

## From the Editor

Welcome to another issue of the AAPP Bulletin. We continue with the format of target article, commentaries, and response by author. Carrying us forward in this issue is Louis Charland, Professor of Philosophy at Western University in Ontario with his target piece, "Consent and Capacity in the Age of the Opioid Epidemic: The Drug Dealer's Point of View."

As is apparent in the commentaries, this article has led to a wide-ranging and spirited exchange of ideas.

As is now our routine, this issue of the Bulletin will be accompanied by a target article and call for commentaries for the next Bulletin issue. Our author is Awais Aftab, M.D., from the Department of Psychiatry of Case Western Reserve University School of Medicine. For the psychiatrists among us, Awais is known for his ongoing interviews in *Psychiatric Times* of prominent figures in our field.

I begin below with my own commentary on Loii Charland's target article.

### Judging Capacity

In this reflection on Louis Charland's fine target piece, I'm relying on ideas gathered from Paul Ricoeur's *The Voluntary and the Involuntary*, and I'm focusing on Charland's notion of 'decision-making capacity'. Charland writes: "Specifically, choice theories do not address the question whether a voluntary choice, whether it is rational or irrational, is capable or not. To repeat: choice does not imply capacity, which in turn means that capacity cannot be assumed just because choice occurs." And later: "The same is true of discussions that are framed in terms of the folk psychological concept of 'free

## President's Column

Christian Perring, Ph.D.

To start my first *President's Column*, I want to thank Peter Zachar for his 4 years hard work as AAPP President. Peter did a great deal for AAPP as President. The more visible part was his work in co-organizing our annual conferences, which are at the heart of AAPP's public face. It was behind the scenes, though, that Peter did most. He revamped the AAPP bylaws and constitution, which had been largely unchanged since the start of our group in 1989, and guided more than one long AAPP Executive Council (EC) meeting through the changes and approval of them. That's work that generally does not generate much enthusiasm, but Peter's emphasis on the importance of the process kept the group focused. His experience as a department chair and a university administrator doubtlessly helped him guide us through the process.

Peter's dedication to philosophy of psychiatry and his belief in the importance of AAPP to help scholars in the field, especially those early in their careers, has been central to his work in the group. He set high standards as President which I know everyone in the EC appreciated. Peter will continue in his work for AAPP, not just serving on the EC, but also running the *Newsletter* for AAPP members, keeping us up to date on the activities of all members. AAPP is a stronger and richer entity due to Peter's continuing contributions.

In the last year those in AAPP have been deeply affected by the COVID-19 pandemic. Those teaching in universities and colleges have had classes moved online or have had to teach hybrid classes, combining online streaming with being in a classroom with students. Those working in administration have had to work with difficult decisions balancing the safety of students and employees with the mission to teach and provide students with a distinctive learning experience. Clinicians have had their work greatly disrupted, with office meetings becoming very rare, and phone or video consultations becoming the norm. Those working with hospitalized patients have had some of the most difficult experiences, bringing immediate ethical and clinical challenges.

The pandemic also affected AAPP directly. Our conference meeting on "Intuitions Meet Experiments: Methods in Philosophy of Psychiatry" planned for 2020 was postponed until 2021, and will now be held online on the weekend of April 17 & 18, through video-conferencing. We will release details of the conference very soon. The AAPP Executive Council held its meetings via Zoom rather than in person in 2020. Unquestionably, we are all yearning for a return to normality, and to be able to meet again in person, which enables better

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will'. The fact that a choice is thought to be 'free' does not in itself settle the question whether it is capable."

To discuss Charland's argument, let me introduce some ideas of Ricoeur.

The first is that notions such as voluntary, free, and capable do not stand alone. They only carry meaning when paired with their opposites. The voluntary requires the involuntary; freedom requires lack of freedom (determinism, if you will); and capacity requires lack of capacity.

Ricoeur adds further that these are not binary, either/or pairings. Rather, in each instance of their application, the individual experiences both at the same time. This is somewhat hard to grasp. How can I be both free and not free at the

## Consent and Capacity in the Age of the Opioid Epidemic:

### The Drug Dealer's Point of View

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Addiction researchers and practitioners embroiled in the Opioid Epidemic who provide opioids like methadone and buprenorphine to persons who are severely addicted to opioids, approach the issue of consent and capacity from the vantage point of improving the health interventions available to persons who are severely addicted. The flip side of this vision is drug dealers – less neutrally: ‘pushers’ – who also seek to provide opioids to persons with severe addictions to those drugs, but instead seek to exploit vulnerabilities in their clients’ decision-making capacity and both undermine and exploit their autonomy. The contrast is revealing.

Good ethnographic data on the lives of drug dealers is available (Bourgeois, 2003), although research in the area is notoriously beset with complex theoretical and ethical problems (Sandberg & Copes, 2013). It seems clear that drug dealers often view their clients as capable of making choices. However, whether or not they also consider those clients to have the requisite decision-making capacity to make those choices is much harder to discern. There is data that can be invoked to initially reflect on and hopefully eventually study this question. But some speculation and liberty of interpretation is required if we are to make any progress.

One especially rich source of evidence on how dealers interact with their clients is the “county lines” drug supply model in the United Kingdom. This is a ‘market trend’ that employs a highly mobile drug distribution system in which drug dealers travel from urban hubs to rural settings, both to sell drugs and exploit local vulnerable populations through coercion and manipulation (Moyle, 2019). Often, dealers set up ‘outposts’ in the homes

of enlisted locals after ‘cuckooing’ them to the point where “victims become imprisoned in their own homes (Spicer, Moyle, & Coomber, 2019, 9). A distinct feature of research on the “county lines” model is the ubiquitous reference to the “vulnerability” of the population that dealers seek to “exploit,” many of whom are said to be ‘dependent’ on, or ‘addicted’ to, “street heroin” or “crack” (Coomber & Moyle, 2017; Robinson, McLean, & Densley, 2019). Some researchers observe that “the notion of vulnerability may contradict life experiences in which involvement in criminality or exploitative labor may *otherwise* be understood as demonstrating a certain level of autonomy” (Moyle, 2019, 752; italics added). Yet they also maintain that “[d]ue to the lack of alternatives for sustaining daily heroin and crack repertoires in local drug markets, we might therefore anticipate drug dependent populations to continue to gravitate toward such opportunities,” and some groups “*persistently engage in county lines labor*” (752; italics added).

Severe addiction to street heroin is by no means the only vulnerability that dealers seek to exploit in the “county lines” model. But it does provide an interesting evidence base from which to extrapolate and infer what drug dealers might believe and assume about their clients’ autonomy and decision-making capacity, at least in this circumstance. What follows is admittedly speculative. However, the exercise seems worthwhile since it helps to shed light on the manner in which assumptions about vulnerability can vary in addiction research concerned with roughly the same clinical population, namely, persons who are severely addicted to opioids, in this case, street heroin.

One can surmise that, statistically, drug dealers know very well that demand for their drugs will continue to be robust – all things being equal – despite the fact they also know that many users will accidentally die as a result of overdose from those drugs. Economically, dealers bet on the assumption that new and current users will continue to buy and use drugs, even though they also know that some of

those clients cannot properly appreciate and weigh the risks and consequences of doing so. Drug dealers thus choose to view their clients as vulnerable rather than as fully autonomous. Their aim is to exploit that vulnerability for personal gain.

Dealers know from experience that, despite the fact that their clients have agency and make choices to delay or avoid drug use, many still return on a *predicable* basis anyway, because *on the whole* they lack the capacity to make informed decisions about their drug use (Sripada, 2019). Ironically, drug dealers capitalize on facts about the decision-making capacity of drug users that many addiction researchers and philosophical commentators appear determined to overlook or deny. Dealers know that: “... for some addicts, at some times, in some contexts, there appear to be compulsions that make it practically impossible for those individuals to successfully curb or control their drug use for a period of time” (L. C. Charland, 2002, 51). What is especially interesting about the dealer’s point of view in matters of consent and capacity is the insight that incapacity in addiction is not solely tied to clearly delimited momentary episodes of intoxication or withdrawal – as addiction researchers typically assume – but is really a *process* that is subject to cycles and sudden triggers and about faces. Dealers know that their clients are ambivalent and why, though they bet on their clients’ decisions to use drugs, rather than abstain from them.

### Agency, Choice, and Decision-Making Capacity

Notwithstanding the above, it must certainly be admitted that, at some level, individuals who are struggling with opioid addiction do exercise their *agency* and make a *choice* when they seek and use opioids and other drugs of abuse (Freckelton, 2002). But are they truly able to properly weigh the risks and benefits of their drug use? It is important to appreciate in this context that the fact that a particular decision, or choice, is made and agency is manifest, does not automatically entail that the choice, or decision, is capable. Capacity requires an additional justification of its own, for which there are established standardized measures, as stated above. Moreover, in this context the terms “choice” and decision” are often interchangeable, although there

exists controversy about exactly whether and how to distinguish them (Abend, 2018). Oddly, in so far as they involve clinical research on individuals with a substance dependence diagnosis, clinical studies in choice theory require that those subjects be judged to have decision-making capacity. But choice theories themselves never seem to inquire into decision-making capacity as an important research topic of its own. This is puzzling.

Choice theories of addiction are often contrasted with the medical, or ‘brain disease’ model of addiction. According to some versions of choice theory, “recovery from addiction is better predicted by a model in which addicts choose to use drugs rather than one in which they are compelled to do so by a disease” (Pickard, Ahmed, & Foddy, 2015, 1). The essential point is that “addicts respond to incentives and use drugs for reasons, and so addictive behavior must be understood as choice” (Pickard et al., 2015, 1). In other words, “addiction is not compulsive drug use, but it also is not rational drug use” (Heyman, 2013, 1). Addiction is ‘suboptimal behavior’ explainable by empirically established principles such as “the matching law, melioration, and hyperbolic discounting,” the details of which need not detain us here (Heyman, 2013, 1). Thus addiction may be destructive but it is still a matter of voluntary choice. Proponents of choice theories often argue that the medical, or disease, model of addiction should be abandoned because “it does not fit the facts” and fails to capture “what the research shows” (Heyman, 2013, 1).

