Medicalizing Temptation

Rutgers University has made this article freely available. Please share how this access benefits you.
Your story matters. [https://rucore.libraries.rutgers.edu/rutgers-lib/21389/story/]

This work is an ACCEPTED MANUSCRIPT (AM)

This is the author's manuscript for a work that has been accepted for publication. Changes resulting from the publishing process, such as copyediting, final layout, and pagination, may not be reflected in this document. The publisher takes permanent responsibility for the work. Content and layout follow publisher's submission requirements.

Citation for this version and the definitive version are shown below.

Citation to Publisher Version: Toby, Jackson. (1998). Medicalizing Temptation. The Public Interest 130, 64-78.


Terms of Use: Copyright for scholarly resources published in RUcore is retained by the copyright holder. By virtue of its appearance in this open access medium, you are free to use this resource, with proper attribution, in educational and other non-commercial settings. Other uses, such as reproduction or republication, may require the permission of the copyright holder.

Article begins on next page
Medicalizing temptation

JACkSON TOBY

WHEN one of the characters in Oscar Wilde's play, Lady Windemere's Fan, says, "I couldn't help it. I can resist everything except temptation," the playwright was kidding. He was implying, slyly, that those who fail to resist temptation prefer what they perceive as pleasant to what is moral.

That was in 1891. Since then, the disciples of Sigmund Freud have taught us that unconscious psychological needs and organic pathologies drive much behavior formerly thought to be the result of deliberate choices: smoking, overeating, drug abuse, alcoholism, promiscuity, shoplifting, gambling. Whereas the word "temptation" suggests choosing an immoral alternative, the word currently used to describe such behaviors, "addiction," suggests that perpetrators are compelled to do what they do regardless of their own inclinations. If addicts have deviance thrust upon them by compulsions beyond their control, they are not responsible for misbehavior. They can claim to be victims deserving of sympathy, not blame.

How uncontrollable is a compulsion?

In order for a compulsion to explain some item of behavior scientifically, the extent of the biological or psychological pressure to commit the prohibited act should be measurable independent of the behavior (e.g., smoking, overeating, gambling) that it purports to explain. Nearly a half-century ago the distinguished criminologist, Donald Cressey, applied this criterion to "compulsive criminality"; he concluded that kleptomania and pyromania do not pass the test. They differ from ordinary criminality only when the motivations for these supposedly "compulsive" crimes cannot readily be explained by the observer. The police call a rich shoplifter a kleptomaniac and a poor shoplifter a thief because the motivation for a rich shoplifter seems baffling. Similarly, a person who burns down a church for no apparent reason is called a pyromaniac, such as the man in Trenton, New Jersey, caught after setting fire to five Catholic churches. His lawyer tried to convince the jury that he was not responsible because anyone so irrational that he torched five churches must be in the grip of a compulsion. After all, the perpetrator was not burning churches for the money -- unlike an arsonist who planned to collect insurance.

But inferring an irrational compulsion merely because the motivation for the behavior is difficult to understand is reasoning in a circle, according to Cressey. Maybe the Trenton arsonist had a grudge against the Catholic Church or maybe he enjoyed burning churches as a hobby. All we know from the church fires is that the arsonist didn't control his firesetting impulse, not that he couldn't. Cressey's point was that offensive behavior
should not be labeled "compulsive crime" without evidence for the compulsion independent of the crime itself.

Take a non-criminal example. Smoking is blamed on nicotine addiction, but in what sense are smokers compelled to smoke? They are aware of the health hazards and of social disapproval; they suffer from the inconvenience of having to find places -- sometimes out-of-doors in inclement weather -- where smoking is permitted. But still they crave cigarettes and are uncomfortable when the craving cannot be satisfied. Among heavy smokers, there is a biological basis for their attraction to cigarettes, just as there is a biological basis for heavy drinkers desiring alcohol. But smokers resist their craving in church, in an airplane, in restaurants where smoking is not permitted. They want to smoke, but in what sense do they have to smoke? After all, smokers deprived of cigarettes do not become comatose; and even if a coma was likely, and even if they knew it was a possibility, why are they compelled to avoid that risk?

