1964 the World Health Organization (WHO) formally abandoned the term "addiction" and began to develop a more complex terminology. WHO EXPERT COMM. ON ADDICTION-PRODUCING DRUGS, REPORT No. 13 (Tech. Rep. Ser. No. 273, 1964) [hereinafter cited as REPORT No. 13]. Central to the new terminology was replacement of the term "addiction" with the word "dependence." (The proposed terminology is now widely but by no means universally used in the professional literature.) The Committee distinguished "psychic dependence" and "physical dependence" and classified drugs accordingly. The opiates and alcohol produce both kinds of dependence, and the study provides a set of categories that characterize the degree of dependence, e.g., "overpowering desire" (opiates) and "strong desire" (alcohol-barbiturate types). In a 1969 Report, the concept "drug dependence" is itself defined: "A state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterized by behavioral and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependent on more than one drug." WHO EXPERT COMM. ON ADDICTION-PRODUCING DRUGS, REPORT No. 16 (Tech. Rep. Ser. No. 407, 1969). The definition is reaffirmed in a 1973 Report. WHO EXPERT COMM. ON DRUG DEPENDENCE, REPORT No. 19 (Tech. Rep. Ser. No. 526, 1973).

The crucial concepts in the definitions of "dependence" (as distinguished from mere use) are those of "overpowering desire" (the early formulations) and of "compulsion" (1969 formulation and after). But no specific analysis or explanation of these concepts appears in any of the official texts (nor in any other treatises I have seen on the topic). The closest approach to such analysis is remote at best: In the 1973 Report, a section entitled "Quantification of Drug Dependence" lists five very general categories of questions whose responses "may help to define the *problems* associated with drug taking and provide a basis for quantifying the presence and intensity of drug dependence." *Id.* at 20.

Some authorities have tried to replace the subjective and vague notions of "overpowering desire" or "compulsion" with more objective language. Isbell defines dependence in terms of "persistent seeking and undergoing great risks to obtain the drug," use of the drug as the chief means of adaptation to life, and a "strong tendency to relapse after treatment." Isbell, *Pharmacological Factors in Drug Dependence*, in DRUG ABUSE: NON-MEDICAL USE OF DEPENDENCE-PRODUCING DRUGS 36, 35-42 (S. Btsh ed. 1972) (vol. 20 of ADVANCES IN EXPERIMENTAL MEDICINE AND BIOLOGY) [hereinafter cited as NONMEDICAL USE]. Lewis, *supra*, at 8, suggests defining dependence in terms of observable withdrawal symptoms and behavior.

In this article the word "addict" generally refers, as indicated in context, to any one or combination of the following: a person who shows distinctive *physical symptoms* upon abstinence from a drug he has been using; a person who experiences a powerful *desire* to continue using a drug as a result of frequent prior use; a person who shows through *behavior* a persistent and intense commitment to seeking and using a certain drug, even though lawfulness and analogous socially approved values must be sacrificed.

43. Authorities in the field agree on this point. With respect to the physical aspects, see A. GOLDSTEIN, L. ARANOW & S. KALMAN, THE PRINCIPLES OF DRUG ACTION 605 (1969) [hereinafter cited as PRINCIPLES]; Chruscial, *Perspectives in Pharmacological Research on*

Thus it is clear that any claim that drug addiction is a disease is not made on the basis of a consensus among researchers and health professionals about its manifestation. Obviously the claim that addiction is a disease has its suggestive, rhetorical, perhaps educational uses. But the controversy surrounding that claim makes it unsuitable as the premise for tightly reasoned argument leading to fundamental innovation in constitutional or common law doctrine.

Even if theories and definitions were clear and uniform, they would not in themselves make clear which aspects of the alleged disease should or should not be reached by the criminal law. In order to see how the lines of argument would be drawn, we list the specific kinds of phenomena associated with the rubric "addiction":<sup>44</sup>

- (1) Autonomous somatic states—specific neurological, physiological or other bodily states that are effects of repeated past use of narcotics, barbiturates, alcohol or other drugs, but which can exist even in the current absence of the drug.
- (2) Autonomous mental phenomena—the powerful desire for the drug, and the related subjective sensations, that can exist after repeated use but in the current absence of the drug.
- (3) The autonomous and distinctive pattern of behavior—the pattern of repeated, persistent, illegal use of the drug, and other behavior distinctively belonging to this pattern, even in the absence of the drug.

It is evident that a minimalist reading of *Robinson* forbids criminal punishment for the existence of the pure status phenomena included in the first category, mere somatic states per se. The phenomena in the second category, mere mental propensities or desires, are similarly protected. Thus insofar as a disease theory of addiction suggests the existence of autonomous bodily and mental states, criminal immunity is exactly coextensive with that arising from the minimalist reading of the status argument.

If the disease argument is to broaden the scope of criminal immunity

*Drug Dependence*, in *NONMEDICAL USE*, *supra* note 42, at 79; Jaffe, *supra* note 41, at 283. With respect to addictive life patterns, see DeLong, *supra* note 19, at 79-81; Jaffe, *The Implementation and Evaluation of New Treatments for Compulsive Drug Users*, in *DRUG DEPENDENCE* 230-32 (R. Harris, W. McIsaac & C. Shuster eds. 1970); *DRUG AMERICA*, *supra* note 42, at 369-70. See generally note 96 *infra*.

Preble and Casey's summary of the various historic phases of heroin use from World War I to the present notes how different they were. Preble & Casey, *Taking Care of Business: The Heroin User's Life on the Street*, in *IT'S SO GOOD, DON'T EVEN TRY IT ONCE* 100-04 (D. Smith & G. Gay eds. 1972) [hereinafter cited as *DON'T TRY IT*].

44. This categorization is not intended as a definitive one but is formulated for the purposes essential to the argument that follows. It includes each of the main types of phenomena that authorities typically speak of as constituting addiction. See, e.g., *REPORT* No. 13, *supra* note 42. The factual questions that arise in connection with these phenomena are discussed in pp. 428-33 *infra*.

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for drug addiction, it must do so by immunizing the phenomena in the third category, addictive behavior.<sup>45</sup> Certainly it is inaccurate to claim that all disease-related behavior can escape the reach of the criminal law.<sup>46</sup> The state can require a nondiseased person to take steps to prevent his catching the disease;<sup>47</sup> it can require the diseased person to isolate or quarantine himself,<sup>48</sup> or to take measures to protect others.<sup>49</sup> But the criminal law may not reach involuntary conduct,<sup>50</sup> and it is this assumption that has formed the basis for arguments for criminal immunity for an addict's behavior.

Since the bodily condition associated with the disease is clearly protected by the status argument, the addict's conduct can be exculpated only insofar as it is involuntary. Thus arguments for immunity may describe the addict's behavior in terms that suggest involuntariness, such as "compulsion symptomatic of the disease."<sup>51</sup> Legal involuntariness, however, must be demonstrated as a matter of fact no matter how the conduct is related to the protected disease status.

The claim that addictive behavior is a "symptom" of the disease thus amounts to an attempt to gloss over the issue of involuntariness. There is no reason to assume that whatever is a medically recognized symptom must be legally involuntary. A symptom is simply an indicator or manifestation of disease.<sup>52</sup> There are some kinds of behavior that can be symptomatic movements of the body and that are not directly sub-

45. See *United States v. Moore*, 486 F.2d 1139, 1236 (D.C. Cir.) (Wright, J., dissenting), *cert. denied*, 414 U.S. 980 (1973).

46. *Robinson v. California*, 370 U.S. 660 (1962); *Holden v. Hardy*, 169 U.S. 366 (1897); *Slaughter-House Cases*, 83 U.S. 36 (1873); *Dowell v. City of Tulsa*, 273 P.2d 859, 861 (Okla. Sup. Ct.), *cert. denied*, 348 U.S. 912 (1954). See note 27 *supra*.

47. *Jacobson v. Massachusetts*, 197 U.S. 11, 23-24 (1905) (vaccination).

48. See *id.* at 25; *Holden v. Hardy*, 169 U.S. 366, 398 (1897). *Compagnie Francaise v. Board of Health*, 186 U.S. 380, 387 (1901).

49. The classic situation involves a driving prohibition for those who know they may lose control because of their disease. Failure to observe reasonable precautions to protect others from such dangers can warrant criminal conviction if, for example, another person's death results. *People v. Freeman*, 61 Cal. App. 110, 142 P.2d 435 (1943); *People v. Decina*, 2 N.Y.2d 133, 138 N.E.2d 799, 157 N.Y.S.2d 558 (1956).

50. M. LAFAVE & A. SCOTT, *HANDBOOK ON CRIMINAL LAW* § 25, at 130 (1972).

51. *Powell v. Texas*, 392 U.S. 514, 569 (1968) (Fortas, J., dissenting) (quoting trial judge with approval); *Watson v. United States*, 439 F.2d 442, 470 (D.C. Cir. 1970) (Bazelon, C.J.) (appendix to rehearing en banc) ("Even if an addict retains some minimal 'free will' not to indulge at a particular moment in time, no one would deny that his use of narcotics is largely involuntary—indeed is the essence of his disease"). See *In re Foss*, 10 Cal. 3d 910, 922, 519 P.2d 1073, 1080, 112 Cal. Rptr. 649, 656 (1974) ("psychological and/or physiological compulsion arising from an addiction").