Choice theories constitute an important contribution to the understanding of addiction. But the relation between such theories and the ‘medical’ model need not detain us. The relevant point is that choice theories of addiction completely overlook the concept of decision-making capacity and that choice does not in itself imply capacity. Specifically, choice theories do not address the question whether a voluntary choice, whether it is rational or irrational, is capable or not. To repeat: choice does not imply capacity, which in turn means that capacity cannot be assumed just because choice occurs. A crucial observation is that on many models of decision-making capacity, a choice may be deemed capable while

at the same time being deemed irrational, for example the refusal of life saving transfusion due to religious doctrinal reasons and values (Louis C. Charland, 2001). This kind of distinction seems impossible to make in choice theories, where the relationship between choice, informed consent, and decision-making capacity remains obscure.

So, while ‘addicts’ obviously manifest *agency* and make *choices* in their quest to seek and use drugs, this does not in itself settle the question of whether they have the *decision-making capacity* to do so. Decision-making capacity is a further determination (L.C. Charland, 2012, 50-51). This is perhaps one of the most important areas of misunderstanding in the ethics of addiction research, much of which is written as if the concept of decision-making capacity did not exist as a distinct research topic. The same is true of discussions that are framed in terms of the folk psychological concept of ‘free will’ (Baumeister, 2017). The fact that a choice is thought to be ‘free’ does not in itself settle the question whether it is capable. Appropriate studies must be conducted (Racine & Barned, 2019).

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## 2021 AAPP Annual Conference

### *Intuitions Meet Experiments: Methods in Philosophy of Psychiatry*

April 17-18, 2021  
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To register for the conference and get a link for Zoom, go to

<https://aapp.press.jhu.edu/meetings>

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## Choice, Compulsion, and Capacity in Addiction

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In his exploration of decision-making capacity (DMC) and addiction, Charland points out that 'choice does not imply capacity' and notes the absence of DMC within ethical and empirical work on 'choice theory' and addiction. He presents addiction as a condition in which impairment of DMC is 'a process that is subject to cycles and sudden triggers and about faces', and endorses the view that addiction does, in certain contexts, involve 'compulsion' and a lack of ability for making autonomous decisions. While his position may be considered controversial, the phenomenon of fluctuating and cyclical impairment of DMC within other mental health conditions is well noted - so why not addiction? Moreover, these ideas are not part of some abstruse ethical debate, but integrally linked to the potential harms associated with addiction. In this regard, Charland makes a very plausible observation. While ethicists argue that addicts have choice and dismiss medical models of addiction incorporating compulsion, drug dealers seem to flourish through assuming and exploiting impairments of DMC associated with addictive disorders.

Charland's view that 'choice does not imply capacity' is instantiated within mental capacity laws, according to which a conscious and deliberated decision may not be truly informed and autonomous. This possibility remains, despite apparent 'rationality' and even while DMC in relation to other matters might be retained. Equally, capacity law maintains that an 'unwise' decision must not, in itself, be seen as indicative of impaired DMC. In relation to mental health conditions, considerable debate and controversy surrounds the difficulties of differentiating between a capacious decision

judged to be 'unwise' and a non-capacious decision. Addiction, even if less frequently discussed within a DMC framework, may very well be a context where such controversies are most pronounced - an idea of impaired DMC might seem pertinent to an opioid addict, when mortal risk and loss of control appear evident, but implausible for the nicotine addict, lighting a cigarette despite awareness of the long-term risks.

Despite such difficulties, the issue of whether addiction involves impaired DMC has major significance for medicine, both from a clinical and ethical perspective, and for Law. New Zealand's Substance Addiction (Compulsory Assessment and Treatment) Act 2017 has already introduced DMC-based statutory provision for involuntary treatment of addiction, while DMC is also central to current discussions surrounding precommitment to treatment for opioid addiction (1). Addiction to substances which are legally or illegally obtained brings a vast global burden of disease (2). In the USA in 2018, for example, 'an average of 185 people died from a drug overdose' every day and 'recent declines in U.S. life expectancy are being attributed to direct and indirect effects of alcohol and drug use disorders'(3). New strategies to combat addiction are being established, both medical and psychosocial (4). If impaired DMC is a feature of severe addiction, understanding this impairment may play an important part in developing new strategies.

### The need for a 'medical model' of addiction.

Charland points out that advocates of 'choice theories' usually reject a 'medical model' of addiction but does not explore this point in detail. Nevertheless, the 'causative nexus' of capacity law involves a 'diagnostic criterion'. This renders judgement of impaired DMC contingent on the impairment of functional decision-making abilities being caused by a diagnosed medical condition (5). Recognition of addiction as a medical condition is therefore central to establishing impairment of DMC and my aim here is to complement Charland's piece by offering some re-

flections on why rejecting a medical model (3,4,6,7) may be misguided.

What, then, constitute key reasons for rejecting a ‘medical’ or ‘disease’ model of addiction within ‘choice theories’? First, there is the assumption that psychological factors and a medical model are mutually exclusive. Pickard, for example, writes ‘Treating addiction as neurobiological disease characterised by compulsive drug use bars understanding of the psychological reasons why addicts use drugs and alcohol’ (8). Yet medical models and research into addiction are very much biopsychosocial, integrating and recognising the impact of environmental and psychological factors, such as ‘adverse social environmental exposures’ and ‘traumatic life experiences’ alongside the biological (3,4,6,7).

Choice theorists also argue that there is insufficient evidence to support a medical model, despite an extensive and growing evidence base supporting biomedical elements of addiction and the effectiveness of many medical treatments (4,9). Pickard argues that we have inadequate knowledge of the brain to support a ‘disease label’ (10), even though similar arguments could be applied to multiple psychiatric and neurological conditions, where our ignorance as to how both disease and treatment affect the brain far outweighs existing knowledge. Heyman even bizarrely attempts to refute the notion of addiction as a chronic medical condition by claiming that most addicts quit substance abuse by the age of 30 and do so ‘without professional help’ (11), despite the massive death toll associated with addiction across all ages and an international body of evidence about the devastating consequences of addiction amongst older adults (12-14).

In Volkow’s insightful exploration of why a ‘brain disease’ model of addiction might engender such controversy she suggests that the key difficulties might lie ‘in accepting as a bona fide disease one that erodes the neuronal circuits that enable us to exert free-will’ (9). ‘Choice the-

ories’ rejecting the medical model seem to involve a ‘weakness of will’ or *akrasia*-type model, in which the addict engages in a rational and capacious process of weighing up long-term practical and moral advantages against immediate gratification – Aristotle says ‘the akratic acts on account of passion, even though he knows it is wrong’ (NE 1145b13). Heyman, for example, writes ‘the correlates of quitting are the practical and moral concerns that affect all major decisions. They are not the correlates of recovery from the diseases addiction is said to be like, such as Alzheimer’s, schizophrenia, diabetes, heart disease, cancer’ (11).

Essentially, choice theories seem to depend on a view that addicts have the power to control their addiction by taking responsibility for their actions and the consequences, and also often incorporate misconceptions about pleasure and gains within severe addiction (3). Medical models are presented as incompatible with views such as Pickard’s ‘responsibility without blame’ choice-based understanding of addiction, which is based on the notion that ‘Framing addiction as a neurobiological disease of compulsion removes responsibility by explaining drug use as compelled by pathological brain states’ (10). However, rather than precluding responsibility, viewing severe addiction as a pathological condition with the power to impair DMC and engender compulsion could facilitate ‘responsibility’. The New Zealand laws, for example, are based on a principle that medical treatment for substance abuse can help restore an individual’s DMC and ‘give them an opportunity to engage in voluntary treatment’.

Treatment and recovery for chronic addiction involve a lasting process of self-managing factors such as psychological and environmental risks, dealing with damage which has ensued from addictive behaviours and finding ways to keep cravings under control. This is fully compatible with seeing biomedical treatments as a means by which an individual might overcome or contain compulsion to reach a point where they are

able to engage with these processes. Ironically, it may well be the view that illness and responsibility are mutually exclusive in relation to addiction which contributes significantly to perpetuating stigmas preventing addicts from receiving the medical treatments which facilitate DMC and the possibility of responsibility (3).

As with other mental health conditions, it seems highly plausible that, with severe addictions, there may be times when a conscious decision or choice does not imply autonomy and could be viewed as ‘compulsion’. This does not mean that this state of impaired DMC would be seen as continuous or permanent within contemporary medical models of addiction – to deny an individual’s ability for autonomy or taking responsibility for their actions at any point would take us back to dark times of attaching permanent labels of incapacity to those diagnosed with mental health conditions.

Even if a choice-based rejection of addiction as a medical condition involving compulsion may fit more instinctively with common views of desire and decision-making, there are, as Charland argues, many reasons to question this view and to support his own view that ‘choice does not imply capacity’. He suggests that, in ongoing endeavours to understand and manage addiction, the question of how compulsion might manifest itself within decision-making must surely be an important consideration. As the significance of DMC within medico-legal frameworks and practice in mental health increases, it seems justified for Charland to claim that there is a need to engage with this issue of DMC and addiction, and its broader implications, despite the considerable difficulties and controversies involved.

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### Compulsion, Competence and Therapeutics in Addiction

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In “Consent and Capacity in the Age of the Opioid Epidemic: The Drug Dealer’s Point of View”, Louis Charland draws evidence from the drug dealer’s point of view that the capacity to make competent decisions regarding substance use is impaired in those suffering from addiction. I would like to follow Charland in his exploration of how the psychopathology of addiction can impair competent decision making in order to inform therapeutic intervention in compulsive substance use. Competent decisions must be voluntary and not coerced. There is a profound sense of a loss of voluntariness that informs what it means to suffer from a compulsion to use substances. But the internalized form of coercion found in compulsive addictive behavior challenges ordinary conceptions of what it means to do something voluntarily. In the absence of an impaired level of consciousness associated with acute intoxication or withdrawal, or a gross cognitive deficit associated with secondary pathology from long term use, it appears that many of the capacities required for competent decision making remain intact in addiction. As Charland notes people with addiction demonstrate agency,

make decisions, and in some sense “voluntarily” make choices about their substance use. Despite the presence of these abilities, Charland argues that *capacity* is impaired in important ways in addiction. Charland is using the term capacity here in a technical sense that is akin to the meaning of competence as in “competence to consent”.

