

NOTES

BEHAVIORAL ADDICTIONS AND THE LAW

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I. INTRODUCTION

The doctrine of free will underlies much of the legal system in the United States. The criminal law, for instance, does not punish a person unless that individual made a choice to commit a wrongful act or otherwise had some sort of control over the wrongful behavior. This principle often arises in the context of individuals with diseases or disorders. Given that a person does not typically choose to be afflicted with a disease, and often cannot control the effects of the disease, the law cannot rightfully hold the person responsible for those effects. For instance, a criminal defendant who committed a wrongful act as a result of suffering from schizophrenia, a mental illness over which the defendant has no control, will likely be punished less severely than a non-mentally ill defendant, or not at all. Similarly, a civil defendant who crashed a car due to a sudden unforeseeable heart attack will likely not be liable for the resulting damage. Implicit in this concept is the idea that any person in the same circumstances would have done the same thing.

A legal system such as ours, built around the concept of free will, is contorted by the concept of addiction. Addicts, by definition, are unable to control their substance use. Implicit in this concept is the idea that any person who is given an addictive substance for a certain amount of time can become addicted to that substance. The law has wrestled with fitting the concept of drug addiction into the many doctrinal areas founded on the concept of free will.

But what if a person is addicted to a behavior, rather than a substance? What if a person suffers from a disease that compels one to engage in

repetitive, self-destructive behavior that cannot be controlled? Can that individual be held responsible for those actions? This is the concept underlying “behavioral addictions”: a category of proposed mental disorders defined by loss of voluntary control over a behavior—such as sex, Internet use, eating, or exercise—resulting in repetitious, excessive engagement in that behavior despite adverse consequences.

Popular culture, the psychiatric community, and the legal system have become increasingly accepting of behavioral addictions as mental disorders. Although media accounts of, for example, “iPhone addiction”¹ can make the issue seem spurious, psychiatrists and academic researchers have gained ground over the last decade establishing behavioral addictions such as “Internet addiction” and “sex addiction” as bona fide mental disorders. This trend is reflected in the fifth edition of the American Psychiatric Association’s (“APA’s”) *Diagnostic and Statistical Manual of Mental Disorders* (“DSM-V”), which is scheduled for publication in 2013. Proposed changes for the DSM-V include for the first time recognition of behavioral addictions, possibly to include Internet addiction and sex addiction.²

Behavioral addictions are also cropping up with increasing regularity in court, where litigants are putting them to use in forming novel claims and defenses. Is Internet addiction a disability within the meaning of the Americans with Disabilities Act, thereby subjecting employers to liability for adverse employment actions taken on the basis of an employee’s improper Internet use?³ Should a judge consider Internet or sex addiction when determining the fitness of a parent in child custody cases?⁴ Does shopping addiction qualify as a “significantly reduced mental capacity” under the United States Sentencing Guidelines, thereby allowing for a reduced sentence?⁵

This Note argues that, regardless of whether the psychiatric community and popular culture ultimately accept behavioral addictions as established mental disorders, the legal system should adhere to the traditional meaning of addiction as dependence on a chemical substance

1. See Dan Hope, *iPhone Can Be Addicting, Says New Survey*, MSNBC.COM (Mar. 8, 2010, 4:37:08 PM), <http://www.msnbc.msn.com/id/35768107/>.

2. See *infra* notes 93–96 and accompanying text. Although this Note concludes that these excessive behaviors should not be classified as “addictions,” for the sake of consistency they are generally referred to as such throughout this Note.

3. See *Pacenza v. IBM Corp.*, No. 04 Civ. 5831 (PGG), 2009 U.S. Dist. LEXIS 29778, at *2–3 (S.D.N.Y. Apr. 1, 2009).

4. See *Bower v. Bower*, 758 So. 2d 405, 411 (Miss. 2000).

5. See *United States v. Roach*, 296 F.3d 565, 566 (7th Cir. 2002).

and not recognize a category of behavioral addictions. The argument proceeds as follows.

