Degrees of Culpability: Aristotle and the Language of Addiction

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Introduction

The language of addiction in contemporary American culture has been popularly employed for a variety of ends. The medical industry has used the language to promote both chemical and behavioral treatments for a number of different sorts of behaviors labeled 'addictive.' The self-help industry, through both print and electronic media, have saturated the marketplace with a multitude of different applications of addiction language and non-prescription remedies. (The newest entry I know of is "Internet Addiction.") And finally, government officials have been using the language for decades to promote various "wars on drugs."

If we were to try to isolate the motives behind these sorts of uses of addiction language, we would, I think, discover them to be primarily economic and political. There is, after all, a mind-boggling amount of money involved in the various facets of drug addiction alone. But it is not the philosopher's central occupation to examine the motives behind the actual uses to which various languages are put. Rather the philosopher's task is to reveal and critique the logic of the concepts purportedly expressed through language.

My central purpose will thus be to reveal and examine the deepest assumptions and implications of the language of addiction as it is currently used in this culture. I will argue that there is a significant cleft in the concept of addiction which results in a systematic ambiguity in the language involved. Most broadly that cleft can be identified as a divi-

Four explanations of addiction.

sion between scientific and religious theories of human behavior. This division has been identified by many before in general terms.[1] I will explore it with particular reference to addiction. In doing so I will appeal to Aristotle, the earliest Western thinker to speak to the topic. Using his *Nicomachean Ethics* I will isolate four different plausible explanations for what we call addictive behavior and attempt to show that none is reducible to the others. And thus the apparent duality in contemporary addiction language in fact masks a pair of dualities that complicate the ambiguities further. Finally, I will conclude with a discussion of some of the obfuscating consequences of these ambiguities for the societal debate about addiction and the appropriate responses to it.

The history of the term 'addiction' goes back to the sixteenth century according to the *Oxford English Dictionary* (*OED*). Originally it was a legal term, having to do with the surrender of something by order of a judge. This evolved into a more general notion of surrendering oneself to some pursuit or being a devotee or habitual practitioner of some activity. The 1971 *OED* does not, however, cite a meaning having to do with the physiological dimension that has come to be an important part of the term's current meaning.

The present cleft in the meaning of the term in this country dates back to nineteenth-century medicine and the Temperance Movement. At that time a number of scientific models of behavior appeared that suggested a purely causal, physiological account of addiction. But at the same time the Temperance Movement relied on an older moral model of addiction (mainly to alcoholic beverages) as sin. Nineteenth century revival meetings, prefiguring some aspects of AA (Alcoholics Anonymous), included drunkards standing to make public confessions and vows of abstinence before the Higher Power. These two historical forces provide the dualistic backdrop for the current uses of addiction language, most of which fall under either the "sin" or "sickness" models.[2]

As 'addiction' is currently employed in American culture I would suggest a definition in terms of two other words with recently evolved meanings: 'dysfunctional dependency.' As this phrase is currently used, it refers to behavioral syndromes that act to fulfill needs at the cost of the overall functional success of the agent/patient. This defini-

[1] Wilfrid Sellars, *Science, Perception and Reality* (The Humanities Press, 1963), Ch. 1.

[2] Stanton Peele, *Diseasing of America* (Lexington Books, 1989), 38-46.

tion, I will maintain, selects the set of things we intuitively regard as addictive and is neutral with respect to the sin and sickness models. It does so by leaving ambiguous the connection between a need and its fulfilling behavior. If the need functions as a reason for choosing the behavior, then the moral and related language of choice seems appropriate. But if the need simply causes the action, then the scientific language of causal laws is primarily relevant. Under the first explanation the addict is an agent, with reason, will and culpability. Under the second he/she is a patient, determined by forces independent of will and reason, a victim of disease. These explanations separate the sin and sickness models, in both logic and semantics. Sin is simply not a relevant concept in the scientific account of behavior. Likewise the notion of physiological sickness is not important to the religious account. Yet the concept of 'dysfunctional dependency' can be defined in both, and can be used to refer to behaviors from the fully voluntary to the most physiologically compulsive. Using this concept thus allows us to discuss various addictive behaviors free of the assumptions and connotations of either model.