Charland explored elsewhere (Charland 2002) how addiction to heroin impacts four requisite capacities for competent decision making. These four capacities form the conceptual backbone of the MacArthur Competence Assessment Tool (Grisso and Applebaum 1998), a tool that is used clinically to demonstrate competence to consent. Charland found that in heroin addiction the requisite capacities to understand a choice, appreciate a choice and communicate a choice may remain intact. While those three capacities are necessary for a competent decision to use a substance, by themselves they are insufficient. There is a further requisite capacity to rationally manipulate information and Charland found this capacity to be undermined in addiction to heroin. But, even in the instance of heroin addiction, a snapshot view could deceptively give the appearance of an intact ability to reason over risks and benefits. Someone suffering from addiction may make a perfectly rational “decision” to stop using based on readily understandable reasons. The impairment lies in an ambivalence that is only revealed over time, when those rational “decisions to stop use” are undermined by difficult to resist cravings. There is a sense in which the voluntariness of the decision to use has been undermined by an “internal” form of coercion, unwanted and involuntary cravings.

The seemingly unrepentant and unconflicted substance user, (channel the specter of Charles Bukowski), presents different challenges to the notion of a competent decision to use. Here there is no using more of a substance than intended because the intent was to use as much as possible. Here there is no unsuccessful effort to cut down because there is no effort to cut down. The ambivalent and seemingly akratic decisions to use that are found in a person who is conflicted about their substance use are absent. With evidence of permanent neurological changes in the brain associated with long term substance use, Charland (2002) asserts that the brain of the addict has been

“hijacked”. The metaphor of hijacking implies coercion and a loss of voluntariness. The “reasons” given for unrepentant use are possibly better regarded as “rationalizations” in the service of a coercive form of addiction. Competence to consent does not entail having the “right values”, but I agree there is certainly plenty of room for skepticism that a person can authentically value getting high over all other things in life including physical well-being, relationships, and work. Clinically, making decisions that seem self-detrimental should raise our index of suspicion that the competence to make decisions may have been compromised. I think Charland has argued persuasively (Charland 2002) that active addiction renders people sufficiently vulnerable such that competence to consent to using a substance to which they are addicted in a research setting should not be assumed. Safeguards of substitute judgement may be warranted to guard against the possibility of exploitation.

The substance of Charland’s arguments about capacity is grounded by an understanding of the compulsive nature of substance use in addiction. I would like to further examine the meaning of compulsion in the context of addiction with a view toward therapeutics. Therapeutically, it is important to keep the tension between the voluntary and involuntary aspects of substance use in full view. It is important to avoid all or nothing thinking regarding compulsion such that urges to use in the addict are regarded as either “irresistible” or endorsed as a matter of completely free choice. I see Cynthia’s assertion in Charland’s (2002) article that someone with an addiction to heroin, by definition, cannot say no to using heroin as a counter-productive example of rhetoric that feeds such all or nothing thinking. Such an assertion taken literally would render recovery from addiction logically impossible. Elsewhere, Charland (2012, p.51) has noted the need for more nuance in thinking about compulsion, “In some cases, at some times, the personal circumstances of addiction may be such that it is practically impossible for that individual to curb or control his or her drug use. The compulsion to use is effectively irresistible. Yet in other cases, at other times, circumstances may be such that addicts can successfully curb or con-

trol their drug use. It all depends on the addict and his or her circumstances. Therefore, this is not a dichotomy where compulsion is always, necessarily, either completely irresistible or not.” Motivational interviewing (DiClemente, et al 1999) in the treatment of addiction forms an interesting counterpoint to dichotomous thinking about compulsion. Motivational interviewing entails recognizing the voluntary aspect of addictive behavior and directly engaging the substance user’s agency and ability to reason about their substance use. Engaging the user’s agency is not a denial of the compulsive nature of addiction. It is understood that marshaling motivation is important exactly because it is so difficult to combat the compulsive urge to use in addiction. Motivational interviewing regards the non-conflicted user who has no ambivalence about their substance use to be at a “prereflective” stage with the assumption that reflection will create ambivalence and counter-motivations to substance use. For motivational interviewing someone making efforts to change their addictive behavior is at a further stage along the path to recovery than someone who is not conflicted about their problematic substance use. It is an irony of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) that it regards people who are conflicted and ambivalent about their substance use as potentially more severely disordered than those who have no such conflicts. Because “unsuccessful efforts to cut down” and “using more than intended” are both symptoms of a substance use disorder, and for the DSM-5 the more symptoms the more severely disordered, then someone who is not making any effort to cut down will, by definition, have fewer symptoms and potentially be diagnosed as less severely disordered.

Charland self-consciously eschews the debate over a “medical disease” model of addiction, but there is a danger that linking assertions about total loss of control to permanent changes in neurocircuitry in the brain can feed into counterproductive forms of “neuroessentialism” (Porter, 2020). The view that addiction is *essentially* a brain disease can serve to marginalize the importance of psy-

chosocial factors involved in the development of addiction and in achieving recovery from addiction. It is possible to steer a middle path where evidence of neurological changes in the brain in addiction is understood to provide further evidence of why addictive urges are exceedingly difficult to resist rather than impossible to resist (Berridge & Holton, 2017). Such a view is in a better position to increase empathy for the plight of those who suffer from addiction, and to underscore the importance of psychosocial factors in achieving recovery from addiction. As Charland (2012) noted, a change in circumstances can impact just how irresistible someone with addiction finds an urge to use. Even if abstinence cannot be achieved, the harms associated with substance use may be exacerbated by certain kinds of social policy such as criminalization or mitigated through other policies such as the availability of clean needles, maintenance treatment, etc. In Charland’s article, the vulnerability of addicted populations to exploitation by criminal forces was directly tied to a “lack of alternatives “and “all things being equal”. Therapeutically it is important to not keep things equal. It is important to create alternatives and opportunities where the voluntary aspects of substance use can be engaged in order to achieve abstinence or, if abstinence cannot be achieved, to at least reduce the harms associated with substance use.

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## What Dealers Know and Others Don't?

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'Addicts' cannot not do (or have great difficulty doing) something that most other people have the capacity to do, namely, abstain from (or pursue in moderation) certain activities. When these activities, from which a person cannot abstain, are more or less continual and impede the realization of other, important, agential projects, such persons are prone to be judged disordered and to suffer an 'addiction.' The various recurring transformations of the organismic foundations (including psychological and social foundations) of action that gives rise to or follow from addictive practices may be relatively clear or obscure.

Put another way, a person who is 'addicted' has a diminished capacity as an agent to decide, on the basis of knowledge and choice, whether to pursue some activity - like work, or physical fitness, or the consumption of opioids and other substances, e.g., alcohol. He or she *must, has to*, is *compelled by desire*, to do it. And with diminished capacity to decide may come diminished responsibility for one's activities. So, it is not surprising that puzzles - empirical, ethical, legal, and social, as well as clinical, arise when someone is addicted in ways that are disabling and harmful. One set of puzzles concern how diminished capacity, or incapacity, is to be identified, explained, understood, and addressed by the addict, by those who seek to aid him, and by those con-

cerned to investigate this sort of disordered and disordering condition of a person as agent.

This is the setting for the two assertions revealed in Professor Charland's essay.

First:

Drug dealers sell, even recognize, that they can sell opioids for profit to addicts by exploiting, in timely ways, their diminished decision-making capacity with regard for the consumption of opioids. Dealers know that the addict's incapacity is not limited to "momentary episodes of intoxication or withdrawal - as addiction researches typically assume - but is a process subject to cycles, sudden triggers," and "ambivalence." In short, dealers know their clients and "bet" that they will, sooner or later, again seek what they cannot not desire. They also know the addicted person's capacity to abstain from the use of drugs is variable.

The informal knowledge of the drug dealer of the addict's diminished agential capacity, as manifested in the intensity of his or her desire for the drug and the lack of ability to abstain from their recurrent use, is essential to the fulfilment of the dealer's desires to profit from a sale.

I observe that this general formula for profitable relations of exchange is well known by auto dealers, real estate dealers, indeed, by dealers and merchants of all kinds throughout history. Find out what the customer desires and/or fears. Therein may lie a vulnerability - a potentially diminished ability of the potential buyer to access his or her full range of his agential powers or capacities - a vulnerability which the dealer can exploit in the quest to secure a profit.

Second:

Contentions about drug dealers serve to usher in a short discussion of "choice theories of addiction" which hold that, while addiction may be destructive, addiction is still a matter of voluntary choice and therefore the "medical or disease model of addiction" should be abandoned.

Rather than contend with this assertion, Charland turns attention to the thesis that 'choice' does not imply the *capacity* to choose. Nor does the

capacity to choose turn on whether the choice is deemed 'rational' or 'irrational.' In the clinical setting, even when a choice is deemed 'irrational,' e.g., for refusing life-saving treatments, a person may be deemed to have the agential capacity to choose or decide for himself, even if the choice results in death. (Otherwise, failure to conform to a norm for a rational decision would be sufficient evidence of a lack of capacity to decide.)

He contends that while the addict displays agency when she chooses to buy and take drugs does not imply "*decision-making capacity* to do so." That a choice is 'free' does not settle the question whether the choice is a capable. In choice theory the relationship of choice, informed consent, and decision-making capacity is obscure.

The author also claims that the ethics of addiction research is written as if the concept of capacity or capability of a person as agent to decide or consent did not exist. I find this contention implausible.

He concludes that more research needs to be done though he does not tell us what research needs to be done or why.