Part II of this Note examines the concept of addiction. Part II.A discusses the traditional definition of addiction, as well as the current state of research on the subject. Next, Part II.B discusses the trend toward defining certain excessive behaviors as behavioral addictions and examines the scientific research supporting this emerging concept. Part II.B goes on to discuss proposals for adding certain behavioral addictions to the DSM. Part III examines the impact recognizing behavioral addictions would have on three areas of the law: employment law, family law, and criminal sentencing. Part IV analyzes the significant impact that the recognition of behavioral addictions could have on the legal system and discusses whether it is justified in light of the scientific research behind such disorders and the current ability of mental health professionals reliably to diagnose behavioral addictions. Part V concludes.

II. ADDICTION THEORY AND RESEARCH

A. TRADITIONAL ADDICTION THEORY

1. Defining Addiction

In Roman law, a debtor who could not repay his debt was assigned to his creditor as *addictus*, slave to the creditor to work off the debt or be sold.⁶ From these roots emerged the modern term “addiction,” the state of being enslaved to a chemical substance. Although the concept of addiction is firmly rooted in modern culture, the scientific definition of addiction is hotly disputed, to the point of being in a state of “conceptual chaos.”⁷ The most common definition is in the current version of the APA’s *Diagnostic and Statistical Manual of Mental Disorders* (“DSM IV-TR”),⁸ which does

6. A DICTIONARY OF GREEK AND ROMAN ANTIQUITIES 656 (William Smith ed., 3d Am. ed., New York, Harper & Brothers 1878).

7. Howard J. Shaffer, *The Most Important Unresolved Issue in the Addictions: Conceptual Chaos*, 32 SUBSTANCE USE & MISUSE 1573, 1574 (1997). See also Martin F. Hill, Jr. & Tammy Westhoff, “No Song Unsung, No Wine Untasted”—Employee Addictions, Dependencies, and Post-Discharge Rehabilitation: Another Look at the Victim Defense in Labor Arbitration, 47 DRAKE L. REV. 399, 405 (1999) (finding “numerous and often conflicting definitions of the term ‘addiction,’” with no single definition generally accepted).

8. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed., text rev. 2000) [hereinafter DSM-IV-TR]. Throughout this Note, the various editions of the DSM will be referred to as follows: “DSM-III” will refer to the third edition, published in 1980; “DSM-III-R” will refer to the revised third edition, published in 1987; “DSM-IV” will refer to the fourth

not use the term “addiction,” but rather “substance dependence,”⁹ defining that term as “[a] maladaptive pattern of substance use, leading to clinically significant impairment or distress,” and setting forth seven criteria to aid in diagnosis.¹⁰

Although no precise definition of addiction is agreed upon, the traditional elements of the condition are “tolerance” and “withdrawal.”¹¹ Tolerance refers to the tendency of a given dosage of a substance to be less successful in achieving the desired effect over time.¹² The addict will increase the dosage of a substance to achieve the same effect, making addiction a progressive disorder. Tolerance occurs through the drug’s effect on two places, the liver and the brain.¹³ Some substances, like alcohol, cause the liver to produce more of the enzyme that breaks down that particular substance, thereby requiring more of the substance to overcome

edition, published in 1994; “DSM-IV-TR” will refer to the text revision of the fourth edition, published in 2000; and the upcoming fifth edition will be referred to as “DSM-V.”

9. The drafters of the DSM-IV-TR split over whether to use the term “addiction” or “dependence,” but the latter was ultimately chosen because it was viewed as a more neutral term. Charles P. O’Brien, Nora Volkow & T-K Li, *What’s in a Word? Addiction Versus Dependence in DSM-V*, 163 AM. J. PSYCHIATRY 764, 764 (2006).

10. DSM-IV-TR, *supra* note 8, at 197. The full text of DSM-IV-TR’s entry on substance dependence reads as follows:

Criteria for Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

- (1) tolerance, as defined by either of the following:
 - (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
 - (b) markedly diminished effect with continued use of the same amount of the substance
- (2) withdrawal, as manifested by either of the following:
 - (a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
 - (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
- (3) the substance is often taken in larger amounts or over a longer period than was intended
- (4) there is a persistent desire or unsuccessful efforts to cut down or control substance use
- (5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects
- (6) important social, occupational, or recreational activities are given up or reduced because of substance use
- (7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

Id.