Nicotine deprivation gives rise to a weaker biological craving than alcohol or opiate drugs. But the meaning of a compulsion is not clear even in cases where the behavior has a stronger organic basis than smoking -- for example, persons dying of starvation, as happened during the siege of Leningrad during World War II. Can it be said that starving Russians were compelled to resort to cannibalism? In point of fact, cannibalism was rare; thousands of people in Leningrad starved to death, although corpses were available. Apparently, "compulsive" does not mean that biological needs take control of the individual so that he cannot suppress them. The most reasonable interpretation of the meaning of so-called "compulsive behavior" is behavior that results from very strong temptations, notably such organismically grounded temptations as hunger and sex. Is that all? If so, no qualitative line can be drawn between addictions and behavior in response to lesser temptations.

Alcoholism and drug addiction are the prototypical addictions. An individual who ingests alcohol or drugs in a manner that others consider self-destructive, irrational, and chronic is described as "addicted." But, if he had stopped using alcohol or drugs before reaching this stage, he would have been described as a social drinker or a recreational drug user, not as an addict. Thus the question arises whether anything useful is added to sheer description of his behavior by calling him an "addict" and saying that his behavior is "compulsive." The criterion of compulsiveness is supposedly that he cannot stop. But there is never independent evidence of inability to desist.

_Lindesmith's theory of addiction_

The concept of addiction has a biological aroma. This is especially true when physiological habituation occurs, and painful withdrawal symptoms result. Alfred Lindesmith, in his 1947 classic analysis of opiate addiction, argued that what is essential to establish an addiction is the intellectual realization on the part of the drug user that he can reduce the misery of withdrawal symptoms by ingesting more opiates. Because Lindesmith believed that lower animals could not establish this intellectual connection, he thought that lower animals could become habituated but that only human beings could
become addicted. Lindesmith was able to demonstrate that his theory could explain the development of chronic opiate use among many human "addicts." Nevertheless, Lindesmith glossed over two hard and stubborn facts that considerably undermine his theory of addiction.

First, he either did not realize or chose to ignore the fact that detoxification does not cure opiate addiction. According to Lindesmith's theory of the causes of addiction, the addict would have no motivation to return to drugs once he has been detoxified. But many drug addicts are repeatedly detoxified and begin using drugs again, presumably because they wish to revisit the pleasant consequences of drug use that they remember -- despite awareness that unpleasant withdrawal symptoms may be another consequence. Second, Lindesmith ignored the fact that a few addicts are able to quit "cold turkey." Granted that abrupt withdrawal is unpleasant; granted that few persons whose bodies have been habituated to high levels of drugs have the inner strength to quit abruptly. But the documented cases of the few individuals who voluntarily accept the pain of withdrawal stress in order to escape the drug treadmill undercut the notion that drug addicts are compelled to seek a "fix." However rare, such cases reveal a choice element in the response to withdrawal stress. Although those who experience withdrawal stress are very, very tempted to look diligently for additional opiate fixes in order to feel better, using the word "compulsion" to describe their strong temptation elevates it into a necessity.

Lindesmith implied that addiction has a biological basis, although he believed that it was also necessary for the addict to recognize intellectually what he needed. But the concept of addiction, as currently used, does not always involve withdrawal symptoms. The term "addiction" has expanded to include "compulsive" gambling, sexual promiscuity, overeating, and a seeming inability to enjoy any activity as much as work ("workaholism"). Compulsive gambling exemplifies an addiction without a biological basis. But, if withdrawal symptoms are not a necessary condition for an addiction, the relief of withdrawal symptoms cannot be an essential step in the development of an addiction. One might argue that speaking of gambling or sexual promiscuity as addictions is metaphorical; that the term "addiction" should, strictly speaking, be confined to biologically based cravings that, if not indulged, produce withdrawal stress. Such an approach would not include much of the "impulse-control disorders" that psychiatrists now classify as compulsive addictions. (The *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association, lists compulsive gambling as an "impulse-control disorder.") Returning to a more restrictive concept of addiction would satisfy those who believe that the concept of "addiction" has been extended too far and has thereby been misused. But it would not satisfy those critics who, like me, believe that the concept of addiction exaggerates the biological basis even of such behavior as drug and alcohol abuse.

Idiosyncratic temptations

Another possibility is to forego the emphasis on a biological basis for addiction, conceding that addictions are merely strong temptations. Once this is done, however, no clear explanation emerges as to why cigarettes, alcohol, and opiates should appeal to...
everyone. In fact, cigarettes, alcohol, and opiates are not universally tempting, as would be the case if there were a strictly genetic basis for their appeal. The concept of temptation leaves open the possibility of human idiosyncrasy based on different learning experiences. Individual A may be sorely tempted by a behavioral possibility that individual B would find repugnant.