The Aristotelian Model

The tension between the sin and sickness models has emerged full blown in our own century. But the conceptual roots of the distinction are in fact very old ones, dating to a time long before the advent of what we think of as science, and even predating Christianity. The classical Greek thinkers discussed these ideas, but without the theoretical assumptions of contemporary science or religion. Aristotle stands out among those thinkers in presenting a remarkably thorough treatment of the relevant concepts. Without scientific or religious axes to grind, he surveys the relevant patterns of human behavior from his rational, naturalist perspective.

In that survey he isolates four conceptually distinct explanations of behaviors we could call dysfunctional dependencies. He endorses none of them as the single 'right' explanation, but recognizes the conceptual differences between them. I will express his distinctions in the language of the Ross translation[3] of the *Nicomachean Ethics* as follows: the self-indulgent person, the incontinent person, the physically ill or damaged person, and the badly habituated person.

[3] Aristotle, *Nicomachean Ethics*, trans. by Sir David Ross (Oxford University Press, 1925).

Aristotle defines the four types and compares them as to the appropriateness of blame and the possibility of change. He does so in the context of his account of the good life for humans. Broadly summarizing, the good life for Aristotle is one that is active, healthy, rational and virtuous. The four conceptions of 'addictive' behavior thus represent several varieties of failure in achieving the good life.

Two of the core notions in Aristotle's view of human behavior are those of 'moral virtue' (*ethikos*) and 'habit' (*ethos*), the former having derived its meaning from the latter. The virtues and vices of civilized people do not arise by nature; they are the product of habituation. (That Aristotle means to confine his generalizations to the civilized is obvious from his frequent references to their differences from the barbarians, as well as his assertion that the study of ethics is a sub-field of politics.) He states that

> by doing the things that we do in our transactions with other men we become just or unjust, and by doing the acts that we do in the presence of danger, and by being habituated to feel fear or confidence, we become brave or cowardly. The same is true of appetites and feelings of anger; some men become temperate and good-tempered, others self-indulgent and irascible, by behaving one way or the other in appropriate circumstances. . . . It makes no small difference, then, whether we form habits of one kind or another from our very youth; it makes a very great difference, or rather all the difference. (1103b 15-26)

Humans are by nature neither good nor evil. They become so through habituation. The importance of this premise cannot be overestimated. It echoes throughout the text of *Nicomachean Ethics* with a force parallel but opposite to the contrary assumption that begins the Judeo-Christian Scriptures. Save for the ill, the injured, and the mad our natures are not prone to corruption. Rather our moral character is a product of practice, shaped both by the environment of our upbringing and our subsequent moral choices as adults. Aristotle's account includes references to both causal and rational/moral sources of behavior. Our youthful environment has causal consequences for adult behavior, yet we can still talk of the latter as voluntary and properly subject to praise and blame. But unlike the later notions of absolute goodness and evil held by some Christians, Aristotle takes praise and blame to be appropriate in degrees, corresponding to the distinction between more and less voluntary actions.

Thus Aristotle does not posit the dichotomy of the sin and sickness models of behavior that dominate the contemporary debate about ad-

diction. To demand that either one of these models be able to account for every sort of dysfunctional dependency is more akin to embracing an ideology than it is to offering an explanation of actual human behavior. Aristotle's account is subtle where the contemporary ones are crude. To say, for example, that heroin addiction is a sin and thus always voluntary is as far from the truth as saying it is an illness and thus always involuntary. But unlike adherents to the sin model, Aristotle is not seeking salvation. And unlike the partisans of the sickness model, he is not simply seeking correlation data. He is rather seeking wisdom, a state distinct from ideology, salvation, or mere empirical knowledge.

Sharp dichotomy between sin and sickness simplistic.