Here is a quick sketch of one sort of research:

If the addict is 'free' of coercion and so voluntarily 'decides' to acquire and take opioids which harm him and others, then, in some sense or senses, compared with others, he has *some* capacity to act for acquiring and taking attests to that capacity. Otherwise 'acquiring' and 'taking' are simply events - like reflexes - human, organismic activities that do not reveal or express in any sense the authorship of the person as an agent.

But when, at the same time the persons as 'addict' cannot, in some sense, choose *not* to acquire or take opioids when compared with others or prior iterations of himself, his capacity to act is correctly understood as 'diminished' yet not absent. This highly variable state of affairs is one of the conundrums that makes compelling general claims about the treatment of addicts, research about addiction, and the struggles by the addict to be free of addiction so messy and difficult - for all concerned.

In sum:



If dealers know the import of diminished agential capacity for their work, why don't students of ethics and investigators concerned with the better ways to aid persons with addictions? Perhaps they do. If not, Charland's short paper will remind them.

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## Addiction and Free Will

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Anyone who has treated drug addicts will have had the experience of working with an intelligent, well-informed patient, who fully understands the destructive influence of his drug use, and has a strong well-formed motivation for abstinence, who nevertheless goes back to using drugs (the use of the term "relapse" begs the question of the medicalized view of drug abuse) within weeks of leaving the protected environment. Philosophers have puzzled over this disconnection between reason and action at least since Plato, and continuing through the work of contemporary philosopher Harry Frankfurt.

Akrasia (usually rendered as "incontinence") is the philosophical term for acting against one's better judgment. In Plato's *Protagoras*, Socrates takes the position that true akrasia is impossible, since if one truly understands a situation, one will act in the right way. Acting in ways that are harmful, or against one's stated intentions, must reflect partial or inadequate knowledge.

Aristotle, in *Nicomachean Ethics*, takes an opposing view, allowing that the conflict between appetite and reason can lead to akratic behavior. Although he distinguishes between two types of akrasia (weakness, and impetuosity), weakness seems most relevant to the case of the addict. Aristotle distinguishes between theoretical and practical knowledge. In the case of the addict, while his theoretical knowledge may be complete, his practical knowledge is not adequate to the task of dealing with his appetite. Perhaps Aristotle did not fully appreciate the autonomous strength of some appetites.

The appetite for a delicious cookie when one is on a diet is of a different order of magnitude from the drive for an opiate when one is physiologically addicted to it.

Akrasia has been a subject of debate for contemporary philosophers. Donald Davidson has been central in this discussion, but I will focus on Harry Frankfurt's contribution in "Freedom of the will and the concept of a person".

Frankfurt usefully distinguishes between first order desire, second order desire, and will. First order desire is the desire to X. Second order desire is to desire to desire X (i.e., desiring X', where X' = a desire). And, crucially, will is an effective desire (of either first or second order). That is, not all desires result in the desired action, for a variety of possible reasons. A desire qualifies as will only when it leads to the desired action. Further, when one desires a desire to be one's will, that second order desire is what he calls "second order volition". For Frankfurt, it is the existence of second order volitions that makes a person truly a person. An entity without second order volitions is a "wanton".

Frankfurt clarifies these distinctions with an example. A researcher might want to know what it feels like to be a drug addict. He would desire (second order desire) to feel the desire for drugs (first order desire) but would not really want that first order desire to result in using drugs. The first order desire is not his will, and the second order desire is not a volition.

The genuine person, in Frankfurt's terms, is guided by volition. This may or may not be effective—that is not required for personhood—but when it is not, the person is aware of acting not through his own volition. And this is the sense in which an addict may be said to be acting not of his own free will. If the volition (second order desire that the first order desire be effective) is itself effective, then the volition is his will.

As Frankfurt says, when the will (that is, effective first order desire) is in conformity with the volition (that is, a second order desire of a will) that constitutes freedom of the will. When there is discordance between the volition and the will, that is felt as the lack of freedom of the will. It

might be said that freedom of the will just is the existence of second order will, since if the second order volition is effective (implying that the first order desire is effective) than the addict's behavior will be in conformity with his second order (and first order) desires for abstinence. For instance, an addict who desires to be abstinent (i.e. desires that his first order desire to be abstinent should be effective) but nevertheless is not abstinent, is not exercising freedom of the will. That is to say, his volition is not his will. He may be exercising freedom (in the sense that he is free to enact his will, his first order desire) but not freedom of the will. In contrast, the wanton addict, who does not have a volition to abstinence, is neither free nor not free—the category does not apply to him. Freedom of the will enters the picture only at the second level of desire. Developing a volition to abstinence would be a developmental step for the wanton addict, a step towards personhood. As Frankfurt says, "The enjoyment of freedom comes easily to some. Others must struggle to achieve it."

Frankfurt's formalism throws light on the relationship between addiction and akrasia. By introducing the distinction between first and second order desires, he makes it clear that an addict can be free, but not exercising his own free will, which is the akratic's situation. Combining a full appreciation of the power of the "appetite" (i.e. the physiologic addiction), the distinction between theoretical and practical knowledge, and the distinction between first and second order desires gives a complex, and powerful, way of viewing the addict's choice.

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## The Point of View of People Who Use Drugs

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I would like to take aim at what I consider to be the strengths of Louis Charland's *Consent and Capacity in the Age of the Opioid Epidemic: The Drug Dealer's Point of View*. It is a timely piece of writing, not just because of the subject matter, but also for what I think it wants to draw our attention to, namely the decision-making capacity, diminished or lack thereof, of people who use drugs.

In the summer of 2020, the provincial government of British Columbia proposed Bill 22 which would allow for the involuntary admission of youth into hospital after an overdose for up to seven days, or until it has been judged that their decision-making capacity has been restored. Involuntary admission, of course, means that physical restraints may be used in order to keep an individual in hospital. The government has since put a hold on the legislative change after criticism, particularly from Indigenous communities, who have been disproportionately affected by the destructive and dangerous provincial and national policies relating to illicit drug use. However, provincial premier John Horgan has also mused publicly at year end about the legislation's return. Conspicuously absent in both professor Charland's piece and the province's legislation are the voices of people who use drugs. Certainly our research and legislation should be composed with the interests of people who use drugs in mind, if not in substance, that is by including people who use drugs in the design of research and legislation. If we do not collaborate with people who use drugs, we will continue the mistakes of paternalistic medicine and drug policy in making decisions about people who use drugs without people who use drugs; and, in the process deny them capable decisions. Matthew Bonn of the Canadian Association of People Who Use Drugs is a self-identified drug user and has contributed to a number of academic papers and reviews, as one such example.

In the midst of daily and mounting deaths what demands our attention is not the decision-making capacity of people who use drugs, but what may be done immediately to save the lives of

more people. Charland is correct to focus on people who use drugs with respect to drug use, but he is off the mark, like the government of British Columbia, in focusing on the decision-making capacity of people who use drugs. Just as with his 2002 paper, "Cynthia's dilemma: consenting to heroin prescription," which I read as an undergraduate, Charland frames his current inquiry as *he* sees the problem for people who use drugs. We are told that the title of the earlier paper is an honorific for Cynthia, whom he identifies as being in recovery. But, we are given little more information about her, other than she was at a local clinic and she shares an opinion of heroin prescription that arguably supports, or helps form Charland's own position. Isn't it high time that we include people who use drugs more often in the actual writing of our papers, rather than just as an honorific, or as an object of study? What appropriate studies do people who use drugs think should take place? What do people who use drugs think should be examined in the ethics of addiction research? Why not ask someone who uses drugs?

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### Masks and Persons

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Louis Charland focuses on opioid addiction from a peculiar perspective: the "pusher" 's point of view. The question he poses is about the moral difference between purchasing (and selling) opioid within the scope of an Opioid Substitution Therapy (OST) and the same actions performed within the drug market. In both cases – he argues – to establish the moral autonomy of the addicted subject is a conundrum: addicted people are simultaneously and incongruously both autonomous and non-autonomous because they are at once capable for making choices and unable for taking the

best decision for themselves. Charland compares the two main theoretical approaches to this paradoxical situation, choice theory and the medical model; he argues that both fail to capture something important, say, the gap between capacity for making choices, and decision-making capacity to do so.

In Italy, a similar argument was used in a famous case by the Court of Appeals in Bologna, which acquitted Vincenzo Muccioli, the founder and leader of the drug rehabilitation community of San Patrignano. In 1983 Mr. Muccioli had been sentenced to 20 months in prison during the so-called "process of chains", in which the prosecution demonstrated that he chained some "guests" of the community who attempted to escape. The Court rejected Muccioli's defense based on the argument that addicted people, entrusting themselves to him, gave him the power to resort to any means (including extreme coercive measures) to prevent them relapsing. Yet, in 1987, the Court of Appeals acquitted Muccioli, arguing that addicts conserve their capacity for making choices, but they lack full decision-making capacity; it is thus justified to apply to them a voluntary involuntary treatment scheme, including extreme coercive measures when they were accepted in advance (i.e., Ulysses contract).<sup>i</sup>

The idea that one of the main ethical issues in drug addiction concerns autonomy and decision-making capacity is commonsensical. Notoriously, the English term "addiction" comes from the Latin *addictio*, verbal noun of the past-participle of the verb *addicere* (1)<sup>ii</sup>. In early Roman law, *addictio* was the assent of the judicial magistrate to the action of an actor (claimant or accuser). The passive form *addictus* meant the insolvent debtor who fell into the hands of his creditor, following the formal assignment (*addictio*) of the magistrate. According to the archaic Roman law, "the creditor had the right to keep the debtor in chains in his private prison and after sixty days within which anyone could pay off the debt and redeem it; he could sell him as a slave outside the city or even kill him" (2). In everyday language in ancient Rome, the

*addictus* was thus someone reduced to slavery. We are used to consider lack of freedom to be one of the main features of slavery<sup>iii</sup>, so we transfer this feature from the slave to the drug user, who is metaphorically imagined to be “enslaved to a substance”. As enslaved to a substance, s/he would not be totally free, and her/his decision-making capacity would be impaired. That seems to be a good point, except that if one had asked a Roman what was the main feature of a *servus* (slave), he would have provided a quite different answer: to a Roman, the slave was not chiefly someone who had lost his liberty rather someone who had lost his public identity and social role.