A sexual example may illustrate the assumption of idiosyncratic temptation. Most urban people do not find the prospect of sex with a sheep tempting. One of my students commented "that an animal offers little more than the [sex] act itself. One cannot very well date or marry a [sheep]." Another student found bestiality repugnant because it was incompatible with informed consent. "Bestiality is essentially rape." Neither of these students identified readily with adolescent shepherds in biblical times, alone with their flocks for long periods during which they could observe considerable sexual activity among their animals. Most shepherds in biblical times probably never thought about copulating with sheep; some might have considered it and quickly dismissed the notion. And a few, in the absence of human sexual opportunities, imagined what it would be like. In short, they were tempted. That such temptation arose is attested to by the biblical prohibition of bestiality; presumably the prohibition was not based on pure conjecture.

My point is that temptation is learned on the basis of idiosyncratic experiences. While biological characteristics make most people receptive to certain common temptations, human beings also learn to be tempted by a wide variety of activities, some socially approved of, at least in moderation, and some strongly disapproved of: television viewing, playing bingo, shopping, tattooing one's body, weight lifting, snorting cocaine. Calling those with a strong motivation to engage in these behaviors "addicts" stretches the meaning of "addiction" to the point of uselessness. Saying that Mother Teresa was addicted to healing the sick and poor of India merely describes her behavior. What is needed is an explanation of how it happens that some people are tempted to do what other people find creditable or mildly or extremely reprehensible.

Learning can explain the process by which individuals develop an overwhelming interest in activities that bring down upon them social condemnation. "Process" is the key word. Take our adolescent shepherd who copulated with one of his sheep. It took time for him to overcome his initial reluctance and to consider that sex between himself and an animal might be possible and, indeed, satisfying. An act must be thinkable before it is doable. Most deviant acts are unthinkable because the individual engages in self-censorship; previous social, cultural, and religious influences prevent the individual from considering the behavior. But some shepherds in biblical times may have been sufficiently ignorant or rebellious that they thought about what was for most others unthinkable. And some of these free-thinkers decided to try bestiality for themselves. Most of the experimenters found the act distasteful; they were ashamed of having tried it; and they never were sexually involved with sheep again. But others derived some sexual pleasure from the experience and, above all, the memory of having done it. Because they could never do it for the first time again, the second experience was easier to initiate. They enjoyed it more than the first time. Now they had two pleasant memories rather than one. As they
repeated the behavior, the remembrance of past pleasures accumulated and served to motivate future behavior that they had come to anticipate would be pleasurable.

Some experiments with socially disapproved behavior do not begin alone, although all of them have to be thinkable before they are doable. Teenage drinking, smoking, or drug use may become thinkable because friends talk about these activities or engage in them before the uninitiated individual. If a boy sees his friends taking drugs, and a glazed but happy look comes into their eyes, he cannot avoid concluding that drug use is sometimes pleasant. If he goes to a party and he is offered a beer, which others are already consuming, social influence reinforces individual curiosity. The puzzle is not why behavior begins that most Americans, including parents, consider wrong but why, after becoming thinkable, such behavior does not become universally doable. The sociological explanation is that the disapproval engendered by conventional cultural and social norms works successfully against deviance most of the time. On the other hand, in free societies, subcultures of deviance exist that encourage generally proscribed activities; hence experiments with deviant behavior arise not only because of individual innovators, as with the shepherd and his sheep, but as a result of sociocultural influence of deviant groups. But whatever the source of deviant experimentation, repetition is required in order for it to become established in the individual's behavioral repertoire. Pleasurable repetition reinforces the anticipation of future gratification. Consequently, postulating a biological basis for alcoholism, drug abuse, or sadomasochism is not needed. One has only to assume reinforced learning, which can occur with many prohibited activities. That is why temptation is idiosyncratic; a vast variety of behavior, from willing exposure to flagellation to setting fire to Catholic churches, can become a cultivated taste.  