11. *Id.*

12. *See id.*

13. AVRAM GOLDSTEIN, ADDICTION: FROM BIOLOGY TO DRUG POLICY 87 (2d ed. 2001).

the enzyme and produce the desired effect on the individual.¹⁴ Other substances cause users to become tolerant to the substance's effects by altering chemicals in the brain itself. This occurs when neurons adapt and become desensitized to the chemical changes induced by the drug.¹⁵

Withdrawal encompasses the physiological side effects that result from the cessation of repeated use of a substance.¹⁶ When the body is exposed to a potent chemical like a drug, it attempts to maintain homeostasis through counter-regulatory mechanisms.¹⁷ For instance, in reaction to long-term exposure to alcohol, which suppresses excitatory neurotransmission, the brain increases production of excitatory neurotransmitters.¹⁸ When alcohol intake ceases, the brain is left with a surplus of excitatory neurotransmitters, and this harmful imbalance manifests in withdrawal symptoms.¹⁹ As this process would predict, the symptoms of withdrawal are generally opposite in character to the relevant effects of the substance. For instance, alcohol is a depressant; alcohol withdrawal is characterized by hyperactivity, tremors, nervousness, and seizures.²⁰ Substances that are stimulants, such as cocaine or amphetamines, have withdrawal symptoms characterized by fatigue, sleepiness, and depression.²¹ The common characteristic of all withdrawal symptoms is a subjective dysphoria and the resulting desire to ingest more of the drug in order to return to a balanced state.²² Some withdrawal symptoms can even be fatal—severe alcohol withdrawal can have a mortality rate as high as 20 percent if left untreated.²³

The criteria used to define addiction have been expanded from the original twin pillars of tolerance and withdrawal to include a greater focus on behavioral markers manifested in the individual's relationship with the substance.²⁴ This approach is exemplified by criteria three through seven in

14. *Id.*

15. *Id.* at 87–89.

16. See DSM-IV-TR, *supra* note 8, at 194.

17. Nathanael J. McKeown & Patrick L. West, *Withdrawal Syndromes*, EMEDICINE, <http://emedicine.medscape.com/article/819502-overview> (last updated Mar. 18, 2010).

18. *Id.*

19. *Id.*

20. GOLDSTEIN, *supra* note 13, at 92.

21. *Id.* at 90, 184.

22. See *id.* at 90.

23. McKeown & West, *supra* note 17.

24. HANAN FRENK & REUVEN DAR, A CRITIQUE OF NICOTINE ADDICTION 30–32 (2000); Shaffer, *supra* note 7, at 1577 (“It is the *relationship* of the addicted person with the object of their excessive behavior that defines addiction.”).

the DSM-IV-TR's definition of substance dependence.²⁵ For example, under these criteria addiction is indicated by "a persistent desire or unsuccessful efforts to cut down or control substance use" and "a great deal of time . . . spent in activities necessary to obtain the substance."²⁶ The World Health Organization's definition displays a similar focus on behavioral markers, describing dependence as "a cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value."²⁷

2. Research Supporting Traditional Addiction Theory

Although research on addiction has progressed tremendously, particularly from advances in neuroscience and neuroimaging, the scientific support for addiction theory is surprisingly unsettled.²⁸ A "drug" is simply a chemical that affects biological functions, and a "psychoactive drug" is one that affects the functions of the brain, altering mood, thought processes, or behaviors.²⁹ Most psychoactive drugs have nothing special about them that would make people take them if they did not have to,³⁰ but a special subset of drugs do cause people to seek and use them even to their detriment; it is these drugs we call "addictive."³¹ Although researching the complex behavior related to the effects of drugs presents substantial difficulty, scientists have identified certain distinguishing characteristics of addictive substances.

One characteristic of an addictive substance is that it allows for "drug discrimination" by the user.³² In other words, the substance causes biochemical changes in the body that enable a person to distinguish it from other psychoactive substances; otherwise, a user could not seek out and repeatedly use that particular drug and could not become addicted to it.³³ This behavior has been demonstrated in rats, which can be trained with

25. DSM-IV-TR, *supra* note 8, at 197. The criteria are quoted *supra* note 10.

26. DSM-IV-TR, *supra* note 8, at 197.

27. *Dependence Syndrome*, WORLD HEALTH ORGANIZATION, http://www.who.int/substance_abuse/terminology/definition1/en/index.html (last visited Nov. 1, 2010).