52. *STEDMAN'S MEDICAL DICTIONARY*, *supra* note 40, at 1231 defines "symptom" as: "Any morbid phenomenon or departure from the normal in function, appearance, or sensation experienced by the patient and indicative of disease." E. DE GOWIN & R. DE GOWIN, *DIAGNOSTIC EXAMINATION* (2d ed. 1969) says: "Symptoms are those variations from normal sensations or behavior that enter the patient's consciousness. They are *subjective* . . . Physical examination discloses *physical signs*; these are *objective* manifestations of disease . . ." *TABOR'S CYCLOPEDIA MEDICAL DICTIONARY*, *supra* note 40, at 5-140 says: "Any perceptible change in the body or its functions that indicates disease or the kind or phases of disease."

ject to the will in certain situations—*e.g.*, fainting, tics, or squints. But there are also behaviors that can be symptomatic in medical terms and that can be directly subject to the will.<sup>53</sup> It is, then, a question of fact and not of definition whether symptomatic behavior is voluntary. Where a symptom is a voluntary act, there is no legal basis for declaring that merely because it indicates or manifests a disease, the person cannot be punished for it. Indeed, if such a voluntary act could cause serious social harm, is there any doubt that the state could invoke the criminal law to prohibit it?

One variant of the disease argument deserves particular mention at this point; it is the claim, explicit or implied, that addiction is a *mental* disease.<sup>54</sup> If this is meant to advance the argument by invoking the insanity defense, it only makes the addict's attempt to escape liability more burdensome: the defendant would have to prove both the existence of a mental disease and either a lack of understanding related to the offending act itself,<sup>55</sup> or a defect in volitional capacity.<sup>56</sup> Proof that addiction is a mental disease would be difficult; there

53. One large category of symptomatic behaviors subject to voluntary control includes partial paralyses or failures of bodily coordination symptomatic of various kinds of neurological or other organic disease or defect. The behavioral malfunction is commonly both evident and symptomatic, but sufficiently limited in degree to be subject to a positive effort of will. For example, in cases where diverging eyes have resulted from partial paralysis of a muscle of one of the eyes, a partial closing of one eye is a typical symptomatic behavior; it can be reversed with some attention and moderate effort of will. The double vision that is distinctively symptomatic of this condition can also be elicited or prevented at will by those who have sufficient use of the muscle to relax it or to activate it sufficiently. 6 S. DUKE-ELDER, *SYSTEM OF OPHTHALMOLOGY* 617 (1958). For other examples of partial paralyses influenceable by effort of will and of voluntary exercises recommended to help in therapy, see the medical treatment discussion of Bell's palsy, and of paralyses due to cerebrovascular accidents in HAVARD, *CURRENT MEDICAL TREATMENT* 454, 460 (3d ed. 1970).

54. Fifty years ago, when people spoke of "dope fiends," it was possible for a court to accept the notion that a morphine addict was *per se* insane. *Prather v. Commonwealth*, 215 Ky. 714, 287 S.W. 559 (1926). More recently the claim that addiction is a mental disease had been put forth by defendant addicts either as a generalized claim, *Robinson v. California*, 370 U.S. 660, 667 n.8, or with respect to the particular case at issue. *Gaskins v. United States*, 410 F.2d 987 (D.C. Cir. 1967); *Rivers v. United States*, 330 F.2d 841 (D.C. Cir. 1964). See *Hutcherson v. United States*, 345 F.2d 964, 970 (D.C. Cir. 1965), *cert. denied*, 382 U.S. 894 (1965) (Burger, J., concurring); *Horton v. United States*, 317 F.2d 595, 597 (D.C. Cir. 1963); note 58, *infra*.

55. In *M'Naghten's Case*, 8 Eng. Rep. 718 (H.L. 1843) this lack of understanding is formulated as a defect of reason from disease of the mind, such that "[the accused did not] 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." This requirement appears as one option for proof of insanity in the MODEL PENAL CODE § 4.01 (Proposed Official Draft 1962), and is described as a defect resulting from mental disease wherein the person "lacks substantial capacity . . . to appreciate the criminality of his conduct."

56. In *Davis v. United States*, 165 U.S. 373, 378 (1897) the Court described this defect as a condition in which "[the] will, . . . the governing power of his mind, has been otherwise than voluntarily so completely destroyed that his actions are not subject to it, but are beyond his control." The MODEL PENAL CODE § 4.01 (Proposed Official Draft 1962), describes this aspect of the insanity defense as an optional alternative to the ground described in note 55 *supra*. Here the defendant "lacks substantial capacity . . . to conform his conduct to the requirements of law." Any trend toward allowing a mere showing that

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is no consensus in the medical profession that addiction is a mental disease.<sup>57</sup> Although courts have shown sympathy for the doctrine that addiction is a disease, they have consistently refused to adopt the doctrine that addiction is a mental disease.<sup>58</sup> Moreover, the very concept of mental disease has been under severe scientific attack and is now plainly a controversial one.<sup>59</sup> But assume the defendant establishes that addiction is a mental disease. If he is being tried for use, possession, or addiction-related theft, for example, the issue of a lack of understanding is unlikely to arise. If an addict committed an act while under the influence of a drug, any resulting lack of understanding would not suffice to establish the insanity defense; such a lack of understanding would not result from the "disease" of addiction, but from the act of taking the drug. Thus, proof of defective volition would still be necessary; the addict would have to show that he was unable to exert the self-control necessary to refrain from drug use. Use of the insanity defense therefore does not avoid the necessity of showing involuntariness; that proof is only one part of the case such a defendant would have to make.

In summary, the disease argument relies on two assumptions in attempting to exculpate the addict. First, it suggests that his psychological and physiological condition, a pure status, is not punishable; this sug-

the offending act resulted from mental disease, without a specific showing of lack of knowledge or lack of free will, collapsed with the abandonment of the rule of *Durham v. United States*, 312 F.2d 847 (D.C. Cir. 1962) (act must be product of mental disease or defect) in *United States v. Brawner*, 471 F.2d 969 (D.C. Cir. 1972) (adoption of *Model Penal Code* test). See generally H. FINGARETTE, *supra* note 39; A. GOLDSTEIN, *THE INSANITY DEFENSE* (1967).

57. See notes 41-43 *supra*; H. FINGARETTE, *supra* note 39, at 19-52. Such a consensus would not in any event control the legal concept of "disease" or "defect" as applied in the insanity defense. See *MacDonald v. United States*, 312 F.2d 847, 851 (D.C. Cir. 1962), *superseded by* *United States v. Brawner*, 471 F.2d 969 (1972). See also *Powell v. Texas*, 392 U.S. 514, 541 (1968) (Black, J., concurring).

58. *Castle v. United States*, 347 F.2d 492, 495 (D.C. Cir. 1965) (Burger, J., concurring), *cert. denied*, 388 U.S. 915 (1967). *Robinson* does not assert more than that addiction is a disease, though there is a footnote quoting (without direct comment or clear contextual indication of attitude) the appellee's brief which claimed that heroin addiction is a "state of mental and physical illness." 370 U.S. at 666 n.8. Courts have also stated that "a mere showing of narcotics addiction, without more does not constitute 'some evidence' of mental disease. . . ." *Bailey v. United States*, 386 F.2d 1, 4 (5th Cir. 1967), *citing* *Heard v. United States*, 348 F.2d 43, 44 (D.C. Cir. 1965). See also *United States v. Collins*, 443 F.2d 550 (D.C. Cir. 1970); *United States v. Freeman*, 357 F.2d 606 (2d Cir. 1966); *Hutcherson v. United States*, 345 F.2d 964 (D.C. Cir.), *cert. denied*, 382 U.S. 894 (1965); *Lloyd v. United States*, 343 F.2d 242 (D.C. Cir.), *cert. denied*, 381 U.S. 952 (1964); *People v. Borrero*, 19 N.Y.2d 332, 227 N.E.2d 18 (1967). Of course, an addict may make an insanity plea and a showing of mental disease independent of a claim of addiction. This strategy may succeed in a case where addiction exists but the addiction per se is not in itself sufficient even to raise the insanity issue. *Castle v. United States*, *supra*, at 494 (Wright, J.); *id.* at 496-97 (Burger, J., concurring). This approach was used successfully in *People v. Kelly*, 10 Cal. 3d 565, 516 P.2d 875, 111 Cal. Rptr. 171 (1973). *But see* *Prather v. Commonwealth*, 215 Ky. 714, 287 S.W. 559 (1926) (morphine addict held insane because of addictive status).

59. See generally H. FINGARETTE, *supra* note 39, at 19-52.

gestion is unnecessary because it merely argues the minimalist holding in *Robinson*. Second, it implies that addictive behavior is involuntary. The latter suggestion has been made even more directly in the case law and is explored below.

### C. *The Involuntariness Argument*

While *Robinson* contains only a brief and cryptic allusion to the involuntariness issue,<sup>60</sup> other cases have extended its implications to introduce directly considerations of involuntariness in ways that would seem to exculpate addictive behavior. Sometimes the argument is that the addictive behavior in question is involuntary;<sup>61</sup> sometimes it takes the more complex form that the addictive behavior is the involuntary result of a nonpunishable status.<sup>62</sup> Some forms of the argument use the word "involuntary,"<sup>63</sup> some the term "compulsion,"<sup>64</sup> and some the term "pharmacological duress."<sup>65</sup> Usually the involuntariness is said to extend to nontrafficking use, possession, and purchase; sometimes it is said to extend to behavior such as theft, if motivated by the need for money for a personal supply of the drug.<sup>66</sup> The theme of involuntariness has also been pressed vigorously in connection with addiction to alcohol. The premise proposed in the *Powell* dissent, and in the decisions in similarly inclined cases, is that alcoholism is a disease

60. 370 U.S. at 667. The Court offers two examples in which addiction may result involuntarily. One is the addiction resulting from medically prescribed narcotics; the other is the newborn infant's addiction resulting from the mother's addiction. Both are not only examples of rare types of addiction relative to the total addict population, but are also examples of innocent development of addiction rather than innocent subsequent, self-initiated use of the drug once addiction exists. It is the ability to refrain from use subsequent to addiction that is most commonly at issue when the assumption of the involuntariness of addict behavior is discussed. The *Robinson* majority opinion says nothing at all on that score, as Judge Wilkey notes in *United States v. Moore*, 486 F.2d 1139 (D.C. Cir.), *cert. denied*, 414 U.S. 980 (1973).