Triumph of the therapeutic

Although many forms of deviant behavior are now considered addictions, acts remain for which the individual is still held responsible. Take a trivial case: An individual who receives dozens of tickets for overtime parking is fined and, in egregious cases, called a scofflaw, not a sick overtime parker in need of medical treatment. More serious deviations from acceptable behavior, like murder, rape, or assault, are also usually blamed on the perpetrator and punished. Subcultural deviance that occurs on college campuses, although frequently unpunished, is also considered the responsibility of the perpetrators, not a compulsion. For example, the streaking fad that broke out in 1974 was considered mere deviance. Spreading from college campuses to other sites, it challenged, in the name of freedom, stuffy adult rules against public nudity. Only a few arrests were made for "indecent exposure." The lack of mass punishment was partly because the behavior was defined as a subcultural prank and partly because arresting such large numbers of young people was impractical. But no one suggested that streaking was a new impulse-control disorder requiring psychiatric help. The criminal law, perhaps because of its premodern origins, tends to assume that adults are responsible for their deviant behavior in the absence of compelling evidence of
insanity, mental deficiency, or other extenuating circumstances. But the assumption of "addiction" increasingly competes with that of responsibility as an interpretation of deviance. The range of behavior now considered compulsive has expanded enormously-and with it therapies modeled after Alcoholics Anonymous. Now more than 60 years old, A.A. has more than one million members in some fifty thousand local groups in the United States alone. Logically enough, treatment programs have been designed to remediate newly identified compulsions. Overeaters Anonymous attempts to deal with eating disorders, not only anorexia and bulimia but large weight gains resulting from caloric intake in excess of caloric expenditure. Spinoffs like Narcotics Anonymous, Gamblers Anonymous, Sexual Addicts Anonymous, and other self-help organizations have taken over the famous 12-step rationale of the A.A. program. If the addiction assumption underlying these programs were correct, therapy based on that assumption would not necessarily be successful, but successful treatment would increase the likelihood that the right problem was being addressed. So it is reasonable to ask whether 12-step programs are more effective at returning deviants to conformity than moral exhortation, punishment, or doing nothing at all.

The widespread impression that A.A. is uniquely successful does not rest on scientific evidence. How large a proportion of those who come to one or more A.A. meetings drop out and return to their "addictive" habits and how large a proportion of the target populations resist the pressures of family, friends, and official agencies to join such programs? No one knows exactly because empirical evaluations are discouraged by A.A. Nevertheless, the 12-step organizations can cite anecdotal instances of alcohol and drug abusers, sex offenders, and gamblers who learn to lead ordinary lives. These individual "successes" are used to support doctrinaire assumptions of what the causes are for heavy drinking or for chronic drug use. For example, one of the 12 steps is that the individual must realize he is powerless to control his addiction and that only his submission to a "higher power" can produce conventional behavior. Is it true that irreligious addicts cannot control their addictions, or does the prophecy fulfill itself by making it impossible for irreligious addicts to participate fully in 12-step programs and thereby obtain useful peer support?

Another doctrinaire assumption of these programs is that there is no middle ground between abuse and abstinence because some people are biologically incapable of moderation. Overeaters Anonymous, while not recommending starvation, does not condone even occasional gluttony; dieting must be maintained 24 hours a day, seven days a week, because addictive overeaters are on a slippery slope that leads inevitably to unstoppable binge eating. The assumption that moderating abusive behavior is impossible for certain types of people seems premature. For example, longitudinal interviews with alcohol abusers show that a substantial proportion of them, when reinterviewed a year or more after the initial interview, report moderating their drinking behavior to acceptable limits, often without involvement in formal treatment, including A.A.-type programs. Experimental alcohol treatment programs to test this possibility have been developed-Moderation Management in New Jersey, DrinkWise at the University of Michigan Medical Center and at the Addiction Research Center in Toronto, Drink/Link in Northern California, the Drinkers Risk Reduction Program at the Center of Alcohol
Studies at Rutgers University, as well as numerous moderation programs in other countries.

In short, the therapeutic approach of A.A. and its progeny rests on unverified assumptions about why alcoholics drink and why cocaine users snort cocaine. To the extent that these assumptions are wrong, the kind of remediation undertaken will be less effective than alternative therapies. If gamblers are mainly people who fail to resist the temptation to experience the high that comes from a big win, a therapy program that emphasizes commitments to spouse and family may well be more effective than one based on an exploration of a hypothetical impulse-control disorder. Or, as in the case of streaking, if the behavior was a subculturally defined lark, no therapy at all was needed. Only if the individual is assumed to be in the grip of a compulsion that he cannot control are medical, surgical, or psychiatric interventions logical.