Once, a Roman citizen was reduced to the status of slave, first he lost his name receiving the master name plus the suffix *-por*<sup>iv</sup> (e.g., *Paulus-por* would have been the name of a Paul’s slave). Losing the name was an event full of legal, civil, and religious meanings and practical consequences. A nameless individual was downgraded to a non-public existence, he became a private individual like minors and women; the slave lost his civil and political right, and he was no longer considered a *persona*. *Persona* – the Latin term for person – meant “mask”, so to Romans the slave was a “maskless” individual; likewise, ancient Greeks called the “mask” the *prosopon*, and slaves were “*a-prosopon*”, individuals without “*prosopon*”. There comes a point hard for our modern sensibility: metaphorically speaking, wearing a mask means today to hide something, to be disguised, false, and it is thus considered an undesirable personal trait<sup>v</sup>; in classic antiquity, it was the opposite, being “maskless” was a negative condition. The mask was not a metaphor for insincerity rather it was considered a sign of the complexity and depth of human spirit. “*Everything deep loves a mask*”, wrote Friedrich Nietzsche, repeating twenty-five centuries later, Heraclitus’ words, “*The lord whose is the oracle at Delphi neither utters nor hides his meaning, but shows it by a sign*”.

The positive symbolic significance of masks is revealed also by their etymology. In classic antiquity, the terms

for masks were not generated from “real life” notions, say, Greeks and Romans did not use words describing persons and faces also to describe characters and masks, but the other way around. The Latin *persona* and the Greek *prosopon* meant primarily mask<sup>vi</sup>, only successively these terms acquired respectively the meanings of person (*persona*) and face (*prosopon*). Greeks and Romans first “invented” the words for theater, then they used these terms also to indicate social roles, persons, and human visages as though words coming from theater were primordial in comparison with their usage in standard life. Greek and Roman actors wore masks during the whole representation, chiefly because of ritual reasons, there were, however, also practical justifications. Practically speaking, actors needed to make themselves recognizable in large amphitheaters, which might host more than 1,000 people, and to amplify their voices outdoor: masks could work well enough for both purposes. This is echoed in etymologies: *prosopon* means “before one’s eye”, while *persona* means “augmented voice”. Being before one’s eye and uttering with an audible voice are two main functions not only of masks but of the whole face region. In primates and notably in humans, faces are vital communication tools through mimic expressions (also involving eyes, eyebrows, mouth) and the emission of sounds and voice. Faces as well as masks are languages. As all languages, they both evoke the tension between presence and reference, appearance and representation, sign and object.<sup>vii</sup> Greeks and Romans were not fond of the modern distinction between true faces and masks (3). They rather considered the “expressive presence” of an individual, which can manifest itself both on theater and on life stage.

In antiquity, slaves were thus maskless, “faceless”, people say, actors without any longer a character, missing people. Ultimately, they were people stripped from their social identity and dignity,<sup>viii</sup> reduced to “bare faces” (“bare body” would say Giorgio Agamben), hardly human

faces, almost animal’s snouts. It is difficult to escape the impression that such a definition could easily apply also to addicts, at least heroin addicts. Addicts are indeed very often characterised by their almost unidimensional profile. Their life is downgraded to a less-than-public condition; even if they do not formally lose their civil and political rights (unless they are sentenced), they hardly exercise them; when they try to keep their social status, their dignity is, however, seriously impaired. Once, one is addict s/he loses his/her social masks (identities and roles) or, at least, these identities became very fragile and shaky; addicts tend to “play” only, or chiefly, the addict character, which becomes predominant in almost all manifestations of life. Their whole life revolves around the substance, they don’t think almost of other. They are enslaved to the substance, but did the substance strip them from their autonomy or rather from their masks? Is autonomy the actual issue with addicts or is it rather their one-dimension existence, their being actors without a character but the stereotyped “addict character”? Their decision-making capacity might be impaired not because they are less capable for autonomy (e.g., because of the pharmacological effect of the addictive substance) but because they lost most facets of their original personality, narrowing down their existential horizon, and dramatically impairing their spectrum of choices. At this point a second question could arise: is craving for the substance the cause or the consequence of their “spiritual misery”? In other words, did they try through the substance to fill the boundless void they feel inside, or was the substance to bring desolation into their soul and mind? It is out of the scope and possibility of this article to answer this question, there is, however, at least an objection to my argument which deserves to be addressed.

I am aware that my appeal to the Greek-Roman definition of slavery could be seen as a mere rhetorical expedient, which does not change the terms of the problem. There are two main answers to this objection; I will briefly outline them.

My first answer is that the identity between masks and faces, characters and persons, was hardly perceived, historically speaking, as a mere literary trope. In classic antiquity, it was rooted in the religious dimension of theater, which was considered a way of representing and capturing the mysterious sense of life (4). Classic world perceived life and theater as cut from the same cloth. It is well known the Nietzschean interpretation on the birth of the tragedy: theater would be the “secularization”<sup>xix</sup> of an early religious ceremony in honor of Dionysus. My hypothesis is, instead, that the drive to theater is co-original to humanization processes, prior any other drive or instinct. To me human beings are “theatrical” in their inner cultural, psychological, and neurological constitution; pace Sigmund Freud, I argue that the “theatrical drive” is likely to be more primordial than even any sexual drive.<sup>x</sup>

To be sure, through centuries, the original Greek “dramaturgic theology” gradually softened and partly turned into a literary trope, becoming already clichéd in late Latin literature (5). Then, the metaphor survived as a theological parable,<sup>xi</sup> to revive in the Renaissance and Baroque periods, when this notion became a cosmological and anthropological concept (6).<sup>xii</sup> The image of the world as a stage was understood by the Renaissance as a metaphor which spoke of the frail, contingent, illusory, nature of human life, destined to dissolve and fade away, like plays and dreams, “and our little life is rounded with a sleep” (The Tempest, Act 4 Scene 1).

The figure of the *Theatrum Mundi*, the theater of the world, gained again momentum in late XIX century, with French social scientist, Gabriel Tarde, who suggested that imitation and representation were vital psychological and societal functions (Tarde, 1890). In XX century, this model was revisited by two prominent American social scientists, Kenneth Duvall Burke, and Erving Goffman. Literary theorist, poet, and essayist, Burke (1897 –1993) argued that theater was the true matrix of human society, say, theater comes before, and informs, society. To Burke, narra-

tive is much more than a way to create meanings through stories; it is the real matrix of our life, the “equipment for living” (7). This makes Burke much closer to Greeks than Goffman (1922-82), who argued instead that human society can be interpreted as though it were theater, but he was quite far from thinking that it was in fact theater. The idea that theatrical representation and imitation are inescapable elements of individual and collective life is central to many contemporary and post-modern philosophers (8) (9). Guy Louis Debord (1931 –1994) (10) introduced the notion of *simulacrum*, an inextricable mix of reality and representation. Later scholars, such as Jean Baudrillard, Gilles Deleuze, Jacques Derrida, built on Debord’s theory. Gilles Deleuze and Félix Guattari rediscovered Tarde (11) and influential French philosopher and historian, René Girard (12), formed an original theory based on imitation (*mimesis*). In the while, also neuroscience rediscovered the theater model, initially thanks to the idea of modularity of the mind. Minsky, Dennett, Gazzaniga, Metzinger, Wilson, and others shared the theory that human brain would be a society of systems (agents) that compete for the control of behavior in the absence of a central processor (13).<sup>xiii</sup> These agents could be conceptualised as an iridescent complex of characters, which play their “roles” on the stage of the mind (14), being kept mutually consistent (when things are going well) by a unifying narrative, the “self”. At the present, the field of performance and cognitive studies is rapidly growing. There are two book series specialising in publishing monographs in performance and cognitive studies, an annual international conference regularly convened, many monographs published, and a companion book published by Routledge in 2019 (15). Eventually, the discovery of a class of neurons called “mirror neurons,” which are activated both when individuals act and when they observe the same action performed by other individuals, shows that higher animals possess a biological system for

“imitating and playing” (16). The system of mirror neurons constitutes the neuronal correlate of “embodied simulation”. In the embodied simulation there is no inference or introspection, but an automatic reproduction of the mental states of the other: the intentions of the other are directly understood because they are “embodied”, shared at the neural level. Since birth embodied simulation is a basic characteristic of the brain, newborns are already able to imitate the movements of the mouth and face of babies just a few hours after birth (17). Humans have developed such a capacity to its highest degree, and this is likely to be one of the main evolutionary advantages of our species (Gallese 2009). Philosophy, social sciences, and neuroscience thus converge to indicate that there is a real possibility of a biunivocal correspondence between mental and theater schemes and representations, considering “representation” in the full spectrum of meanings of 1) symbolization; 2) enaction; 3) performance; 4) interpretation; 5) account. Greek and Roman civilizations captured very well such a non-metaphorical reality of the theater model, expressing it through their language, which was chiefly a religious and mythological language. It is now up to us to express the same concepts in contemporary terms (18).

The second answer to the objection against my appeal to the Greek-Roman definition of slavery aims to show that my strategy works better than the standard approach. One must remember that, according to the original Latin definition, *addictus* was not any a slave but a free citizen reduced to slavery because of insolvency. While there could be endless discussions whether addicts could be considered autonomous subjects, I think that most- if not all – practitioners would agree that addicts must be considered unreliable and undependable individuals. This point is independent from any assumption on free agency and decision-making capacity, it is just a description of addicted individuals as they phenomenologically are, people who can be never trusted because they have no mind outside drug and the way to get it. Finally, this was the point at

stake also in the Muccioli trial that I quoted early in this paper. Not entirely as a joke, if one offered to a practitioner two assessment tools, the first to assess addict reliability, the second to assess their autonomy, I am quite sure that most practitioners would choose the former.