61. See *United States v. Moore*, 486 F.2d 1139, 1209-10 (D.C. Cir.), *cert. denied*, 414 U.S. 980 (1973) (Wright, J., dissenting).

62. See *Watson v. United States*, 439 F.2d 442, 475 (D.C. Cir. 1970) (McGowan, J.).

63. *Watson v. United States*, 439 F.2d 442, 470 (D.C. Cir. 1970) (Bazelon, C.J.) (appendix to rehearing en banc).

64. See p. 420 *supra*; *United States v. Lindsey*, 324 F. Supp. 55, 59 (D.D.C. 1971).

65. *Watson v. United States*, 439 F.2d 442, 467 n.18 (D.C. Cir. 1970) (Bazelon, C.J.) (appendix to hearing en banc); *Castle v. United States*, 347 F.2d 492, 494 (D.C. Cir. 1965), *cert. denied*, 388 U.S. 915 (1967). See *United States v. McKnight*, 427 F.2d 75 (7th Cir.), *cert. denied*, 400 U.S. 880 (1970); *United States v. Henry*, 417 F.2d 267, 269 (2d Cir. 1969) ("pharmacological coercion").

66. *United States v. Moore*, 486 F.2d 1139, 1210 (D.C. Cir.), *cert. denied*, 414 U.S. 980 (1973) (nontrafficking possession) (Wright, J., dissenting); *id.* at 1260 (trafficking and robbery to obtain funds for purchase of drug) (Bazelon, C.J.); *Watson v. United States*, 439 F.2d 442, 470 (D.C. Cir. 1970) (Bazelon, C.J.) (appendix to rehearing en banc); *Lloyd v. United States*, 343 F.2d 242, 245 (D.C. Cir. 1964), *cert. denied*, 382 U.S. 894 (1965) (purchase and possession) (Bazelon, C.J., dissenting); *United States v. Lindsey*, 324 F. Supp. 55 (D.C. Cir. 1971) (nontrafficking possession). See *Easter v. District of Columbia*, 361 F.2d 50, 52-53 (D.C. Cir. 1966) (being drunk in public; holding severely limited by *Powell v. Texas*, 392 U.S. 514 (1968)); *Driver v. Hinnant*, 356 F.2d 761, 764 (4th Cir. 1966) (alcohol addiction, being drunk in public; holding severely limited by *Powell v. Texas*, *supra*).

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that is involuntarily and nonculpably caused and maintained.<sup>67</sup> Yet even where courts have doggedly resisted the exculpatory legal implications of these arguments, they often seem to do so without a firm logical basis. This is because, paradoxically, these courts often seem to acquiesce in the fundamental assumption of involuntariness, or at least fail to challenge it.<sup>68</sup>

On its face the involuntariness argument seems to raise a simple question: Does the addict have any control over the behavior motivated by his desire for the drug? To answer this question we must confront a set of deeply rooted myths about drug addiction. The legal issues can be clarified only if they are reviewed against a carefully redrawn picture of the factual background, one that reassesses these myths and stereotypes. In the face of such an analysis the simple picture of the narcotic addict as a slave to the drug disappears. We are left with deeper substantive insight, but also with greater humility, appreciating the extent of our ignorance, the complexity of the problems, and the hopeless inappropriateness of trying to deal with those problems in terms of a blanket concept of involuntariness.

### II. The Factual Background

A typical layman's view of drug addiction is dominated by the myth of the addict's slavery: In this view drugs typically associated with drug-dependency have powers such that their repeated use even for a short period will "hook" the user. Once hooked, he will be unable voluntarily to abstain from use thereafter; he will make any sacrifice to get his daily supply. If he fails to obtain a supply of the drug, he will undergo excruciating withdrawal suffering. If he is forced to abstain for a period of time—as a result of imprisonment or compulsory hospitalization, for example—he will inevitably relapse into addictive use upon his release.

67. *Powell v. Texas*, 392 U.S. 514, 560-61, 567-68 (1968) (Fortas, J., dissenting); *Easter v. District of Columbia*, 361 F.2d 50 (D.C. Cir. 1966) (holding severely limited by *Powell v. Texas*, *supra*); *Driver v. Hinnant*, 356 F.2d 761 (4th Cir. 1966) (holding severely limited by *Powell v. Texas*, *supra*). See generally H. FINGARETTE, *supra* note 39.

68. *Smith v. Follette*, 445 F.2d 955, 961 (2d Cir. 1971); *Bailey v. United States*, 386 F.2d 1 n.4 (5th Cir. 1967); *United States ex rel. Swanson v. Reincke*, 344 F.2d 260, 263 (1965); *People v. Zapata*, 220 Cal. App. 2d 903, 906-07, 34 Cal. Rptr. 171, 174 (1963), *appeal dismissed for lack of juris.*, 377 U.S. 409 (1964). If addictive conduct is in truth involuntary, there seems to be no logical basis for the criminal law to deny the addict a blank check to do whatever is necessary to get the drug. Any limitations on that license would simply be arbitrary. The implications for the criminal law are "revolutionary" and disturbing. 392 U.S. at 544 (Black, J., concurring); *Powell v. Texas*, 397 U.S. 514, 534 (1968). *But see* 392 U.S. at 559 n.2 (Fortas, J., dissenting). Judge Bazelon makes this point eloquently in arguing that a poor and unskilled addict may have no "meaningful choice" but to commit a crime. *United States v. Carter*, 436 F.2d 200, 210 (1970).

Greater sophistication will no doubt suggest that such an extreme view needs qualification. But the main substance of the portrait is widely accepted even in more sophisticated circles: indeed, the involuntariness argument presupposes acceptance of the myth for all practical purposes. This acceptance accounts for the widespread failure of the courts to challenge the fundamental assumptions of the argument. This section of the article offers such a challenge. It reports a number of basic factual considerations that cast doubt on the accuracy of this portrait of addiction. The discussion focuses on four aspects of drug use that belie this myth: the existence of a population of drug users who do not become addicts, the successful elimination of addictive patterns among formerly addicted groups, the relative rarity of a heavy physiological addiction in addicts in this country, and the correspondingly widespread influence of social and psychological inducements to addictive behavior.

The community's deep concern with the serious social problems associated with addiction undoubtedly focuses attention on those relative few who do take up an addictive pattern of use, thus distracting attention from the larger numbers who use drugs for medical or non-medical purposes, but who do not take up such a pattern. Narcotics constitute the most effective analgesics (pain relievers) known to medicine, and their use is a widespread and conventional procedure for medical relief of substantial pain.<sup>69</sup> Yet only a small fraction of the many millions of patients who receive morphine ever attempt to take the drug again,<sup>70</sup> and only an exceedingly small proportion of addicts owe their dependence to medically initiated narcotic use.<sup>71</sup> These data alone prove that repeated use of narcotics does not automatically hook users to continued use of the drug.<sup>72</sup> One can make similar com-

69. See, e.g., Jaffe, *Narcotic Analgesics*, in PHARMACOLOGICAL BASIS OF THERAPEUTICS, *supra* note 41, at 247.

70. PRINCIPLES, *supra* note 43, at 474 (there is "no valid evidence" that legitimate medical administration of opiates might "create" addicts); DeLong, *supra* note 19, at 79; Lasagna, *Addicting Drugs and Medical Practice*, in NARCOTICS 55 (D. Wilner & G. Kassebaum eds. 1965).

71. Villareal, *Recent Advances in the Pharmacology of Morphine-Like Drugs*, in DRUG DEPENDENCE, *supra* note 43, at 84; J. BALL, L. BRILL, R. GLASSCOTE, J. JAFFE & J. SUSSE, THE TREATMENT OF DRUG ABUSE 19 (1972) [hereinafter cited as BALL & BRILL] report that "Iatrogenic addiction [medically induced physical dependence] appears to be an inconsequential component of the drug abuse problems."

72. One important study summarized:  
[I]n the population as a whole, very few of those who could obtain morphine or heroin illegally, if they wished, become addicts. It is noteworthy that although D-amphetamine has been used very widely to counteract fatigue and sleeplessness, only an occasional person who used it became habituated to it. And despite the nearly universal exposure of the population to the "legal" psychotropic drugs (alcohol, caffeine, and nicotine), some become habituated and some do not.  
PRINCIPLES, *supra* note 43, at 474. See generally Hill, *Chairman's Introduction to BASIS OF DEPENDENCE*, *supra* note 42, at 288. With regard to opiates specifically, see Geber, *Non-*



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ments about the sedatives and tranquilizers; these can and do come to be used addictively, but only by a relative few of the many millions who use such drugs.<sup>73</sup>

Among the minority of drug users who do develop addiction, many give it up.<sup>74</sup> Contrary to widespread skepticism about drug rehabilitation, there has been substantial success in measures to control and eliminate addiction in the United States. Skeptics probably assume that anything less than 100 percent success in achieving total, permanent abstinence from narcotics as the result of exposure to any one program is a failure and proof of the hopelessness of the task. This conclusion is unreasonable and misleading. More important than such total successes are the days spent free of drug use and the direction of the trend for a population even though specific individuals may relapse on occasion. Impressive achievement in these latter aspects<sup>75</sup> is often overlooked because attention is focused on the relapse incidents.

*Dependent Drug Use: Some Psychological Aspects*, in BASIS OF DEPENDENCE, *supra* note 42, at 375-87; D. LOURIA, OVERCOMING DRUGS 84 (1971); Wald & Hutt, *The Drug Abuse Survey Project: Summary of Findings, Conclusions and Recommendations*, in DEALING, *supra* note 19, at 5. Weil discusses the inadequacy of the "addict" stereotype and the individuality of patterns of use. Weil, *Altered States of Consciousness*, in DEALING, *supra* note 19, at 333.