**Sexual offenses or sexual addictions?**

Once upon a time, "sexual offenses" conjured up the meaning of willful misconduct: rape, child molestation, public masturbation, incest, adultery. Child molestation still evokes fear, rage, and indignation, as shown by the prosecution and imprisonment of child-care workers accused, even on the basis of dubious evidence, of molesting their charges. (More recently, the public outcry following the rape and murder of seven-year-old Megan Kanka in Hamilton Township, New Jersey, prompted states and even the federal government to pass laws requiring community and/or police notification when a sex offender is released from prison and takes up residence in a neighborhood.) Despite outraged responses to cases of possible child molestation, the range of tolerated sexual behavior among consenting adults has expanded in recent decades. Thus sexual activities portrayed nowadays in song lyrics, television sitcoms, plays, and movies would have been shocking 30 years ago. For instance, a recent film, “The Kiss,” depicts an attractive female embalmer choosing between her erotic involvement with corpses and her relationship with a live boyfriend. In short, what used to be considered sexual misconduct has become mere foibles. When the American Armed Forces chose recently to handle several cases of consensual heterosexual adultery as grave misconduct, threatening court-martials, the press and the public were underwhelmed.

But in addition to greater tolerance of sexual behavior that would have produced pariah status in the past -- and still does in some niches of American society, a second development has served to define sexual deviance down: reinterpreting sexual behavior as compulsive rather than as freely chosen. Two examples come to mind. Promiscuous heterosexual behavior used to be labeled "philandering" -- that is to say, "immoral" behavior. Now promiscuity tends to fall within the purview of a medical condition, and residential centers and out-patient programs have been established to deal with "compulsive" sexuality as an addiction. Compulsiveness is inferred invariably from behavior alone, not from an independent measurement of the strength of the person's sexual drive. Consequently, the diagnosis of sexual addiction never passes Cressey's test: identification of the underlying pathology without independent knowledge of the sexual behavior.
The other example is homosexuality. Homosexuals, though not called addicts, are generally assumed to be biologically incapable of becoming heterosexuals. Their sexual orientation is thought to be biologically determined just as addicts are believed to be incapable of resisting their temptations. But suppose that homosexuality is learned as a result of idiosyncratic sexual experiences and is no more imprinted biologically than is the sexual attachment to sheep on the part of some shepherds. Homosexuality would subsequently be reinforced by repeated experiences and would, in time, seem innate. The critical question, however, is the extent to which idiosyncratic learning experiences can account for homosexual development. If they can, homosexuality is indeed a sexual preference in the sense that it is voluntarily maintained and is thus a behavioral choice.

Choosing homosexuality

No one denies that the capacity to obtain pleasure from sex is biologically programmed. What is at issue is whether biology is responsible for how, and with whom, that pleasure is obtained -- in the case of homosexuality, what Freudians call "object choice." The activities from which people can derive sexual pleasure range widely: from willing submission to humiliation and pain or inflicting cruelties on others to cannibalism; from caressing items of clothing to self-stimulation; from sex with corpses and lower animals to sex via various body orifices of a partner of the same or opposite sex. Some people require nudity for sexual stimulation and others prefer to be fully clothed; some require darkness and others can perform in bright lights, before an audience or a camcorder. This variety of sexual predilections suggests that idiosyncratic learning experiences lie behind sexual tastes.

On the other hand, many practicing homosexual adults insist that they have felt homosexual desires for their entire lives, even before adolescence. Retrospective memories are not entirely trustworthy; memories are filtered through present needs and identities. But, even if these recollections are accurate, learning could still be responsible. Recent hormonal studies by Martha McClintock and Gilbert Herdt at the University of Chicago reveal that adrenal activity starts as young as six years of age and, by nine or 10, reaches a high enough level to stimulate sexual attractions. Preadolescent children may not understand the sexual aspect of their attraction to a member of their same-sex playgroup. Nevertheless, such attractions can become deeply imbedded in the personality through fantasies, which social psychologists explain are a powerful mechanism of self-reinforcement. When full sexual capacities emerge a few years later, an object choice is already available. This does not make homosexuality as widespread as preadolescent crushes; sociocultural directives to choose a heterosexual target for sexual interest may override the initial predisposition. However, this explanation of sexual development does not rely at all on a biological basis for homosexual behavior.