Why are addicts that, and critically, unreliable? To be sure, this a consequence of craving for drug and of the social construction of their role, but this is what happens *after* their becoming addicts. Yet, if one takes seriously Latin etymology, addicts were insolvent debtors *before* addiction, in fact they were reduced to slavery (*addictus*) precisely because they did not honor debts, they were unreliable from the onset. What was the initial debt they did not pay?

Being alive means willing, desiring, longing, wanting to achieve, striving, and so. In their foundation and inner structure, human beings are “machines désirantes” (desiring machines) (19). When they do not dream and desire, humans betray their mission and sense of life. Think of the episode of Lotus eaters in the *Odyssey*: the inhabitants of the lotus island were totally uninterested in life, they only searched for the magic flowers which gave them the oblivion. In the eyes of Odysseus, the danger they represented was in their will to erase the past and the future, living in a vague, eternal present. Through their search for forgetfulness, they wanted to lose the memory of their homes and loves, to cancel from their hearts any nostalgia for the past and the future. This point is very well captured by Joyce in the chapter of the *Ulysses* devoted to Lotus eaters, that he describes as affected by “narcissism”, not in technical psychiatric terms but meaning self-indulgent people, who are afraid by the sweet but still poignant pleasure of living. The debt that addicts try not to pay is thus the debt we all have toward life. We all feel that it exists, but we can hardly say what it is.

There is a short, nice, poem, written by a great contemporary Italian poet, Giorgio Caproni, which describes very well this concept. The reader, who cannot read Italian, will be obliged to put up with my poor English translation.

#### GENERALIZZANDO

Tutti riceviamo un dono.  
Poi, non ricordiamo più  
né da chi né che sia.  
Soltanto ne conserviamo  
- pungente e senza condono -  
la spina della nostalgia.

#### GENERALIZING

We all receive a gift.  
Then, we don't remember anymore  
neither by whom nor what is.  
We only keep of it  
- pungent, without remission-  
the thorn of nostalgia.

#### Footnotes

i. *Sentenza 28 Novembre 1987; Pres. Ricca, Est. Guarino; Imp. Muccioli E Altri*. 1987. (Corte d'Appello di Bologna, Il Foro Italiano 111 (1988): 587/588-603/604 28 Nov). Consultato il giorno Jan 2, 2021. <http://www.jstor.org/stable/23179780>.

ii. *Addicere* is a compound of *dicere* (to speak, to declare, to state) and the proposition *ad* (near, at, toward, addition). *Addictio* is a statement that adds (value) to an action made, or a statement uttered, by someone else (Oxford Latin Dictionary 2012, vol. 1, p. 40).

iii. The word “slave” is a Medieval term which comes from “Slav”, “because of the many Slavs sold into slavery by conquering peoples” (8). In the Medieval and modern times, slaves were chiefly prisoners, characterized by lack of freedom; we still use the word “slave” with this main meaning.

iv. Later on, when the master has too many slaves, they also got a personal name to be distinguished from one another.

v. Till the XVII century wearing a mask was a way of embellishing and enriching physical appearances as well as the “*dissimulazione onesta*” (honest dissimulation) was

central to court life. To be barefaced meant to be impudent and crude. It was in the XVIII century that the idea that veracity, transparency, truthfulness gained ground; consequently, “honest, open, faces” became positive attributes as well (22).

vi. Roman and Greek masks were, however, quite different. Roman masks represented dramatic facial expressions and were “exaggerated and statuesque” (11), while Greek masks were “simple and naturalistic” (11) they were almost expressionless. Greek masks were not built to be durable since performers would probably wear them for only one performance before placing them in Dionysus’ temple. In fact, Greek and Roman approaches to theater were quite different and they should be treated separately. Yet, giving that late Roman theater was basically imitation of Greek theater, I will consider them together for the purposes of this article.

vii. The Greek term *prosopon* focused more on visual presence, while the Latin word focused more on acoustic presence.

viii. In the Roman world, dignity (*dignitas*) was the value attributed to each citizen according to his social role, the idea of dignity as universal value of all human beings dates to Renaissance.

ix. Inverted commas are indispensable because in the Hellenic world no social fact or public action could be considered only and truly “secular” in modern sense.

x. I am aware that this statement should be substantiated by robust arguments and evidence, which is not possible in such a short paper. I ask the reader to accept provisionally my hypothesis, waiting for a larger paper only devoted to theater drive in humans.

xi. E.g., the plot of a famous 17th-century drama, close to Christian sacred mysteries—*El Gran teatro del mundo* (4) — which was entirely based on the representation of the world as a stage directed by an Almighty art director.

xii. E.g., Jacques' speech in Shakespeare's "As You Like It" (II, 7).

xiii. The notion of modular mind has suggested that addiction might be explained in terms of "weakness of the will" ("akrasia" in ancient Greek, literally "lack of strength"). The modern definition of akratic behavior was provided by Davidson (7): "*An agent's will is weak if he acts, and acts intentionally, counter to his own best judgement; in such cases we sometimes say he lacks the willpower to do what he knows, or at any rate believes, would, everything considered, be better.*" There is an endless debate among scholars whether addiction (at least, heroin addiction) could be considered a case of akratic behavior (9); in fact, some authors argue that neurobiological variables in opioid addiction are as significant as minimizing the autonomy of the subject and consequently the role of the will (10).

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## Response to Commentaries

Louis C. Charland, Ph.D.

**Bibliographical Update:** The piece on which my readers were invited to comment, namely, 'The Drug Dealer's Point of View: Consent and Capacity in the Age of the Opioid Epidemic'. was initially a draft section in a longer chapter on consent and capacity in the age of the opioid epidemic. That chapter, entitled, 'A Puzzling Anomaly: Decision-Making Capacity and Research on Addiction', has since been published in online form in *The Oxford Handbook of Research Ethics*, edited by Ana S. Iltis and Douglas MacKay (Oxford: Oxford University Press). Readers interested in consulting the longer piece can find it online at the address below, or email me directly for a pdf version.

### Response to the Commentaries

I am very grateful to Jim Phillips for inviting me to submit my short piece, the 'Drug Dealer's Point of View: Consent and Capacity in the Age of the Opiate Epidemic', to this issue of the *Bulletin* of the Association for the Advancement of Philosophy and Psychiatry (AAPP). I also want to thank all my commentators for taking the time to express their opinions on that piece. I am not surprised that the comments on my arti-

cle are quite eclectic and at times and invoke very different perspectives on the nature of addiction. Some commentators apparently refuse to discuss the issues in the terms in which I state them, preferring instead to set their own terms, which effectively changes the topic.

Some commentators took the initiative of referring to my earlier work in this area (Charland 2002), leaving aside what I judge to be most novel and original contribution in this latest piece. This is the drug dealer's point of view, which is meant to highlight the precarious status of decision-making capacity as theoretical construct, which is capable of protean transformations in the hands of different stake holders. This is disappointing. However, at the same time, some of my commentators suggest or directly point to new issues that are of great importance, like the nature and status of 'knowledge by experience', 'epistemic authority', and the importance of including the views of 'people who use drugs' in discussions of this sort. This is very positive.

Let me begin with those commentators whose views align directly with the issues as I state them. Tania Gergel clearly understands and supports my plea for the kind of research on decision making capacity that I say we need. She writes, rather sympathetically, that 'the phenomenon of fluctuating and cyclical impairment of DMC within other mental health conditions is well noted - so why not addiction?' Douglas Porter concurs and goes even further when, invoking my earlier work, he agrees with me 'that active addiction renders people sufficiently vulnerable such that competence to consent to using a substance to which they are addicted in a research setting should not be assumed'.

On his side, Robert Daly appears to agree with my contention that in the settings I describe, persons who are addicted to drugs are subject to a 'vulnerability which the dealer can exploit in the quest to secure a profit'. However, his observation that the drug addict nonetheless retains 'some capacity to act' is unhelpful. Somewhat paradoxically, he criticizes my piece on the grounds that 'more research needs to be done though he does not tell us what research needs to be done or why'. Yet, at the same time, he states (without explanation) that he finds my approach to the matter is 'implausible'. Perhaps

Daly is unfamiliar or unsympathetic with kind of clinical research on decision-making capacity that I am explicitly advocating for? Or maybe he is one of those who does not like or accept the terms in which I state the issues I am concerned with – and the path I recommend to their investigation and resolution. It does however seem a bit disingenuous to say that I do not 'tell us what research needs to be done or why'. I would think instead that this is very clear.

Note that both Gergel and Porter directly address my discussion in the same theoretical terms in which it is conducted. As Porter notes: 'Charland is using the term capacity here in a technical sense that is akin to the meaning of competence as in competence to consent'. Gergel mentions recent legal developments in New Zealand law that relate directly to decision-making capacity in addiction, that align directly with the kind of clinical research I am calling for. Moreover, both Gergel and Porter see the point of the comparison I attempt to draw between the (*ex hypothesi*) different assumptions that health care workers and drug dealers make on the decision-making capacity of their severely addicted clients. Gergel puts it poignantly: 'While ethicists argue that addicts have choice and dismiss medical models of addiction incorporating compulsion, drug dealers seem to flourish through assuming and exploiting impairments of DMC associated with addictive disorders'. On his side, Porter notes 'the vulnerability of addicted populations to exploitation by criminal forces' as a relevant concern that implicates questions of decision-making capacity.

The striking difference between the two points of view to which I allude – health care providers on the one hand, and drug dealers on the other – towards the decision making capacity of persons with severe opiate addictions is the main point I wanted to raise in my piece for this *Bulletin*. They cannot both be right, so which is right? Is it the clinician who sees a severely addicted 'client' who is fully capable of consenting to their drug of choice? Or, the drug dealer, who sees the same severely addicted 'client' but judges that their capacity for consent is so impaired they will predictably return for more, even though their peers

may be dying in front of their eyes? In both cases, the subject can be understood to express agency: they choose to use their drug. There is agency. But the capacity to make such choices, and how we determine *that*, is really what is in question. Clearly, in such cases, we cannot suppose that choice implies capacity. Perhaps because Gergel is the only one among my commentators who seems to conduct research in this area, she is the only one to appreciate the immense challenge that this last observation poses for choice theory.