73. PRINCIPLES, *supra* note 43, at 474.

74. With respect to government and government-related programs created for this purpose, see note 75 *infra*. Experience in private and purely voluntary residential programs such as Synanon demonstrates that "many former compulsive drug users are able to remain drug free and to function productively so long as they remain in residence." Jaffe, *Development of a Successful Treatment Program for Narcotic Addicts in Illinois*, in DRUG ABUSE, DATA AND DEBATE 62-63 (P. Blachly ed. 1970). Unknown numbers simply quit drug use of their own volition. DeLong reports that "there is some evidence that a substantial number of addicts—perhaps as many as one-third—'mature out' of addiction when they reach their 30's and 40's." DEALING, *supra* note 19, at 214.

75. BALL & BRILL, *supra* note 71; A. LINDESMITH, ADDICTION AND OPIATES 52-54 (1968); Fraser & Grider, *Treatment of Drug Addiction*, 14 AM. J. MED. 571 (1953); Gearing, *Methadone Maintenance: Six Years Later*, 1 CONTEMP. DRUG PROB. 191 (1972); Jaffe, *supra* note 74, at 48-63. Maddux, *Hospital Management of the Narcotic Addict*, in NARCOTICS, *supra* note 70, at 159-76. O'Donnell, *A Follow-Up of Narcotic Addicts*, 34 AM. J. ORTHOPSYCHIATRY 948 (1964); Vaillant, *A Twelve Year Follow-Up of New York Addicts*, 122 AM. J. PSYCHIATRY 727 (1966) (pt. 1); 275 NEW ENG. J. MED. 1282 (1966) (pt. 2); 15 ARCHIVES GEN. PSYCHIATRY 599 (1966) (pt. 3); Wood, *18,000 Addicts Later: A Look at California's Civil Addict Program*, 37 FED. PROBATION 26 (1973). See generally Chapple, Somekh & Taylor, *A Five Year Follow-Up of 108 Cases of Opiate Addiction*, 67 BRIT. J. ADDICTION 33 (1972); May, *Narcotic Addiction and Control in Great Britain*, in DEALING, *supra* note 19, at 345-94. For discussion of alcoholism and rehabilitation programs, see note 94 *infra*. In the large corporate anti-alcoholism programs, which tend to identify and deal with the most advanced, chronic cases, recovery rates ranged from 50 percent to 77 percent, averaging 66 percent nationally. Von Wiegand, *Alcoholism in Industry (USA)*, 67 BRIT. J. ADDICTION 181 (1972).

In reviewing 11 follow-up studies of narcotic addiction treatment programs in 1965, O'Donnell noted that high percentages of relapse were valid "only for a highly restricted definition of relapse" such as a single occasion of use. The studies did not indicate that "most addicts, after a period of treatment or enforced abstinence, relapse to drugs and continue to use drugs, or that addicts spend most of their time outside of institutions using drugs." O'Donnell, *The Relapse Rate in Narcotic Addiction: A Critique of Follow-Up Studies*, in NARCOTICS, *supra* note 70, at 242-43. One study suggests that there is a reduction in criminal behavior of patients in treatment. DRUG AMERICA, *supra* note 42, at 177. Such a benefit is obscured by the "all or nothing" approach to assessing results.

A recent study of Vietnam veterans<sup>76</sup> confirms the notion both that addiction does not always follow drug use and that addiction can be eliminated voluntarily. The Vietnam experience was "a natural experiment in the exposure of masses of young men to narcotic drugs,"<sup>77</sup> barbiturates, amphetamines, and marijuana. Pure forms of heroin and other drugs were easily available, and at low cost. In Vietnam in 1971, "almost every soldier had the opportunity to experiment with heroin and almost all personally knew other soldiers who used heroin with some regularity."<sup>78</sup> In September, 1971, the study examined the entire group of 13,240 young Army enlisted men who were then returning from Vietnam. Eight to 12 months later they reexamined this group with regard to drug use during the period following their return. Widespread use was not followed by comparable rates of addiction: Almost half had tried heroin or opium while in Vietnam, but only about 20 percent developed signs of physical or psychological dependence.<sup>79</sup> Where addictive patterns had developed, voluntary nonaddiction upon return home had almost always followed. Although about 20 percent of the total group of 13,240 had shown actual signs of addiction while in Vietnam, only one percent of the total experienced such signs at any time after their return to the United States.<sup>80</sup> A number of the ex-addicts among these veterans did use narcotics after their return, but without readdiction. The study concluded:

These results are surprising not only in that men who report having been addicted in Vietnam so seldom report any addiction in the United States during the 8 to 12 months since their return, but that many of them avoided readdiction *without* completely abstaining from narcotics. The ability of men formerly dependent on narcotics to use them occasionally without readdiction challenges the common view of narcotic addiction as a chronic and intractable condition.<sup>81</sup>

The phenomenon is not unique to Vietnam veterans.<sup>82</sup> The nature of drug dependency in this country further belies the myth of addict

76. L. ROBINS, A FOLLOW-UP OF VIETNAM DRUG USERS (Interim Final Rep., Special Actions Office for Drug Abuse Prevention, Executive Office of the President, 1973).

77. *Id.* at 22.

78. *Id.*

79. *Id.*

80. *Id.* Zinberg essentially confirms this finding on the basis of his surveys and interviews. Zinberg, *Rehabilitation of Heroin Users in Vietnam*, 1 CONTEMP. DRUG PROB. 263, 284 (1972).

81. L. ROBINS, *supra* note 76, at 13, 22-23.

82. See, e.g., A. LINDESMITH, *supra* note 75, at 48; Alarcon, Rathod & Thomson, *Observations on Heroin Abuse by Young People in Crawley New Town*, in BASIS OF DEPENDENCE, *supra* note 42, at 338.

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slavery to drugs. It is highly unlikely that much physiological addiction exists in the United States. Drugs sold illegally are usually highly adulterated. In one survey of street drugs in New York, 10 percent of the purchases contained no active ingredient whatever, and it has been estimated that illegally purchased bags of heroin typically range from one percent to five percent active material.<sup>83</sup> Thus, if we look solely at the chemical factors involved in drug addiction in this country, we find that the addict's strictly physiological dependence is at most moderate and very often quite mild in degree.<sup>84</sup>

On the other hand, the social inducements to adopt addictive patterns of behavior are often maximal. A very large proportion of new addicts in the United States today are young, psychologically immature, occupationally unskilled, socially uprooted, poor and disadvantaged. Many engaged in crime before they were addicted.<sup>85</sup> The myth of the

83. Louria, Hensle & Rosa, *Major Medical Complications of Heroin Addiction*, 67 ANNALS INTERNAL MED. 1-2 (1967). The reports of heroin "overdose" as the leading cause of teenage death in New York City are probably a mark of impurities or special sensitivity, since recent studies show that "overdose deaths" are not usually associated either with high concentrations of the drug or with the usual symptoms of narcotic overdose. See Cherubin, *The Medical Sequelae of Narcotic Addiction*, 67 ANNALS INTERNAL MED. 23 (1967); Chein, *Psychological Functions of Drug Use*, in BASIS OF DEPENDENCE, *supra* note 42, at 14-15; Wesson, Gay & Smith, *Treatment Techniques for Narcotic Withdrawal*, in DON'T TRY IT, *supra* note 43, at 165 speak of the "monumentally poor quality" of the heroin available on the West Coast. A summary of recent studies of "street" drugs shows that less than 50 percent of samples surveyed contained the alleged ingredients, and doses varied widely. Schnoll, *Drugs and Therapy—How To Interpret What You Read and Hear*, 1 CONTEMP. DRUG PROB. 15 (1971-72). At one point the quality of street heroin sold on the Eastern seaboard rose from about 5 percent to a 10 percent concentration; somewhat more intense withdrawal symptoms for addicts resulted. Cohen, *Patterns of Drug Abuse—1970*, in DRUG ABUSE 336 (C. Zarafonitis ed. 1972). Plainly local fluctuations are common. This variation suggests that the persistence in the life-patterns is not a direct consequence of the physiological action of a certain dose of the drug, but is highly influenced by other (social, psychological, and cultural) factors.

84. "Because of [the highly adulterated doses generally sold] it is now easy to withdraw the majority of heavy heroin users from their drug. Even those using six to eight bags a day (a \$30- to \$40-a-day habit) often can be rapidly withdrawn without a substitute narcotic, by using mild tranquilizers during withdrawal." D. LOURIA, *supra* note 72, at 83-84. *Discussion Remarks*, in BASIS OF DEPENDENCE, *supra* note 42, at 89 (remarks of I. Chein). Physiological dependence may also be moderate among members of the "needle cult," addicts who seem to be addicted more to using the needle on themselves (whether or not there is anything in it) than to the drug itself. See May, *supra* note 75, at 370; notes 99, 100, 105, 107 *infra*.

Undoubtedly there are narcotic drug-users in this country who are strongly dependent physiologically as well as psychologically. One cannot say how many. No doubt significant groups within this class are the health professionals who are addicts, and the "street dealers." See, e.g., Preble & Casey, *supra* note 43, at 106; *Discussion Remarks*, *supra*, at 89 (Chein). Both groups have ready access to reasonably potent concentrations of drugs, but far larger groups do not.