Aristotle defines a spectrum of what we would call addictive behaviors from the most to the least blameworthy. At the most blameworthy end is the vice of self-indulgence (*akolasia*), the opposite of the virtue of temperance (*sophrosune*). Self-indulgence is blameworthy because it is the result of deliberate choice:

> the man who pursues the excesses of things pleasant, or pursues to excess necessary objects, and does so by choice, for their own sake and not at all for the sake of any result distinct from them, is self-indulgent; for such a man is of necessity unlikely to repent, and therefore incurable, since a man who cannot repent cannot be cured (1150a 18-23).[4]

Aristotle is here developing a point he has made earlier:

> to the unjust and to the self-indulgent man it was open in the beginning not to become men of this kind, and so they are unjust and self-indulgent voluntarily; but now that they have become so it is not possible for them not to be so (1114a 20-23).

Here Aristotle has blended the language of the sin and sickness models to recognize the cases of repeated behaviors that begin as voluntary and become less so over time. When he states that "he who cannot repent cannot be cured" he recognizes a category of behavior that neither the sin nor sickness models can individually capture. Yet it is a category that we intuitively recognize to be real, and one which, incidentally, the AA program would seem to assume. The self-indulgent person is the worst sort of addict, and the most blameworthy. The self-indulgent person engages in harmful forms of behavior without thought as to their longer-term consequences. Like the "beasts," he/she is without reason, acting on impulse for immediate pleasure or the

[4] The term for 'repent' could also be translated as 'regret,' to avoid the later Christian connotations.

absence of pain, caught up in vice with no desire to become virtuous. This is as far from wisdom as a person can get.

The incontinent person (*akrates*), by contrast, is not vicious and possesses rationality. He/she is simply weak in the face of temptation, yet knows what is rationally and morally good. Incontinence is blameworthy, but not to the degree of self-indulgence. An incontinent person is one who is

> carried away as a result of passion and contrary to the right rule—a man whom passion masters so that he does not act according to the right rule, but does not master to the extent of making him ready to believe that he ought to pursue such pleasures without reserve; this is the incontinent man, who is better than the self-indulgent man, and not bad without qualification; for the best thing in him, the first principle, is preserved (1151a 20-26).

Self-indulgence born of vice.

The "first principle" here concerns the rational, moral sense. It informs the incontinent person correctly as to the rightness and wrongness of various kinds of actions. But weakness of the will subverts it. Passion clouds reason, resulting in error. Aristotle's analysis of this error reveals an intuitive understanding of this kind of behavior. Moral decisions in his view can be expressed in the form of the following practical syllogism: "actions of kind A are wrong; to do x would be an action of type A; thus one should refrain from doing x." The incontinent person knows the truth of the first premise, the general rule of conduct that is the "major premise" of the argument. But the force of passion distracts the person from the truth of the "minor premise," that to do this particular x would be to commit A. So to have the "first principle" is to believe the major premise of such an argument, as the incontinent person does. But weakness of will causes the person to ignore the truth of the minor premise, thus not to act on the conclusion. (See the example of the smoker below.) Hence for Aristotle the incontinent person is only "half-wicked," since his/her general moral beliefs are correct. Such a person "is not a criminal, for he does not act of malice aforethought" (1152a 18-19).[5]

Incontinence born of weakness.

In this way the incontinent person represents a different sort of addict than the self-indulgent. Incontinence is not born of vice, but of weakness. The incontinent person is both more curable and less mor-

[5] As I have done with regard to several technical issues, I am here passing over the debate among Aristotle scholars on how best to interpret his account of practical syllogisms. For more detail see, for example, J. L. Ackrill, *Aristotle the Philosopher* (Oxford University Press, 1981), 147-49.

ally culpable in that, unlike the self-indulgent person, he/she recognizes the truth of the major premise of the moral argument in question. It is just that his/her passions are too strong to recognize its application to the present action. Here, once again, Aristotle is subtle where the contemporary models are crude. The sin model conflates viciousness and weakness, whereas the sickness model ignores the voluntary aspects of each. Again Aristotle melds the language of the two models. He recognizes how incontinence can involve passions that "actually alter our bodily condition, and in some men even produce fits of madness" (1147a 17-18). He clearly suggests that weakness of the will is an effect of physiological changes which cannot be eliminated from its explanation. What happens in our bodies directly influences the force of rational thought, sometimes even to the point of madness.