28. See GOLDSTEIN, *supra* note 13, at 94 ("[A] coherent picture has not yet emerged to explain fully—for any addictive drug—either the immediate rewarding effects (the 'high') or the long-term tolerance and dependence.").

29. *Id.* at 4.

30. See *id.* (noting the "compliance problem" physicians have when trying to get patients to take their prescribed drugs regularly).

31. *Id.* at 4–5.

32. *Id.* at 54.

33. *Id.* at 54–56.

repeated injections of a drug like cocaine or morphine so that they exhibit certain behavior when experiencing that particular drug, but not other drugs or a placebo. For instance, in one experiment a rat is injected with a substance and sent running down a tunnel. At the end of the tunnel the rat can turn left or right; each direction ends in a door. When the rat is injected with a placebo, the right door is open. When the rat is injected with nicotine, the left door is open. This process is done repeatedly until eventually the rat learns to turn right when it receives the placebo and turn left when it receives nicotine.³⁴ A trained rat can also discriminate between one drug, such as nicotine, and a drug belonging to a different family, like morphine.³⁵

A second characteristic of an addictive substance is that it reinforces the behavior that resulted in administration of the substance. For instance, animals hooked up to receive an intravenous injection of heroin every time they press a lever will press the lever again and again.³⁶ Similarly, experiments with monkeys have shown that they will ignore food and water, even until it results in death, in order to self-administer cocaine.³⁷

The process by which certain substances cause addiction can be thought of as a positive-negative feedback loop. First, the addictive substance induces some kind of subjectively enjoyable experience—essentially positive feedback. Drugs in the opiate family—including morphine, heroin, codeine, and synthetic opiate painkillers like oxycodone—produce a relaxed euphoria and an “intense feeling of sublime pleasure.”³⁸ Stimulants, particularly cocaine and amphetamine, increase activation of the central nervous system and cause a rush of euphoria.³⁹ Drugs generally create this euphoric or enjoyable experience by stimulating or mimicking naturally occurring chemicals in the brain at an extreme level.⁴⁰ For instance, by both stimulating the release and blocking the reuptake of dopamine (a naturally occurring neurotransmitter), amphetamines increase dopamine levels in the brain to an extent that could never be obtained in the absence of a drug.⁴¹

34. *Id.*

35. *Id.* at 56.

36. *Id.* at 59.

37. *Id.*

38. *Id.* at 159.

39. *Id.* at 182.

40. Kent C. Berridge & Terry E. Robinson, *What Is the Role of Dopamine in Reward: Hedonic Impact, Reward Learning, or Incentive Salience?*, 28 BRAIN RES. REV. 309, 340–41 (1998).

41. GOLDSTEIN, *supra* note 13, at 180; Constance Holden, “Behavioral” Addictions: Do They Exist?, 294 SCIENCE 980, 980 (2001) (“[D]rugs are far more powerful than any ‘natural’ pleasure when

Second, the addictive substance produces subjective dysphoria upon cessation—negative feedback. Opiate withdrawal, which is often described as a sickness, produces intensely aversive symptoms including nausea, vomiting, diarrhea, and severe flu-like symptoms.⁴² This sickness is relieved, as if by magic, by another dose of the opiate.⁴³

This cycle of positive and negative feedback is the engine that drives addiction. Intense positive feedback derived from the pleasurable effects of the drug causes the user to seek out more of the drug. Then, powerful negative feedback in the form of withdrawal symptoms results when use of the drug ceases, further compelling the user to obtain more of the drug.

Despite the vast body of research devoted to quantifying and measuring addictions, the concept remains normative and value laden.⁴⁴ Many substances that produce tolerance and physical dependence are used without the user's being labeled an addict. Millions of hospital patients receive opiate painkillers, require increased dosages as they grow tolerant, and experience withdrawal symptoms once they stop taking the drugs; however, we do not refer to these patients as addicts.⁴⁵ Similarly, most people consume alcoholic beverages regularly, but only a certain percentage do so with such intensity that they receive the label addict.⁴⁶ Thus, the concept of addiction necessarily includes a judgment that the use is "problematic" rather than "normal." Although scientific studies undoubtedly provide useful information to guide this inquiry, whether an individual is an addict still remains to a large extent a normative determination.