So both Gergel and Porter, at least, address the issues I raise in the terms in which they are stated. Daly is ambiguous on this question but should probably be classified with the rest of my commentators who reject my theoretical terms and approach. Jim Phillips is one of those. However, commendably he is self-conscious and very deliberate and clear about it.

Phillips objects to my 'effort to evaluate capacity with "standard" measures' and argues that this 'is one of those areas in which the individual case overwhelms [...] general, research-grounded, principles'. Inspired by the philosopher Paul Ricoeur, Phillips argues that a better mode of inquiry into this question 'would involve a judgment on this person's capacity, in his life context, with these limitations'. I concur, but would insist that it does not follow from this that we can entirely dispense from the search for clinical measures, even if they can only yield modest and fallible generalizations. After all, it is the widespread idiosyncrasy, unreliability, and even abuse, of the sole reliance on subjective 'bedside' clinical judgments of capacity, that led us to the search for reliable clinical instruments for assessing capacity in the first place. Philosophical analyses inspired by the work of Ricoeur may indeed play an important role in helping us understand decision-making capacity in a nuanced and narrative manner that goes beyond the standard 10-20 minute time-frame of typical clinical assessments. However, medical science and health law also require empirically sound and more objective theoretical means for assessing capacity in a short time, that result in clear binary yes-or-no determinations. In sum, I am sympathetic with Phillips. But I don't see why we cannot admit that both kinds of modes of inquiry into capacity are theoretically and ethically desirable.

Like Phillips, Marshal Mandelkern also decides to change the manner in which I state the issues I am concerned with. Instead of decision making capacity, he prefers to speak of free will. I respectfully disagree and judge this suggestion to be extreme. More specifically, Mandelkern tells us that we should address my questions about decision-making capacity and addiction in the philosophical theoretical vocabulary of Aristotle and Harry Frankfurt. In particular, he argues that Frankfurt's distinction between first and second order desires 'makes it clear that an addict can be free, but not exercising his own free will, which is the akratic's situation'. This is an interesting and pertinent observation. However, even so, I would object that the philosophical vocabulary of free will is precisely the kind of conceptual bog we want to avoid in considering chronic, severe addiction. Instead, I prefer to work with the concept of decision-making capacity, which is a clinical, evidence-based and operationalized theoretical construct. To paraphrase the philosopher Daniel Dennett: in my view, there are no 'varieties of free will worth wanting' when it comes to understanding addiction.

Mandelkern's commentary also somewhat innocently raises the question of epistemic authority. At the very start of his commentary, he states that, 'anyone who has treated drug addicts will have had the experience of working with an intelligent, well-informed patient, who fully understands the destructive influence of his drug use, and has a strong well-formed motivation for abstinence, who nevertheless goes back to using drugs ...' I say that Mandelkern 'innocently' raises the question of epistemic authority, because he does not appear to explicitly set-out to debunk and silence claims about drug addicts by other types of academics and professionals who are interested in drug addiction, but do not treat drug addicts. Yet, from my own standpoint, there is still an important assumption about epistemic authority lurking here that it would be good to expose and discuss.

The reason is that I disagree with Mandelkern's statement of what an addict is like. Certainly, it seems to me a false depiction of the kind of addicted individuals I am speaking about in my piece. The individuals I am speaking of are (tragically) typically *not* well

-informed about the nature and exact composition of the addictive substances they are buying from their dealers, and therefore they cannot possibly properly weigh and know the risk and benefits involved in consuming them. But who am I – writing as a philosopher – to disagree with an expert like Mandelkern on a question like this? Presumably, Mandelkern has the authority to make such a statement on account of his professional designation as a medical doctor who has treated persons who are addicted to drugs. Note that I am not personally accusing Mandelkern of inappropriately appealing to epistemic authority. I am merely noting the manner in which he seems to be suggesting that his observation on addiction has a *special* cachet of authority that derives from the fact that, as a medical doctor, he has treated people with addictions. Where does that leave me, a philosopher who has made innumerable statements about addiction? Do I have the epistemic authority to make such claims? Or even engage in discussion?

Josh Richardson, explicitly and boldly raises just this kind of objection against me. Not against my written piece, but *me*, personally, the writer of that piece. In his insightful commentary, he stresses the epistemic limitations of what a person who does not use drugs can say about 'people who use drugs'. True, Richardson also praises me for the timeliness of my topic, which I think we both believe has become even more practically and ethically *urgent* with the pandemic. But then he immediately criticizes me (*ad hominem*, it seems), when he says: 'Charland frames his current inquiry as *he* sees the problem for people who use drugs' (italics in the original).

Richardson then goes on to suggest that I might remedy this epistemic shortcoming in my work by looking at a website by the *Canadian Association of People Who Use Drugs*, but does not follow-up on that recommendation or make any others. He also criticizes me for the manner in which I invoke the opinion of a 'person who uses drugs' in a much earlier paper of mine (Charland 2002). I have never seen such a criticism voiced so openly so it seems important to respond. The

matter is also timely in my own research and writing on addiction, since I have just started speaking publicly on the issue of the 'ethics of disclosure' and 'epistemic authority' in relation to 'knowledge by experience' (Charland 2020a).

In response to the last point about my earlier work, let me point out I that have already clarified the matter in a few commentaries specifically directed at mistaken interpretations of that specific point (Charland 2017; Charland 2003). The short response is that, by way of *anecdote*, I did indeed ask a person in recovery from severe heroin addiction ('Cynthia') what she thought of the idea of assuming that people who are severely addicted to a drug can give voluntarily consent to a sanitized version of that drug, when it is offered to them in the context of research or treatment for their addiction. She certainly had a strong opinion and expressed it: "That's crazy," [...] "if you're addicted to heroin, then by definition you can't say 'No' to the stuff" (Charland 2002, 37). But obviously this is only meant to be an anecdote: not a clinical argument or generalization. And certainly not evidence for any such generalization! I sense the winds of disinformation blowing here.

In the article that mentions Cynthia's observation, I then went on to inquire into whether there might be any published scientific evidence to substantiate such an opinion and found that there was in fact *a lot of evidence* in so-called 'brain disease', or 'medical', models of addiction where compulsion and 'loss of control' are said to play a central role in the kind of severe and chronic heroin addiction I was concerned with. Many of my critics responded by trying to shoot the messenger to kill the message. But the message is not *mine*! It is based on claims that come directly from addiction science, as Gergel aptly shows, and Porter also appears to concede (up to a point). Do we really want to say that all the victims of opiate overdose straightforwardly voluntarily consented to use the drugs from which they overdosed? Can we simply standby and accept that, by legal *fiat*, their decision-making capacity is intact despite their addiction and usually dire personal and social circumstances? I think there is sufficient evidence to have grave doubts about this and doing the appropriate sort of research on decision-making capacity is



the strategy to adopt. Why is that not happening? I sense denial in the air here.

I don't know why Richardson immediately assumes that someone like myself who writes about drugs has never used drugs. However, even so, the fact that I may have used drugs – even to the point of severe, life-threatening chronic addiction – does not epistemically entitle me to any special authority on the topic of mental capacity in addiction *per se*, other than what concerns my own personal experience. And do I have the same automatic epistemic authority at any and all points of my history of drug usage? What happens when testimony at different stages conflicts with testimony from other stages? Which is right? These are not easy questions. Admittedly, they may seem almost an insult to claims of epistemic authority – which I certainly take seriously and do not mean to ridicule in any way. Yet I think they need to be asked. And I am speaking from *experience*.

To be sure, there are countless autobiographical accounts of addiction in literature. My favorite is *Morphine* by physician and novelist Michael Bulgakov (Bulgakov 1925). Owen Flanagan (2011) and Marc Lewis (2012) are two famous contributors to the field of addiction who have also chosen to share their own personal stories. However, no matter how courageous and laudable such disclosures may be, in my view they do not (yet) constitute science. They are personal opinion, and without further development, not suitable for policy or program development. This is not to say that addiction science does not need literary or other autobiographical evidence about lived addiction. It certainly does and also need phenomenological and other narrative approaches. But these are daunting epistemological and ethical matters. Not a place for quick jabs and asides.

Ironically, in writing my piece, I searched for research on what 'people who use drugs' say about the choice to use drugs that might bear specifically on decision-making capacity. I found hundreds of testimonies in books based on Alcoholic's Anonymous Twelve-Step approach to addictive disorders that all concur that there is a 'loss of control' in addiction that compromises voluntary choice. But I did not find any other evidence from 'people who use drugs' in the scien-

tific literature I was searching in. Indeed, this is just the kind of research I am calling for.

When I used the search function on the website Richardson recommends, I found no compelling results for search terms like 'consent', 'competence', 'capacity'. I would love to be corrected on this point. I might add that I have longed to conduct the required kind of research myself, but alas do not have the required empirical training for that, nor any available and willing clinical colleagues to help. And so, I remain humbly stuck to the proverbial philosophical armchair, using what data I can find. Nonetheless, I can assume an empirical voice from my limited philosophical point of view. I can simply note and inquire into the existence or lack of data I am calling for. My point here is that it is both scientifically puzzling and ethically unacceptable that so little direct clinical research has been done in the area of decision-making making capacity in addiction, given the scale of social harms at stake. Is no one else concerned about this?

Regarding the commentators, Mordini is harder to interpret. On the one hand, he seems committed to changing the terms of the topic as I state them, by proposing a novel historical and more continental philosophical reading of the issues. Yet, on the other hand, he also appears to offer anecdotes that fit the terms of the clinical situations I am concerned with precisely.