Madness is not blameworthy for Aristotle. It is an involuntary state. In this respect he treats it in the same way as illness and injury to the system. These physical problems can give rise to behaviors that in a normal person would be seen as incontinent. Aristotle describes these as incontinent in an "extended sense," citing the example of epilepsy as such a condition. His pathology is thus similar to our own in that he recognizes no distinct line between mental and physical illness. The soul, in his view, is the form of a living body, not some ontologically distinct thing. Further there are no demons, spirits or other supernatural forces causally affecting human actions. We are natural creatures in a natural environment. And as such we are subject to natural accidents (of birth and development) that have their effects on both our physical and mental lives.

Finally, the other form of incontinence in the "extended sense" is that which arises from unfortunate habituation from youth. Interestingly enough, the example he cites is of pederasty in the cases of "those who have been victims of lust from childhood" (1148b 29-31). Bad habituation is possibly curable, he believes, but not blameworthy as vice or incontinence, as long as the habit does not arise from earlier adult choices themselves vicious in nature.

Aristotle's four kinds of addiction clearly reveal the superficialities of the sin/sickness dichotomy. His naturalistic grasp of the varieties of addiction provides a much richer basis for discussion than the bipolar classifications of our own day. This is further revealed in the interpretation of the terms of the definition suggested earlier. There are varieties of dysfunction as well as varieties of dependence. Let us consider the "logical geography" of these terms from the Aristotelian perspective.

Critical Implications for the Contemporary Models

To begin with the obvious, the terms 'dysfunctional' and 'dependency' are not equivalent. There are dysfunctional behaviors which do not involve dependencies, e.g., unsuccessfully attempting to beat a train through a crossing. And there are certainly dependencies that are not dysfunctional, e.g., our dependence on air. Dysfunctional behavior for humans is ultimately a cognitive-theoretic classification. That is, it cannot be defined solely in terms of behavior and/or physiological integrity. The same type of behavior may be functional in one intentional context and dysfunctional in another. Morphine addiction for the terminal cancer patient may well be a functional behavior given the rational goal of reducing pain in a situation where there are no long-term considerations. And whereas a diet of anything more interesting than roots and berries probably does not promote long-term physiological integrity, still only a fanatical few would want to call the occasional indulgence in French cuisine dysfunctional. This because the functionality of behavior must ultimately be assessed with reference to the rational and moral goals of the agent. Heroic self-sacrifice, for example, is often a bad thing physiologically. But we do not think of it as dysfunctional since it is in accord with personal moral goals that we consider praiseworthy.

Dependency, on the other hand, is at base a physiological category. There are two ways to talk about it: the first in terms of feelings and the second in the language of physiology, particularly neurophysiology. Consider the addiction to gambling. To what is the gambler addicted? Surely the answer does not include such behavioral categories as pulling handles or watching horses run in circles. Rather it involves the feelings that attend these behaviors in certain contexts. It is the particular form of excitement that the gambler seeks. Or to put it physiologically, the organism acts to reproduce particular kinds of brain states. (This is why the notion of a merely psychological dependency makes no sense to the neurophysiologist. Whatever has psychological reality also has physiological reality. There are no changes of feeling unaccompanied by changes of brain states.)

Addiction partly intentional, partly physiological.

Thus the concept of addiction is hybrid—part intentional and part physiological. And it is for this reason obvious why neither the sin nor sickness models can capture it. The sin model focuses on the intentional factors and the sickness model on the physiological. Aristotle understood both, and the relations between them. His naturalistic conception of the soul as the form of the body made this understanding

possible, by incorporating both the intentional and physiological.[6] Let us consider some examples.