B. EMERGING BEHAVIORAL ADDICTION THEORY

1. Defining Behavioral Addictions

In the early 1990s, researchers began arguing that addiction disorders should include not just excessive substance use, but also certain patterns of excessive behavior—"behavioral addictions."⁴⁷ The most frequently

it comes to the amount of dopamine released.").

42. McKeown & West, *supra* note 17.

43. GOLDSTEIN, *supra* note 13, at 93.

44. See Gio Batta Gori, *Failings of the Disease Model of Addiction*, 11 HUM. PSYCHOPHARMACOLOGY S33, S33–38 (1996) (discussing the value judgments implicit in the concept of addiction).

45. See GOLDSTEIN, *supra* note 13, at 159.

46. See *id.* at 137.

47. See, e.g., Isaac Marks, *Behavioural (Non-Chemical) Addictions*, 85 BRIT. J. ADDICTION

proposed new disorders include Internet addiction, exercise addiction, shopping addiction, sex addiction, and food addiction.⁴⁸ The popular media has been the most enthusiastic dispenser of the addiction label, ranging from the generally innocuous “chocolate addiction” to serious treatment of “work addiction,”⁴⁹ “text-message addiction,”⁵⁰ “BlackBerry addiction,”⁵¹ and “golf addiction.”⁵²

Perhaps more surprising, however, is that academic researchers and scholars, in fields ranging from psychology to law, have followed suit. Serious research studies have been published on “religious addiction,”⁵³ “television addiction,”⁵⁴ and “work addiction.”⁵⁵ Moreover, a substantial body of literature exists on the core behavioral addictions mentioned above—Internet, exercise, shopping, sex, and food addictions.⁵⁶

The DSM-IV-TR does not recognize non-substance related, or “behavioral,” addictions.⁵⁷ Similar conditions related to obsessions and compulsions do appear in a variety of categories, including “Eating Disorders,”⁵⁸ “Sexual and Gender Identity Disorders,”⁵⁹ and “Impulse-Control Disorders Not Elsewhere Classified.”⁶⁰ Pathological Gambling is the closest thing to a behavioral addiction recognized by the DSM-IV-TR;

1389, 1389 (1990).

48. See Cary W. Horvath, *Measuring Television Addiction*, 48 J. BROADCASTING & ELEC. MEDIA 378, 379 (2004) (listing examples of behavioral addictions).

49. Dana Mattioli, *Worried You're a Workaholic?: Five Telltale Signs Hint There's a Problem*, GLOBE & MAIL (Toronto), Jan. 10, 2007, at C8.

50. Subha Ravindhran, *Is Text Messaging a Mental Illness?*, ABC7.COM (Mar. 26, 2008), <http://abclocal.go.com/kabc/story?section=news/health&id=6043089>.

51. Sinead McIntyre, *Blackberry Addiction "Similar to Drugs,"* MAIL ONLINE (Aug. 22, 2006, 4:09 PM), <http://www.dailymail.co.uk/news/article-401646/Blackberry-addiction-similar-drugs.html>. Often the BlackBerry is used as shorthand for all smartphone devices, possibly because its name lends itself to the pithy title “crackberr[y].” See *id.*

52. Roberta W. Coffey, *In the Rough: Calling Golf Nuts Addicts May Not Be Far off the Mark*, L.A. TIMES, July 23, 1991, at E1.

53. Cheryl Zerbe Taylor, *Religious Addiction: Obsession with Spirituality*, 50 PASTORAL PSYCHOL. 291 (2002).

54. See, e.g., Horvath, *supra* note 48.

55. See, e.g., Gayle Porter & Nada K. Kakabadse, *HRM Perspectives on Addiction to Technology and Work*, 25 J. MGMT. DEV. 535 (2006).