Another piece of macroscopic evidence for attributing a homosexual orientation mainly to life experiences, rather than to biological programming, is the existence of bisexuality and the related phenomenon of individuals who shift sexual orientations during the life cycle. If sexual orientation were biologically determined, bisexuality would be extremely
rare, and changes from homosexuality to heterosexuality, or vice versa, would be even rarer. It can be argued that bisexuality does not really exist, that, because of the stigma of homosexuality, some homosexuals prefer to call themselves bisexuals or to try to play a heterosexual role by marrying and having children until they recognize their true sexual identity. Such people, who "come out" as homosexuals after previously living a heterosexual or bisexual lifestyle, may say in retrospect that they were miserable concealing their "true" natures. But no one knows how many individuals had homosexual temptations that they either resisted or succumbed to but later went on to repudiate, in the course of developing a satisfactory heterosexual style of life.

Bisexuality, if it is not merely a mechanism to reduce the stigma of homosexuality, indicates that the individual could gain satisfaction from heterosexuality but prefers not to be exclusively heterosexual. This suggests that homosexuality and heterosexuality are choices, not compulsions. Saying that homosexuality is chosen does not preclude the likelihood that the choice is strongly influenced by personal experiences that may deflect the individual's interest from a partner of the opposite sex or attract the individual to a sexual partner of the same sex. But a constrained choice is still a choice.

The choice of homosexual partners must override not only sociocultural disapproval in most societies but, in the face of the AIDS epidemic, risk of contracting a fatal disease. Isn't a biological imperative the best explanation of such risky behavior? Not necessarily. A great deal of self-destructive behavior is engaged in without anyone claiming that it is biologically based, e.g., drag racing. In the second place, AIDS did produce dramatic changes in the behavior of homosexuals, at least for a time, thereby showing that something else was involved than raw biological drive. In San Francisco, which has the largest concentration of homosexual males in the United States, the gay community undertook a massive AIDS prevention campaign, the result of which was to reduce new AIDS infections from 10 percent of uninfected gays in the early 1980s to 1.4 percent in 1990. Then, over the next six years, the rate crept up again.

In the September 15, 1996 issue of the New York Times Magazine, journalist Jesse Green examined the reasons why gay men continue to have anal sex with other men without at least the protection of a condom -- despite their intellectual awareness of the risks of AIDS. For his article, titled "Flirting with Suicide," Green interviewed a number of such men and concluded that they were making what was from their point of view a rational choice. The following is a quotation from his interview with a homosexual man who, though he was not HIV positive at the time, subsequently became so:

"It was like I was finally inside the candy store I'd been looking at forever. I wasn't about to deny myself now. So during that time, those two or three months, I guess I had over 20 partners. A lot of the time I was drunk, though, so I can't say for sure. Sometimes you go home with somebody you might not really want because of loneliness, and in that position I sure wouldn't mention safe sex. I'd always wait for them to say something about it." He nods his head sharply, as if dismissing an underling. "But no one did."
Master of my fate

Regarding addiction as a medical condition reduces the onus of reprehensible behavior. The deviant individual no longer feels personally degraded, and he has no need to sever his ties with the respectable community. Both his less damaged self-esteem and his unbroken connection to the community may help him return to conformity. On the other hand, when persons tempted to violate a social prohibition can justify giving way to that temptation by suggesting that they have a medical problem that they cannot help -- "I am an alcoholic" -- it surely lowers their threshold of resistance to impulses. Thus the epidemic of addictions feeds on itself, producing more criminal and non-criminal deviance than would otherwise occur. According to the temptation perspective, alcohol abusers, for example, despite withdrawal symptoms, still retain the human capacity to set goals for themselves. Sexual "addicts" do also. When St. Augustine prayed to God to make him chaste and added, "but not yet," he did not think of justifying his promiscuity by claiming that his sexual urges were uncontrollable. The addiction assumption not only excuses behavior that could have been controlled. It may underestimate the altruism of those who do good works; Mother Theresa can be dismissed as having been merely addicted to benevolence.

Ultimately, what fuels the addiction epidemic is the belief that humans are powerless in the face of temptation. But human beings are not dominated by instinct, as lower animals are. We retain the ability, at our best, to override social, psychological, and even biological pressures. In the words of a nineteenth-century poet, himself disabled by tuberculosis of the bone, "I am the master of my fate, I am the captain of my soul."