I begin with nicotine addiction. The typical nicotine addict is the perfect example of incontinence. Currently one must be in deep denial not to recognize the threats posed by this substance to physiological integrity. But the dependency—the "passion" in Aristotle's terms—is a strong one for many. Smokers by and large are not vicious, merely weak. Most long-term smokers are addicted to nicotine. What this means is that they are dependent on it to produce pleasure and avoid pain in the short run. And all but the most fatalistic harbor the notion that they will somehow escape the long-term physiological consequences. In Aristotelian terms, they recognize the truth of the major premise that one ought not to cause oneself physical harm, but they believe that their particular habit will not have such consequences, or at the very least, the next cigarette will not. To be weak in the face of physiological/passionate compulsion is revealed in such self-deceptions, as well as the bouts of guilt that occur when the deceptions are revealed for what they are.

In contrast let us consider the self-indulgent vice of anger. Aristotle is careful to distinguish the righteous from the vicious forms of angry behavior. And to the latter he attaches a higher level of moral culpability than to incontinence. The viciously angry engage in acts of gratuitous cruelty, refusing to accept the major premise that all such acts are morally evil. The man, for example, who unthinkingly beats his wife and children because of frustrations primarily unrelated to the home is surely acting in vicious anger. He is more culpable and less curable than the merely incontinent. He does not even recognize that there is a moral principle at stake.

Such behavior is morally distinct from that of the insane or diseased man. The latter's behavior may be seriously harmful to himself or others, but is not blameworthy, since it is due to forces beyond his rational control. The epileptic may do serious harm, but is physiologically caused to do so by forces that transcend rational thought. Such persons are typically least culpable and least curable in Aristotle's view. In the latter respect, he must be excused for not anticipating the successes of modern medicine with such afflictions.

And finally, a fourth separate category of addictions are those aris-

[6] For a surprisingly modern account of the relation of soul and body see also Aristotle's *De Anima*, Book I, Chapter 1.

ing from improper socialization. As I noted above, Aristotle's example is sexually abusive behavior toward children that arises out of similar abusive treatment of the agent as a child. Such behavior is more curable than madness or illness for Aristotle, but only marginally more blameworthy. Aristotle fully recognizes the force of early habituation. He takes it to be a central responsibility of the state to ensure the installation of virtuous habits in the young.

The Contemporary Debate

Contemporary American culture is profoundly divided over the degree of responsibility the state has for inculcating virtue. And in a parallel way it is divided over the sin and sickness models. Further, the adherents of these two models are themselves divided. All of this division results in a cacophony of conflicting claims that have been reduced virtually to the level of bumper stickers. In short, confusion reigns. Not surprisingly, political and economic forces have made use of the confusion.

Consider the interesting dichotomy between two high-profile women of influence, Betty Ford and Nancy Reagan. Each in her own way has become a cultural icon of the war on drugs. Betty Ford established a famous clinic to treat addicts, having recognized her own tendencies to addiction. Nancy Reagan, on the other hand, came to be identified with the slogan "just say no." The former is premised on the sickness model and the latter on the sin model. After all, if a person has to go to a clinic, he or she is generally thought to be sick. But if it is possible to "just say no," then the behavior in question is voluntary and therefore not taken to be a sickness. For while it is possible for someone not already addicted to just say no—and indeed much of Mrs. Reagan's campaign was directed at such individuals—the slogan begs the central question when addressed to an addict.