85. DRUG AMERICA, *supra* note 42, at 171-72; Vaillant, *The Natural History of Urban Narcotic Drug Addiction—Some Determinants*, in BASIS OF DEPENDENCE, *supra* note 42, at 347; Wald & Hutt, *supra* note 73, at 6. This is a common finding in many studies, but of course it is related to the nature of the populations among which addictive drug use is currently prevalent. In other epochs, other results would be obtained. See Preble & Casey, *supra* note 43, at 100-04 (historical review); Weil, *supra* note 72, at 340 (cross-cultural review). Similar contemporary statistics are reported from England. May, *supra* note 75, at 381.

addict as a helpless slave to his habit only lends further strength to the inducements for addicts to continue addictive patterns. It provides such persons with a rationale for ignoring alternatives to crime and the drug culture. Young people who are disadvantaged, and alienated, may find the foundation of a socially authenticated identity in addiction. For such persons, drug use provides at last a "constructive" focal activity in life, generating its own occupational responsibilities, opportunities for success and achievement, social status, and ideological, philosophical, or religious meaning.<sup>86</sup> The "hustling" required by drug addiction is not always a burden<sup>87</sup> or a separation from a socially productive life; for certain groups it may be one natural outgrowth of the values of an alienated subculture, values that are by definition inconsistent with those of the dominant society.<sup>88</sup> When some writers characterize the addict as one who will seek the drug at "great risk"<sup>89</sup> or "at the cost of unbelievable sacrifices,"<sup>90</sup> the sacrifice in question may be one of values important only to the writer and not to the addict.<sup>91</sup> A person who has developed roots in conventional society and skills for leading a productive life is substantially less likely to find a meaningful social identity in the drug culture, and such a person can more readily abandon addiction once it develops.<sup>92</sup>

Because addiction in this country has far deeper social roots than physiological ones, judicious use of sanctions and threats of sanctions, especially if coupled with suitable constructive aid, can be an effective tool in deterring addicts from continuing drug use. Such sanctions may be rooted in the powers of the criminal law; they often are under present policies (*e.g.*, revocation of parole, use of prison sentences).<sup>93</sup>

86. R. ASHLEY, HEROIN—THE MYTHS AND THE FACTS 73 (1972); Preble & Casey, *supra* note 43, at 116. See generally E. BRECHER, LICIT AND ILLICIT DRUGS, ch. 6 (1972). Chein, *supra* note 83; Vaillant, *supra* note 85, at 351.

87. See I. CHEIN, D. GERARD, R. LEE & E. ROSENFELD, THE ROAD TO H 360-61 (1964).

88. J. DOUGLAS, YOUTH IN TURMOIL 52 (1970); Feldman, *Ideological Supports to Becoming and Remaining a Heroin Addict*, DRUG DEPENDENCE 10 (March 1970); Chein, *supra* note 83, at 23. See note 116 *infra*.

89. Isbell, *supra* note 42, at 36-37.

90. A. LINDESMITH, *supra* note 75, at 49.

91. R. ASHLEY, *supra* note 86, at 64 reports: "Most of what we learn about the heroin user comes from the reports of the police, physicians, psychiatrists, and social workers. As a group they are essentially middle- and upper-middle class, operating under a value system quite different from that held in the urban ghetto...."

92. Vaillant, *supra* note 85, at 335, finds that addicts with a history of stable work patterns and stable early family matrices were the ones who eventually became abstinent. Von Wiegand, *supra* note 75, at 185, reports a two-thirds average national recovery rate in the large United States corporation programs dealing mainly with advanced, chronic alcoholism in career corporate employees.

93. These policies are employed in the California Civil Commitment Program and the federal programs at the United States Public Health Service Hospital at Lexington, Kentucky. See Wood, *supra* note 75; Vaillant, *supra* note 85; Carrick, *The Government's Role in Affecting Change in the Treatment of Narcotic Addiction*, in DRUG ABUSE: DATA AND DEBATE 136-52 (P. Blachly ed. 1970). Vaillant's 12-year follow-up of New York nar-

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Sanctions and aid may also be rooted in other values and institutions—for example, in personal freedom, work or family.<sup>94</sup> What is essential, however, is that the addict perceive both the sanctions and the aid in terms of his own values.<sup>95</sup>

### III. Theories of Drug Addiction

In light of the preceding factual discussion, we now turn to a discussion of the main types of hypotheses used to explain addictive drug use and to prove its involuntary nature. There are basically two types: one explains addiction in terms of physiology, the other in terms of psychology. It might be sufficient response simply to point out that there is no generally accepted scientific explanation of addiction,<sup>96</sup>

cotics addicts committed to the Lexington hospital reports, "Effective treatment appears to depend on the compulsory alteration of the addict's behavior for substantial periods of time. . . [A] long prison term [9 months or more] coupled with a year of parole was vastly more effective" than short or long prison terms alone, or hospital treatment alone. BASIS OF DEPENDENCE, *supra* note 42, at 355-56. A. LINDESMITH, *supra* note 75, at 52-58, reports various studies showing that sanctions, parole, threats of job-loss or license-loss (for physician-addicts) have produced significant results in producing abstinence.

94. For many of the narcotics rehabilitation programs, variable rules of internal discipline allow increased personal freedom as the addict abstains from narcotics and pursues work assignments. See Maddux, *supra* note 75; BALL & BRILL, *supra* note 71, at 63-241. Far more alcoholics in the United States have well developed family and career roots than do narcotics addicts. Not surprisingly, the use of carefully worked out family-job sanctions has been showing dramatic success in recent years in dealing with alcoholics. Pfeffer, Feldman, Feibel, Frank, Cohen, Fleetwood & Greenberger, *A Treatment Program for the Alcoholic in Industry*, 161 J.A.M.A. 827 (1956). See Mello, Mendelson, McNamee & O'Brien, *An Experimental Approach to the Drinking Patterns of Alcoholics*, in BASIS OF DEPENDENCE, *supra* note 42, at 259-69; Saslow, *Where Do We Go From Here?*, in DRUG ABUSE: DATA AND DEBATE 247-48 (P. Blachly ed. 1970); Von Wiegand, *supra* note 75.

95. Lindesmith notes that introducing values that the addict accepts can positively affect the successful implementation of sanctions. A. LINDESMITH, *supra* note 75, at 53.

96. See pp. 421-22 & note 43 *supra*. For an elaboration of the various types of hypotheses that have been proposed to account for drug dependence, see WHO EXPERT COMM. ON DRUG DEPENDENCE, REPORT No. 18 (Tech. Rep. Ser. No. 460, 1970). The generality and range of disciplines covered by these hypotheses reveals the utter lack of specific, or definitive causal understanding. They are cast in terms of psychiatric categories, delinquency theories, miscellaneous personal motives (e.g., pleasure, distress and crises, social ambitions, social rebellion), "metabolic lesions," conditioned responses and learning, socio-cultural "pressures," and various combinations of these factors. Indeed, a later report states that "these hypotheses are non-specific with respect to drug use." WHO STUDY GROUP, YOUTH AND DRUGS 20 (Tech. Rep. Ser. No. 516, 1973). In short, these theories are all very general speculations about social malaises.

The analysis which follows in the text does not critically discuss the sociologically oriented hypotheses. The assumption is that the existence of generalized social influences does not amount to the conditions for involuntary behavior in the context of criminal responsibility. It is true that there has been recent argument that for some members of alienated subcultures the social influences may reach the point of establishing irrationality and involuntariness of a kind justifying a finding of absence of criminal responsibility. This novel and highly controversial view admittedly faces formidable obstacles to acceptance in law. In any event no analysis of the bearing of such a doctrine specifically on narcotic addiction has yet been provided. See Floud, *Sociology and the Theory of Responsibility: "Social Background" as an Excuse for Crime*, in THE SCIENCE OF SOCIETY AND THE UNITY OF MANKIND 204-21 (R. Fletcher ed. 1974). There is good reason to suppose that social factors are very important in understanding much addictive conduct, but to say this is very different from saying or even meaning to suggest that the conduct is therefore "involuntary."

and perforce no scientific basis for establishing that addictive behavior is generally involuntary. But if we are to dissolve the myths that dominate this field, we must go beyond this generalization and examine specific types of explanations that promote them.

The first type of hypothesis is a qualified version of the simple theory that mere use of a narcotic drug inevitably causes addiction in all persons. According to this hypothesis, the physiological effects of the drug interact with a biological, possibly genetically determined, sensitivity found only in a certain subgroup of all users; for this special subgroup the physiological impact of the drug suffices to produce an addictive pattern of conduct.<sup>97</sup>

As a scientific or empirical claim, this type of hypothesis is speculative, neither substantiated by medical evidence nor supported by medical consensus;<sup>98</sup> it hardly warrants reshaping constitutional or common law doctrine. But even if these hypotheses were substantiated to some extent, it is unlikely that such a biological predisposition could account for a significant portion of drug-related conduct. Biological signs indicate that many of those who demonstrate fullblown, extreme drug-addict patterns of conduct are, at most, only moderately physically dependent. Common addictive patterns of conduct exist in which the known biological after-effects of the particular drug used are minimal or nil.<sup>99</sup> It is empirically implausible, in the absence of strong independent evidence, that a physiological influence so slight, even if related to unique bodily predisposition, should absolutely and irresistibly transform a whole way of life. A conceptual incongruity also pervades this type of hypothesis, an incongruity in kind between the supposed biological cause and its supposed behavioral effects. There are, of course, instances where a particular physiological process or directly associated feeling may seem to produce an automatic behavior-response. It seems plausible, for example, that intractable and overwhelming pain, or

97. See, e.g., Dole & Nyswander, *Methadone Maintenance and Its Implications for Theories of Narcotic Addiction*, in *THE ADDICTIVE STATES* 359 (A. Wikler ed. 1968).

98. DeLong, *supra* note 19, at 212, summarizes the questions concerning the physiological components of addiction and concludes that there are no clear answers and that most scientists are at least skeptical about validating their effects. *PRINCIPLES*, *supra* note 43, at 474, raises the possibility that a genetic factor might explain the addictive response in the relative few who become addicts, but acknowledges a "paucity of evidence" for such a view. Specific comments such as those above are also confirmed by the more general acknowledgments that medical science today lacks *any* accepted fundamental understanding of the causes of addiction.