Certainly, in one respect, Mordini seems to be right on target and very much accepting and aware of the clinical dimensions of my topic and its policy implications. He alludes to a 1987 court of appeals judgment in Bologna where it is decreed that 'addicts conserve their capacity for making choices, but they lack full decision-making capacity.' Later in his commentary, he also makes a point that is directly clinically relevant to the topic of my article. He states that the fact that 'addicts must be considered unreliable' is 'independent of any assumption on free agency and decision-making capacity.' He tells us that this is 'just a description of addicted individuals as they phenomenologically are, people who can never be trusted because they have no mind

outside the drug and the way to get it.' He then goes on to say that 'if one offered to a practitioner two assessment tools, the first to assess addict reliability, the second to assess their autonomy, I am quite sure that most practitioners would choose the former.'

However, on this last point, I respectfully disagree. First, sometimes we just have the tools we have, in this case, probably the Mac-CAT-T and Mac-CAT-R seem the best and most available tools around, though they famously have their problems and limitations (Grisso & Appelbaum 1998; Charland 1998; Hawkins & Charland 2020). There are also now important precedents to build on in this area, which can be found in recent New Zealand legal statutes on involuntary treatment for addiction, and their supporting documents (N.Z. MH, 2017). Secondly, 'unreliability', as Mordini describes it, may not be the best term to serve the purpose he has in mind. For while addicts (of the severe and chronic sort we are discussing) are often notoriously unreliable and cannot be trusted in some contexts (e.g. to quit when they say they will quit), they are highly reliable and predictable in other contexts (e.g. seeking and using drugs). For example, drug dealer's certainly count on the reliability of their client's addictions.

A fascinating aspect of Mordini's commentary is the central role he allocates to history in his discussion. I also examine the history of the term "addiction" in the fuller chapter from which this excerpt on the drug dealer's point of view is drawn, so a few brief comments on this question are in order. As background, it is worth referring readers to Peter A. Martin's very recent 'Historical Vocabulary of Addiction', published by the International Network for the History of Neuropsychopharmacology. His work stresses the historical ties of the term "addiction" to substances with neuropsychopharmacological properties in particular, and the role of the Latin "addictus" in this, as do my own pronouncements in the area. Mordini's strategy seems to be exactly the opposite.

Let me begin by praising Mordini's account of the historical and social-political context of "addictus" in Roman times. He draws our attention to the importance of the role of

the term as a ‘mask’ which defines an individual’s social role and persona. If I understand him correctly, Mordini’s point is that as an analogy used to help us understand the modern concept of substance related disorders and addiction, the Roman historical sense of the term “addiction” is not in fact as appropriate as it is often supposed to be as a starting point. This is because historically the mask label provides limits to autonomy without implying or requiring any connection to addictive substances with neuropsychopharmacological properties. So, for example, Mordini asks, rhetorically: ‘They are enslaved to the substance, but did the substance strip them from their autonomy or rather from their masks?’ The answer is No. It is the mask that enslaves and compromises autonomy in this case, more than any actual substance they may be abusing.

This, moreover, is a point with contemporary relevance. For example, Daniel Steel and his colleagues have recently argued that the essence of the putative impairments in decision-making capacity that I am interested in, may not lie only ‘in the brain’, as often seems to be supposed, but also in socio-economic factors outside the brain (Steel et al. 2017). The point at hand is perhaps best expressed in Mordini’s own words: ‘decision-making capacity might be impaired not because ... [the addicts] ... are less capable for autonomy (e.g., because of the pharmacological effect of the addictive substance) but because they lost most facets of their original personality, narrowing down their existential horizon, and dramatically impairing their spectrum of choices.’ My own view is that while this may indeed be a defensible interpretation of the nature of “addiction” in early Roman history, that history also contains other branches leading to present day usages of the term. One is through an association with “devotion” and ‘enslavement’ with gradual ‘loss of self’, which is perhaps more relevant to the issues at hand than Mordini’s account of the term as a socio-political ‘mask’ (Charland 2020, 3-4).

Mordini also refers to ‘engines of desire’ and reputable authors in continental philosophy to approach the concept of choice with impaired decision-making capacity in addiction that I discuss. In this case, I would argue that he is probably changing the topic in a manner that is less helpful than the

historical and legal anecdotes he provides.

However, it is time to move on to my other commentators, in this case Jim Phillips, who also invokes continental philosophy. He objects to my ‘effort to evaluate capacity with “standard” measures” and argues that this ‘is one of those areas in which the individual case overwhelms [...] general, research-grounded, principles’. Inspired by the philosopher Paul Ricoeur, Phillips argues that a better mode of inquiry into this question ‘would involve a judgment on this person’s capacity, in his life context, with these limitations’. I concur, but would insist that it does not follow from this that we can entirely dispense from the search for clinical measures, even if they can only yield modest and fallible generalizations. After all, it is the widespread idiosyncrasy, unreliability, and even abuse, of the sole reliance on subjective ‘bedside’ clinical judgments of capacity, that led us to the search for reliable clinical instruments for assessing capacity in the first place. Philosophical analyses inspired by the work of Ricoeur may indeed play an important role in helping us understand decision-making capacity in a nuanced and narrative manner that goes beyond the standard 10-20 minute time-frame of typical clinical assessments. However, medical science and health law also require empirically sound and more objective theoretical means for assessing capacity in a short time, that result in clear binary yes-or-no determinations.

In sum, I am sympathetic with Phillips. But I don’t see why we cannot admit that both kinds of modes of inquiry into capacity are theoretically and ethically desirable.

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(President, continued from page 1)

of experience that meeting via video lacks.

Nevertheless, teaching and clinical work continued despite the pandemic. People adapted. For some, the changes were rather small. As a teacher of philosophy, I had been doing most of my teaching online already, so some of my classes were hardly dis-

turbed at all by the move to online formats. For other classes which had been in person, I was already using a learning management system (LMS) as part of the class, and students mostly moved smoothly to the whole class being taught via the LMS. While many faculty who have been teaching via video have found it very difficult, it is also true that there have been advantages compared to the classroom experience. Most obviously, there has been a great deal less time spent traveling to campus. But there are also advantages in learning.

Some students learn more in an online format. They find it easier to contribute to the discussion compared to speaking in class. In asynchronous learning, students have more time to mull over material and compose their responses. Generally, in an online class, all tasks are set out ahead of time for the whole term, which allows some students to plan ahead more. My experience has been that a proportion of students have unexpectedly thrived in the online format.

I have heard less about the variety of experiences of psychiatric patients and clients as they adapt to the different conditions, except that some have been glad to avoid the travel to see their clinicians. There have been reports of an increase in mental health problems due to the stress of lockdowns and social isolation, confinement with family, extra financial strain, and worries about medical conditions. However, it may be some time before we get a clear picture of the overall effects of the pandemic on mental health. Hopefully, there will be ways in which we can learn from the strengths of adaptations.

For AAPP, we have confidence that our 2021 online conference will be able to attract more attendees to talks and discussion than our previous conferences with limited physical spaces were able to. We did find that more of our EC members were able to attend online video meetings than had previously been able to attend physical meetings. The skills we have developed in the last year in adapting to the pandemic should not go to waste as we slowly emerge from it. My hope is that we can find ways to attract more people to joining and actively participating in AAPP with the use of technology.

We already have a newly developed website (<https://aapp.press.jhu.edu>) and we have a twit-

ter account (@aapp\_PhilPsych) and a Facebook group (<https://www.facebook.com/PhilosophyandpsychiatryAAPP>). Increasingly, AAPP members have been active in excellent online talks, seminars, and conferences. These have been accessible to a wider group of people than ever before. There were moves in this direction already before the pandemic, but we have been moving more rapidly to greater accessibility because we had to adapt.

A central issue for AAPP in the coming years will be how to reach more people, and how to combine the continued service to its existing base with more outreach to others. New technology will certainly play a part in that, and we will be working on how to implement it. I welcome suggestions from readers.

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same time? Here another element of Ricoeur's analysis comes into play. The negative side of each pairing involves limitations. Thus, being free and not free at the same time indicates being free with limitations, and these can be physical or mental. Physical limitations are mostly those of the body. If I am paralyzed, I am free to act but not to run around the block.

Everything I've written so far is straightforward and consistent with Charland's analysis. Where he differs, however, is in his emphasis on capacity. This is his key concept that overrides all the others: "It is important to appreciate in this context that the fact that a particular decision, or choice, is made and agency is manifest, does not automatically entail that the choice, or decision, is capable. Capacity requires an additional justification of its own, for which there are established standardized measures, as stated above."

Let's try to relate this to the addict. First, we recognize that an addict has massive limitations, as de-

scribed above, on capacity, freedom, choice – everything. Physically, he is corporally addicted, with all the pressure and need involved in the addiction. Mentally, all he can think about is satisfying the physical need. Add to this the dealer's cunning exploitation of his addicted condition.

Ricoeur suggests leaving a causal, medical model out of the discussion because it ignores the subjective experience of the individual. Charland appears to be in agreement with this position when he writes, quoting Heyman, "Proponents of choice theories often argue that the medical, or disease, model of addiction should be abandoned because "it does not fit the facts" and fails to capture "what the research shows".

Where Ricoeur (and I) come to loggerheads with Charland, however, is the latter's effort to evaluate capacity with "standard measures.

Capacity requires an additional justification of its own, for which there are established standardized measures, as stated above... Oddly, in so far as they involve clinical research on individuals with a substance dependence diagnosis, clinical studies in choice theory require that those subjects be judged to have decision-making capacity. But choice theories themselves never seem to inquire into decision-making capacity as an important research topic of its own. This is puzzling.

Thus, although Charland rejects the medical model, he turns to the causal thinking of the medical model to evaluate someone's capacity. Find the right scale, make it a research project. Ricoeur's argument here would be that judging someone's capacity/lack of capacity could not be accomplished with something like a capacity scale or other research tool. It would involve a judgment on this person's capacity, in this life context, with these limitations. That is not matter for a research project, which can only end up in broad generalities with little relevance for the addict being evaluated. Judging capacity, then, is one of those areas in which the individual case overwhelms the general, research-grounded, principles. The general principals are of course there for consultation, but the judgment remains individual.

JP

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