That the culture has simultaneously assented to both these icons reveals a confusion in service to an ideology. For when we consider the economic divisions of the culture, the dichotomy is dissolved. The addicts who turn up at the Betty Ford Clinic are those with resources and social support systems typical of the most privileged segment of the population, while those who endure punishment for their addictions tend to occupy the opposite end of the socio-economic ladder. In short, wealthy addicts are considered sick while poor ones are seen as vicious. This political/economic division is in turn seemingly reinforced

by the associated behaviors of the two groups. Wealthy addicts are usually not forced by their habits to commit violent criminal acts. They can afford their addictions for a long while and are typically driven only to white-collar crime. Poor addicts, on the other hand, have daily or weekly difficulty maintaining their addictions and are thus driven to smaller scale, but often more personally threatening, criminal acts. But from these differences in behavior we should infer no inherent differences in morality or physiology. The poor heroin addict is not necessarily more vicious or weaker of will than his rich counterpart. From an Aristotelian perspective this is obvious. Yet American culture persists in the tendency to draw such moral distinctions between addictive behaviors of differently situated individuals.

This tendency is surely due in part to the influence of our collective historical denial of the class structure of American society—a structure based primarily on financial status rather than Old World ideas about aristocracy. We are, as it were, in "cultural denial" regarding the patterns of class-generated inequities that have characterized the society for generations. Such denial is manifest, for instance, in various American myths. A prominent one is that of Horatio Alger. The moral of the myth, of course, is that in America anyone who works hard enough can be rich. From this it follows that if one is not rich, then one has not worked hard enough. (This implication makes it clear why the myth is just that—a myth. America has been home to countless millions who worked hard every day of their lives and never attained real economic success.) But there is a further inference from the myth which many in the society have fallaciously drawn, viz., that anyone who is wealthy must have worked hard. Even if we took the myth to be true, this conclusion would not follow from it. But it is to this false conclusion that a crucial moral premise has been attached in our culture, namely that hard work is morally virtuous, from which, in conjunction with the premise just mentioned, it would seem to follow that the rich must be morally virtuous.

Given the latter conclusion it becomes clear how our cultural denial of class inequities can lead to moral distinctions between rich and poor addicts. The rich are, by the argument just given, naturally hard-working and virtuous. Thus they cannot be given to weakness of will and vice. The poor, on the other hand, are not assumed to be virtuous. And their failure to obtain wealth is taken to reveal an inherent lack of resolve associated with the weak willed. Thus wealthy persons who become addicted to something must be ill, since such behavior is not

natural to them, whereas the poor addict is acting out of a characteristic weakness and is easily led into sin. These differences, in turn, are taken to call for different social responses. The former deserve treatment for their illness; the latter deserve punishment for their sins.

Virtue and vice characteristic of individual *natures and nurturings.*

The contemporary cultural mix of science and religion has resulted in a hybrid American ideology that recognizes only two possible explanations of addiction. But the hybrid nature of the concept of addiction itself renders each of those explanations inadequate unless we adopt the view that the rich are naturally more virtuous than the poor. If so, then it is appropriate for science to offer remedies to the rich while leaving the poor to be dealt with by religion. But if we reject that premise and follow an Aristotelian line of reasoning, then we must conclude that virtue and vice are not characteristics of socio-economic classes, but of *individual* natures and upbringings. Individuals of all social classes are vicious, weak-willed, badly habituated and physiologically abnormal. The cause of an addiction and the nature of the possible cures, on the Aristotelian view, has nothing to do with social or economic status, but rather with moral training, rationality and environmental/hereditary luck. It matters not what socio-economic position one holds; if one is not habituated to virtuous deeds as a youth, then vice will follow. If one is not schooled in the prudential logic of long-term self-interest, then self-destructive behavior is more likely. If one is inordinately subject to passionate impulse, then even knowledge of moral truth may not prevail. And if one is a true victim of psychological or physiological disease, then all the morality and reason in the world will not suffice. Thus in Aristotle's naturalistic vision the vicious must be regarded as guilty; the weak-willed must be made strong; the badly habituated must be retrained; and the sick must be made comfortable, if not well. Aristotle's distinctions are in accord with common sense. The sin and sickness models are in accord with Judeo-Christian and scientific cultural ideologies, the first of which is grounded in large part on the assumption that one and only one ancient text contains moral wisdom, and the second on the notion that there are no ancient truths at all, save perhaps the Oath of Hippocrates. I hope I have raised genuine doubts about both these assumptions.