99. Addictive patterns of conduct are associated with the dependence-producing drugs which WHO lists as *not* producing physical dependence, e.g., cocaine. The addictive pattern of conduct can also exist when no narcotic has been used, such as in the not uncommon cases of addicts who have been unwittingly buying pure milk sugar from their dealers over substantial periods of time. Vaillant, *supra* note 85, at 352.

the last extreme of exhaustion or of hunger, may lead to a kind of immediate, instinctive reflex, an uncontrollable sound or gesture. Yet even in such cases, the notion that this reaction is a direct behavioral effect of a physiological cause, that the mind can play no significant role in mediating the behavior, may be factually incorrect. The biological drive of hunger can be influenced by cultural and psychological factors. Indeed, eating can be suspended altogether to the point of death by the mediation of mind, either by a voluntary hunger strike or by neurotic loss of appetite. Recent medical research has dramatically revealed how much even our extreme pain-distress reactions are psychological rather than direct physical response.<sup>100</sup>

Yet even if one accepts the image of an automatic and involuntary behavioral response to a specific physiological drive, this very limited range of behavior does not constitute the kind of response that could account intelligibly and fully for the typically elaborate addictive lifestyle. A pattern of conduct must be distinguished from a mere sequence of reflex-like reactions. A reflex knee jerk is not conduct. If we regard something as a pattern of conduct, whether criminal or not, we assume that it is mediated by the mind, that it reflects consideration of reasons and preferences, the election of a preferred means to the end, and the election of the end itself from among alternatives. The complex, purposeful, and often ingenious projects with which many an addict may be occupied in his daily hustling to maintain his drug supply are examples of conduct, not automatic reflex reactions to a single biological cause.<sup>101</sup>

Nothing in the preceding is intended to deny that chemical predisposition or other biological causes may be some among a number of factors significantly influencing addictive patterns of conduct. But even if such causal factors were shown to exist, it would be implausible to expect that they would be sufficient to resolve the question of the legal voluntariness of the various kinds of conduct in which addicts

100. H. BEECHER, MEASUREMENT OF SUBJECTIVE RESPONSES 161-66 (1959), reports that during World War II two-thirds of the wounded at Anzio did not wish pain-relieving medication, whereas four-fifths of a group of civilians with far less tissue trauma did. The gravely wounded who did not wish medication for wound-pain complained vigorously, however, at inept injections. "*Great wounds with great significance . . . are made painless by small doses of morphine, whereas fleeting experimental[ly induced] pains with no serious significance are not blocked by morphine.*" *Id.* at 165. Beecher's experimental reports show that, generally speaking, half the pain-relieving effect of morphine is due to "placebo" reaction, a reaction to the *idea* that a pain reliever has been given rather than to the chemical action; the placebo effect is greater as the stress is greater. *Id.* See also A. GROLLMAN & E. GROLLMAN, PHARMACOLOGY AND THERAPEUTICS 99 (7th ed. 1970).

101. "[T]hough drugs may have specific physiological effects, their effects upon behavior and experience are largely nonspecific." A. BERNSTEIN, L. EPSTEIN, H. LENNARD & D. RANSOM, MYSTIFICATION AND DRUG MISUSE 57 (1971).

engage. One must conclude that there is no substantiated biological explanation of drug addiction nor is there a reasonable hope that further research in this area could settle the questions of law concerning the voluntariness of addictive conduct and ways of life.

It is therefore necessary to turn to theories that would explain addictive conduct by introducing psychological considerations: theories of motivation, learning, or conditioning, or of personality structure and mental pathology. We turn first to theories based on motivation. These explanations of addictive conduct assume that either the drug-induced euphoria or the addict's withdrawal stress or both provide mentally overpowering motives for addictive behavior.<sup>102</sup>

Some would emphasize that either the experience of withdrawal stress or the fear of it can serve as an absolutely overriding motive<sup>103</sup> for continuing addictive patterns of conduct. Immediate total abstinence from drugs, especially in heavy narcotic users, can be associated with a temporary but intensely distressing reaction that includes chills, muscle twitching, vomiting, diarrhea, and general debility. But "cold turkey" withdrawal from narcotics, in and of itself, is apparently never fatal; it is temporary, continuing at its worst for no more than several days.<sup>104</sup> Moreover, since most addicts are not heavily addicted physiologically, the reaction is not nearly so severe.<sup>105</sup> For the moderately addicted, it is comparable to a bad case of flu.<sup>106</sup> It is not uncommon for young people who think themselves heavily addicted to find that they can withdraw, "cold turkey," with only minimal discomfort.<sup>107</sup> And drugs associated with addictive conduct do not always produce withdrawal stress.<sup>108</sup> Most important, there is no need for "cold turkey" withdrawal. The standard, gradual withdrawal procedures used under

102. REPORT NO. 13, *supra* note 42, at 13, uses the phrase "overpowering desire."

103. See, e.g., McMorris, *supra* note 11, at 1084.

104. Glaser and Ball, who studied the literature written since 1875, found no documented case in which opiate withdrawal was "the sufficient cause of death." Glaser & Ball, *Death Due to Withdrawal of Narcotics*, in *THE EPIDEMIOLOGY OF OPIATE ADDICTION IN THE UNITED STATES* 287 (I. Ball & C. Chambers eds. 1970). See, e.g., Maddux, *supra* note 75, at 168.

105. BALL & BRILL, *supra* note 71, at 10. See p. 431, notes 83-84 *supra*.

106. Wesson, *Treatment Techniques for Narcotic Withdrawal*, in *DON'T TRY IT*, *supra* note 43, at 165; Jaffe, *Drug Addiction and Drug Abuse*, in *PHARMACOLOGICAL BASIS OF THERAPEUTICS* 302 (L. Goodman & A. Gilman eds. 4th ed. 1970). See Zinberg, *supra* note 80, at 285.

107. Preble & Casey, *supra* note 43, at 110.

108. See Deneau, *Psychogenic Dependence in Monkeys*, in *BASIS OF DEPENDENCE*, *supra* note 42, at 199-207; Isbell, *supra* note 42, at 36-38; Villareal, *Contributions of Laboratory Work to the Analysis and Control of Drug Dependence*, in *DRUG USE: DATA & DEBATE* 97 (P. Blachly ed. 1970). On the other hand, it should be noted that physiological dependence and consequent withdrawal stress can occur without psychological dependence, without the self-conscious craving to use the drug and therefore without the addictive life pattern. See Eddy, Halbach, Isbell & Seevers, *supra* note 19.



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professional care keep narcotic withdrawal discomfort to a quite moderate and readily bearable level.<sup>109</sup>

Furthermore, it is well established that withdrawal symptoms (as well as the effects of drug use) are mediated to a great degree by mental attitudes.<sup>110</sup> Not only can the intensity and stress of symptoms vary greatly with changes in the addict's state of mind and the social-psychological setting, they can even be made to appear and disappear with changes in setting or circumstance.<sup>111</sup> Drug dependence facilities take advantage of this fact: Increasing numbers of lay groups, therapeutic communities, and medical and social welfare agencies provide a variety of withdrawal and post-care settings in which the medical, social and moral support is maximal.<sup>112</sup>

This discussion suggests that the experience or fear of drug withdrawal cannot render addictive conduct legally involuntary. The criminal law demands that citizens refrain from criminal conduct even at the cost of temporary moderate personal discomfort; fear of such discomfort alone could neither establish a criminal law defense nor an absence of *mens rea* on the ground of involuntariness. Thus arguments for defenses such as "pharmacological coercion"<sup>113</sup> due to drug addiction are fatally flawed. Such arguments implicitly reveal profound factual misapprehensions about the assumed horrors of withdrawal symptoms. The common law defense of coercion requires a showing of reasonable fear of imminent mortal or grave bodily injury;<sup>114</sup> only if one erroneously equates the narcotic addict's withdrawal stress with

109. Blachly, *Management of the Opiate Abstinence Syndrome*, 122 AM. J. PSYCHIATRY 742 (1966); Fraser & Grider, *Treatment of Drug Addiction*, 14 AM. J. MED. 571 (1953); Maddux, *supra* note 75, at 168 (withdrawal technique in U.S. Public Health Service hospitals).

110. A. LINDESMITH, *supra* note 75, at 34-39, takes it as "conclusively established" that under controlled conditions addicts can be deceived into thinking they have received opiates when they have been given placebos. See generally A. BERNSTEIN, L. EPSTEIN, H. LENNARD & D. RANSOM, *supra* note 101, at 57-62; BALL & BRILL, *supra* note 71, at 34; notes 99, 101 *supra*.

111. Chein and associates report that the distress level in withdrawal depends on the setting: "Alone, it can be an almost unbearable experience. In a hospital ward, remarkably little medication often stills the distress associated with quite severe physiological disturbance, e.g., painful cramps and diarrhea. Conversely, patients with minor overt symptoms may be very demanding of medication." I. CHEIN, D. GERARD, R. LEE & E. ROSENFELD, *supra* note 87, at 247-48. See R. PHILLIPSON, MODERN TRENDS IN DRUG DEPENDENCE AND ALCOHOLISM 1 (1970); Lennard, Epstein & Katzung, *Psychoactive Drug Action and Group Interaction Process*, 145 J. NERVOUS & MENTAL DISEASE 69 (1967).

112. See, e.g., Jaffe, *supra* note 74, at 48. See generally BALL & BRILL, *supra* note 71.

113. *Castle v. United States*, 347 F.2d 492, 494 (D.C. Cir. 1965), *cert. denied*, 388 U.S. 915 (1967); *United States v. Henry*, 417 F.2d 267, 269 (2d Cir. 1969). See *Watson v. United States*, 439 F.2d 442 (D.C. Cir. 1970) ("pharmacological duress," *id.* at 447) ("physiological duress," *id.* at 461) (Bazelon, C.J., concurring and dissenting).

114. *D'Aquino v. United States*, 192 F.2d 338 (9th Cir. 1951); *Gillars v. United States*, 182 F.2d 962, 974 (D.C. Cir. 1950).

these dangers could a defense like pharmacological coercion have any legal force.

Moreover, if courts were to make this erroneous equation they would only encourage addictive conduct by validating the myth that withdrawal stress is an agony to be avoided at any cost; the myth often influences addicts themselves.<sup>115</sup> The belief in the myth of addict-slavery can encourage addicts to surrender to, and even to embrace, their "destiny" as helpless victims.<sup>116</sup> This attitude can provide a dimension of drama in a formerly drab or frustrating life. Such a belief and attitude, often reinforcing counterculture values, provide a rationale for pursuing a life of crime as a member of an addict culture.<sup>117</sup>

Euphoria is another important effect of drug use that many believe provides a principal motive for addiction.<sup>118</sup> It is obvious that in settings other than addiction prospective euphoria is not a motive that will normally serve to excuse criminal conduct. But one might argue that anticipation of euphoria in the case of drug addiction could be so intense that it could be shown to be overpowering to the point where it negates voluntariness in the criminal law. Even if one strains to entertain the logic of this argument, the facts are otherwise. The narcotic addict typically does not reach or anticipate reaching such an intense level of pleasure. Most addicts in this country cannot amass the money, even through a life of active crime, to buy the quantity of narcotics needed to achieve this kind of euphoria regularly. The "rush," which may be more common at stages of early use, becomes increasingly rare with the development of tolerance to the drug.<sup>119</sup> Thus a legal defense based on ecstatic drug euphoria would simply have no basis in fact. Nor could the prospect of the loss of tranquil euphoria associated with routine drug use preclude criminal liability for addictive conduct; presumably this motive would be even less overwhelming.<sup>120</sup>

115. See Freedman, *Non-Pharmacological Factors in Drug Dependence*, in *NONMEDICAL USE*, *supra* note 42, at 30.

116. I. CHEIN, G. GERARD, R. LEE & E. ROSENFELD, *supra* note 87, at 248: "[A]mong adolescent addicts . . . the self-identification as addicts—i.e., as persons who require opiates for comfortable functioning—is an important phenomenon in their developing addiction. . . . There is another aspect to the withdrawal syndrome; it is not merely the bane of addiction to opiates, but also its badge . . ."—a subject of much boastful humor and exaggerated story telling.

117. See, e.g., Feldman, *supra* note 88; Preble & Casey, *supra* note 43; Chein, *supra* note 83, at 23-24; R. ASHLEY, *supra* note 86, at 73.

118. See BALL & BRILL, *supra* note 71, at 21; A. LINDESMITH, *supra* note 75, at 34; Maddux, *supra* note 75.

119. Holahan reports: "[T]he habit size of a long-time heavy user is often not at the level of euphoria but only at a level sufficient to suppress withdrawal or to keep the withdrawal mild." Holahan, *The Economics of Heroin*, in *DEALING*, *supra* note 19, at 290. Other commentators confirm this point. BALL & BRILL, *supra* note 71, at 11; A. LINDESMITH, *supra* note 75, at 23-45.

120. In the addict's routine daily injections a relief and calm is achieved. Each new injection abates the tensions and discomforts that emerge as the effect of the preceding

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Human beings respond to conditioning that influences complex forms of learning. Conditioning and habit-learning can operate without the necessity for (at times with hardly an opportunity for) conscious motivation or reflective choice or will. Could addiction be a form of conditioned or learned "automatic" response that overrides the conscious will? There is no empirical proof that simple pleasure-conditioning or positive reinforcement in operant conditioning can of itself determine a whole way of life.<sup>121</sup> Of course a person may learn to alleviate certain discomforts by the use of a tranquilizing drug such as heroin that has short run, immediate effectiveness. That person may then develop a strong, habitual propensity to respond to subsequent discomfort this way. In the absence of strong countermotives, such as a commitment to law or to other cultural values reflected in it, a person who has been positively conditioned to desire and use a drug might indulge this desire persistently, in spite of the illegality of the conduct necessary to do so. But is it plausible that a person who has genuine, urgent contrary values and commitments would find it impossible either to inhibit such a conditioned or learned behavioral response, to substitute another, or at least to take steps that would indirectly bring about extinction of the learned or conditioned response? The availability of any of these measures<sup>122</sup> could establish the legal voluntariness of his drug use. The fact is that there is no independent empirical evidence or generally accepted scientific theory that warrants an assertion that human beings can be conditioned to the point where these options cease to exist. Theories along these lines remain highly speculative and controversial.<sup>123</sup>

Yet another group of psychological hypotheses are based on claims of psychiatric derivation. According to the arguments, whereas mentally healthy persons do not allow the pleasure, fears, or learning associated with drug use to become imperative or paramount in their lives, the addict is psychologically vulnerable. He suffers from "mental illness," "personality defect," "character disorder," or psychic "compulsion."

dose begins to wear off. During standard withdrawal procedures, with decreased dosages leading to abstinence, this tranquil "euphoria" is normally lost. Jaffe, *supra* note 41, at 302-03.

121. For a classic discussion of these concepts, see B.F. SKINNER, *THE BEHAVIOR OF ORGANISMS* (1938); DEALING, *supra* note 19, at 133-34. A. BERNSTEIN, L. EPSTEIN, H. LENNARD & D. RANSOM, *supra* note 101, at 83, point out that the capacity of the many who reside in such groups as Phoenix House to abstain refutes the hypothesis that addiction is an automatic, internally triggered pattern. See Thompson & Pickens, *Drug Self-Administration and Conditioning*, in *BASIS OF DEPENDENCE*, *supra* note 42, at 177-98.

122. See Jaffe, *supra* note 74. See generally BALL & BRILL, *supra* note 71.

123. See, e.g., B.F. SKINNER, *BEYOND FREEDOM AND DIGNITY* (1971). Wald and Hutt conclude that it is a high priority "question" whether there is any inborn physiological predilection, drug-induced vulnerability, learned response to external stimuli, or none of these, that bear on addiction. Wald & Hutt, *supra* note 72, at 45.

In response to these arguments, one might point to the problems and inadequacies in invoking a generalized concept of disease (including mental illness) that were discussed in an earlier section; we deal here with more specific descriptions of mental illness and how they may relate to the criminal law.<sup>124</sup>

For example, one writer reports that a large portion of addicts suffer from "some form of personality disturbance, . . . [an illness often] manifested by a pattern of anti-social behavior, rather than by observable mental symptoms."<sup>125</sup> This concept of personality disturbance does little to distinguish the addict from other persons who have a tendency to get into difficulties with the law and with their neighbors and who often manifest no discernible mental abnormalities. Nor is it a helpful means of distinguishing addictive disorders to note that addicts manifest personal failings of the sort found in the general population: "The majority of addicts . . . do not fall into clear-cut nosological entities, but rather present mixtures of traits of the kind found in neuroses, character [personality] disorders, and inadequate personalities."<sup>126</sup>

The psychiatric concept of "compulsion" is perhaps the most widely accepted basis for an implicit argument that the addict's conduct is involuntary.<sup>127</sup> The term means something different in psychiatric usage than it does in criminal law. In criminal law "compulsion" designates what is conceptually and observationally quite simple in common sense terms: Either there is an exterior physical force greater than the person's physical strength to resist, or, if one considers coercion

124. See pp. 424-25 *supra*. The general concept of "mental illness" has no more weight than its more specific forms taken jointly. That is, if "compulsion," "inadequate personality," "character defect," and other psychiatric diagnoses provide no independent proof of involuntariness, the generic concept, which refers vaguely to some or all of these, can do no more.

125. Bowman, *Narcotic Addiction and Criminal Responsibility under Durham*, 53 GEO. L.J. 1017, 1031 (1965).

126. Bowman, *supra* note 125, at 1033 (citing an AMA Report on Narcotics Addiction). The labelling process can often simply obscure the legal issues. In *Washington v. United States*, 390 F.2d 444 (D.C. Cir. 1967), the court was confronted with such a situation. It commented:

These labels and definitions were not merely uninformative. Their persistent use served to distract the jury's attention from the few underlying facts which were mentioned. For example, the fact that Washington's difficulties 'in relating adequately to other people are more severe or more extreme than the average [person's]' was immersed in a dispute about whether to classify these difficulties as a 'personality defect,' a 'personality problem,' a 'personality disorder,' a 'disease,' and 'illness,' or simply a 'type of personality.'

*Id.* at 449.

127. Redlich and Freedman find that this characteristic may be singularly descriptive of addicts:

It is questionable, then, whether one can speak meaningfully of an addictive personality beyond the tautological statement that such a person, for one or another reason, has the compulsion to take drugs. At present we are inclined to believe that addicts are a heterogeneous lot.

R. REDLICH & D. FREEDMAN, *THEORY AND PRACTICE OF PSYCHIATRY* 728 (1966).

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to be a form of compulsion, there is a plain and imminent threat by another person to do grave bodily injury or even mortal harm unless the victim acquiesces.<sup>128</sup> In psychiatric usage the term means neither of these things, but it does have several other meanings that cannot accurately be used to describe addictive behavior.

Being "compelled" is often regarded as the result of tensions among psychic energies or psychic forces within the individual.<sup>129</sup> In the latter usage, the psychic forces behind the addict's propensity to use the drug are presumed to be quantitatively stronger than any contrary forces. However, they are presumed stronger not because they have been independently measured, but because the theory, post facto, merely interprets in those terms the fact that the person engages in the repetitive conduct rather than inhibits it. In this usage, compulsion is a speculative theoretical construct about human behavior generally rather than a scientifically discovered, distinctive feature of the individual defendant's behavior.<sup>130</sup>

"Compulsion" may also be used in a more specific, descriptive sense in psychiatry to refer to "an insistent, repetitive, intrusive, and unwanted urge to perform an act which is contrary to the person's ordinary conscious wishes or standards."<sup>131</sup> This characteristic definition cannot apply generally to addictive conduct, however, since the drug and the life are often consciously and wholeheartedly "wanted."<sup>132</sup>

128. For discussion of the legal concepts of compulsion, coercion, and necessity, see J. HALL, *GENERAL PRINCIPLES OF CRIMINAL LAW* (2d ed. 1960). Of course a defendant could try to prove that the psychiatric concept of "compulsion" implied a mental disease or defect within the meaning of the insanity defense. Such proof would have to be made independently of a showing of the mere fact of addiction. See note 56 *supra*.

129. The doctrine is set out in some of Freud's classic works, and is summarized in R. REDLICH & D. FREEDMAN, *supra* note 127, at 351. See generally C. BRENNER, *AN ELEMENTARY TEXTBOOK OF PSYCHOANALYSIS* 191 (2d ed. 1973).

130. The remarks in text above do not imply that these general psychiatric doctrines have no use at all. They have uses *within* psychiatry; they can be helpful in gaining an overview of the human psyche, in organizing the specific insights of the clinic, and in guiding research and therapy. Moreover, the psychiatrist can make important contributions in certain aspects of the criminal trial. He or she may have insights into the mind and character of the individual on trial, or at least into a well-understood psychological type to which the defendant demonstrably belongs. However, *specific knowledge* about addicts as a "type" is lacking, although vague, speculative, and often conflicting statements abound in the psychiatric and other literatures. See R. REDLICH & D. FREEDMAN, *supra* note 127.

131. AM. PSYCHIATRIC ASS'N, *A PSYCHIATRIC GLOSSARY* (2d ed. 1964). This definition would not necessarily preclude a finding of criminal liability. As Justice Black noted:

When we say that appellant's [offending conduct] is caused not by 'his own' volition but rather by some other force, we are clearly thinking of a force that is nevertheless 'his' except in some special sense. The accused undoubtedly commits the proscribed act and the only question is whether the act can be attributed to a part of 'his' personality that should not be regarded as criminally responsible. Almost all of the traditional purposes of the criminal law can be significantly served by punishing the person who in fact committed the proscribed act without regard to whether his action was 'compelled' by some elusive 'irresponsible' aspect of his personality.

Powell v. Texas, 392 U.S. 514, 540 (1968) (Black, J., concurring).

132. C. BRENNER, *supra* note 129, at 191. See notes 86-94, 116-17 *supra*.

Sometimes, however, psychiatrists define "compulsion" as an urge that *cannot* be inhibited.<sup>133</sup> But on what grounds and in what sense can one say that the addict cannot inhibit the impulse? Only two grounds are ever offered: (a) the observation that the addict does continue to use the drug in spite of attempts to threaten and persuade;<sup>134</sup> and (b) the theory of the balance of conflicting psychic forces; as noted above, it hypothesizes that the urge that wins out must therefore have been the strongest. But the latter explanation is only a restatement, in the terms of the theory, of the observed fact that the individual does persist.<sup>135</sup> Neither formulation is an independent scientific determination that the individual does so because he *must*.

Moreover, the question of legal voluntariness cannot be resolved until we know, at least, whether the addict had the option of taking some preventive measure that would have either eliminated the compulsive urge or restrained him from satisfying it. These and other legally essential questions are lost when courts employ too readily the psychiatric term; such questions are simply irrelevant in the psychiatric use of "compulsive."<sup>136</sup> Indeed, psychiatrists themselves recognize that the logical relation between the concepts of "psychic forces" in psychiatry and "will" and "choice" in the law remains unclear.<sup>137</sup> How, then, can the psychiatric formulations of "compulsion" warrant the creation of legal doctrine that labels addictive conduct involuntary?

In the scientifically perplexing context of addiction, all these con-

133. H. ENGLISH & A. ENGLISH, *A COMPREHENSIVE DICTIONARY OF PSYCHOLOGICAL AND PSYCHOANALYTICAL TERMS* (1958).

134. The universal characteristic common to all types of drug dependence is *psychic dependence*, a psychological compulsion to take a drug....Psychic dependence is difficult to define and measure but is recognized clinically by alterations in behavior such as undergoing great risks to obtain the drug, obsession with maintaining a supply, use of the drug as the chief means of adapting to life and a strong tendency to relapse after treatment.

Isbell, *supra* note 42, at 361.

135. See p. 441 *supra*. The National Commission on Marijuana and Drug Abuse urges discarding of the "unidimensional concept of individual loss of self-control which has long dominated scientific and lay concepts of 'addiction'" on the grounds that it is simply inaccurate. *DRUG AMERICA*, *supra* note 42, at 139.

136. See notes 74-75 *supra*.

137. The eminent psychiatrists Alexander and Staub acknowledge the incongruity of outlook in the two fields:

We may for practical purposes hold the individual responsible for his acts; we assume an attitude as if the conscious Ego actually possessed the power to do what it wishes. Such an attitude *has no theoretical foundation*, but it has a practical, or still better, a tactical justification.

F. ALEXANDER & H. STAUB, *THE CRIMINAL, THE JUDGE AND THE PUBLIC* 72-73 (1931) (emphasis added). See, e.g., Louisell & Diamond, *Law and Psychiatry: Detente, Entente, or Concomitance?*, 50 *CORNELL L.Q.* 217, 220 (1965). C. BRENNER, *supra* note 129, at 183, acknowledges that the distinction between the normal expression of character and the abnormal symptom is "necessarily an arbitrary decision" from the purely psychiatric standpoint. R. REDLICH & D. FREEDMAN, *supra* note 127, at 350, say the distinction is "very difficult or impossible" to make. See H. FINGARETTE, *supra* note 39.

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cepts of mental disorder are mere vague rubrics. They obscure our vast ignorance in this area by imparting an aura of scientific knowledge because of their technical appearance. At most they merely obfuscate familiar facts: When we talk about "addicts," we often have in mind persons with an intense commitment, one that seems unreasonable and excessive, to a pattern of life centering on drug use.

### Conclusion

In spite of a vast literature, professionals in the field of drug addiction acknowledge that no satisfactory scientific understanding of drug addiction has been reached. Thus there is no medical foundation for adopting the general proposition at the crux of the exculpatory legal arguments, the proposition that addictive conduct is involuntary. On the other hand, massive descriptive evidence indicates that individuals often make choices to abandon addictive conduct or abstain from drug use permanently or temporarily. Moreover, authorities observe that narcotic addiction often involves little in the way of chemical or biological influences. Yet it may provide an important individual or group identity for many who lack socially approved skills or are socially alienated. Popular beliefs about the chemically-induced hell of withdrawal agony or the insatiable craving for ecstatic pleasures are profoundly at odds with the facts, though they have deeply colored the thinking of the courts. All this information forces abandonment of the argument that drug addiction—and acts associated with it—be regarded as legally involuntary.

Once we conclude that addictive conduct is legally voluntary, however, we do not express a basic substantive insight into addiction, but merely free ourselves from a false idea. Courtroom cliché has obscured the fact that the problems at issue concern intricate and poorly understood relationships that link character, personality, and mind to upbringing, social setting, and cultural values, and in turn to biochemical and neuropsychological processes. Indeed, courts have been ill-served by those psychiatrists who have promoted the notion that addiction is involuntary and who have seen this notion as a legal formula that will permit medical models to supersede the use of criminal sanctions.<sup>138</sup> The very complexity of the problem calls for legislative determinations

138. This imputation of motive rests upon inferences that seem repeatedly apparent as one reads the court records, and psychiatrists' statements about the irrelevance and inappropriateness of the criminal law in the areas of mental disease and addiction. See H. FINGARETTE, *supra* note 39, at 37-52.

concerning rehabilitation, regulation of drug trafficking,<sup>139</sup> and the general administration of criminal law in this area.<sup>140</sup>

Undoubtedly there are those who regard possible legal approaches to addiction in polar terms: Either we inflict harsh, punitive and degrading measures on the addict, or we declare the person sick and therefore not responsible for his conduct. What is needed here is the abandonment of such extreme and fixed positions.<sup>141</sup> In the present antipunitive atmosphere in many enlightened circles, it is appropriate to recall that the lawful and proper threat of sanctions may be not only a pragmatically effective approach,<sup>142</sup> but also a morally humane approach. It regards the addict as an autonomous person, responsible for guiding his own life, and subject to law.<sup>143</sup> The medical approach can also reflect a humane concern, a concern for the weak and ailing and for those who cannot, in some respects, handle their own lives. By now it is no news that both of these approaches, however inspired, can in practice disregard human dignity when ignorance, social prejudice, well-intentioned dogma, lack of funding, or routinization take over. We need to rethink the implications of both approaches against the background of the limited knowledge that we have. Coordinating the attack on the complex problem of drug abuse is preeminently a legislative responsibility. For the courts to assume that addictive drug use or addiction-related conduct is involuntary and to build such an unworthy assumption into constitutional and common law doctrine would be a grave error.

139. *United States v. Moore*, 486 F.2d 1139, 1159 (D.C. Cir.) (Wilkey, J.), *cert. denied*, 414 U.S. 390 (1973).

140. *Marshall v. United States*, 414 U.S. 417, 427-29 (1974) (Burger, C.J.).

141. A recent polar formulation reflects a common doctrinaire approach: "Medicine views the drug misuser as a patient who needs treatment; law enforcement views him as a criminal who must be punished." GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, *DRUG MISUSE* 12 (1971). Too often such a formulation merely sidesteps a set of complex personal, social, legal, and spiritual problems:

Oftentimes... the desire to avoid the implications of criminality while maintaining formal control has resulted in compulsory treatment of an 'illness' which has never been adequately defined. The Commission warns against the tendency to assume that when its motives are benevolent, society need not attend to the philosophical and constitutional issues raised by its actions.

DRUG AMERICA, *supra* note 42, at 257; Goldstein & Katz, *supra* note 7.

142. See notes 93-95 *supra*.

143. See H.L.A. HART, *PUNISHMENT & RESPONSIBILITY* 23 (1968):

Criminal punishment as an attempt to secure desired behavior differs from the manipulative techniques of the Brave New World (conditioning, propaganda, etc.) or the simple incapacitation of those with anti-social tendencies, by taking a risk. It defers action till harm has been done; its primary operation consists simply in announcing certain standards of behavior and attaching penalties for deviation, making it less eligible, and then leaving individuals to choose. This is a method of social control which maximizes individual freedom within the coercive framework of law....