56. See, e.g., Rachel Warner & Mark D. Griffiths, *A Qualitative Thematic Analysis of Exercise Addiction: An Exploratory Study*, 4 INT'L J. MENTAL HEALTH & ADDICTION 13 (2006) (discussing food, exercise, gambling, and sex addiction); Peter J. Rogers & Hendrik J. Smit, *Food Craving and Food "Addiction": A Critical Review of the Evidence from a Biopsychosocial Perspective*, 66 PHARMACOLOGY BIOCHEMISTRY & BEHAV. 3, 7 (2000) (discussing food addiction).

57. See DSM-IV-TR, *supra* note 8, at 191–295 (“Substance-Related Disorders”).

58. See *id.* at 583–95.

59. See *id.* at 535–82.

60. See *id.* at 663–77.

however, that condition is categorized under Impulse Control Disorders Not Elsewhere Classified along with Kleptomania (stealing), Pyromania (fire setting), Trichotillomania (hair pulling), and Intermittent Explosive Disorder (aggressive attacks).⁶¹

Howard J. Shaffer, director of the Division on Addictions at the Cambridge Health Alliance, a Harvard Medical School teaching affiliate,⁶² is one of the major proponents of expanding the notion of addiction to include excessive behaviors.⁶³ According to Shaffer, any activity that is characterized by the “three Cs” can qualify as an addiction: “Behavior that is motivated by emotions ranging along the Craving to Compulsion spectrum[;] Continued use in spite of adverse consequences[;] and [l]oss of Control.”⁶⁴

The classification of the proposed disorder “sex addiction” displays how this expansive notion of addiction, advocated by Shaffer and others, functions in forming new disorders.⁶⁵ The DSM-IV-TR recognizes “paraphilic,” that is, abnormal, sexual disorders, including Exhibitionism, Fetishism, Pedophilia, and Sexual Masochism.⁶⁶ Sex addiction, however, refers to excessive “normophilic” (nonparaphilic, or normal) sexual behaviors, with the additional requirement that they be associated with “significant adverse consequences.”⁶⁷ The proposed criteria for sex addiction mirror those identified by Shaffer: (1) *craving*, in the form of “recurrent and intense sexual fantasies, sexual urges, or sexual behaviors”; (2) *continued use despite adverse consequences*, described as “clinically significant personal distress or impairment in social, occupational or other important areas of functioning”; and (3) loss of *control*, in terms of “[r]epetitive but unsuccessful efforts to control or significantly reduce these

61. See *id.* at 663, 671–74.

62. See *About Us*, DIVISION ON ADDICTIONS—CAMBRIDGE HEALTH ALLIANCE, <http://www.divisiononaddictions.org/aboutus.htm> (last visited Nov. 1, 2010).

63. See Howard J. Shaffer, *What Is an Addiction?: A Perspective*, DIVISION ON ADDICTIONS—CAMBRIDGE HEALTH ALLIANCE, <http://www.divisiononaddictions.org/html/whatisaddiction.htm> (last visited Nov. 1, 2010).

64. *Id.* The careful reader will note that this formulation technically amounts to four “Cs.”

65. See, e.g., John Bancroft & Zoran Vukadinovic, *Sexual Addiction, Sexual Compulsivity, Sexual Impulsivity or What? Toward a Theoretical Model*, 41 J. SEX RES. 225 (2004); Aviel Goodman, *What’s in a Name? Terminology for Designating a Syndrome of Driven Sexual Behavior*, 8 SEXUAL ADDICTION & COMPULSIVITY 191 (2001).

66. Martin P. Kafka, *Hypersexual Disorder: A Proposed Diagnosis for DSM-V*, 39 ARCHIVES SEXUAL BEHAV. 377, 378 (2010). See also DSM-IV-TR, *supra* note 8, at 566–76.

67. Kafka, *supra* note 66, at 377, 378. Even among proponents of ascribing disorder status on excessive sexual behavior there is significant disagreement regarding whether the condition is best described as an “addiction,” a “compulsivity” disorder, an “impulsivity” disorder, or something unique like “hypersexuality.” See *id.* at 378–79. For present purposes the “sex addiction” label is used.

sexual fantasies, urges or behaviors.”⁶⁸

2. Research Supporting Behavioral Addictions

Each of the various proposed behavioral addictions is premised on one or both of the following rationales: (1) the behavior corresponds with activity in the brain’s reward circuitry similar to that which occurs during drug use (the “dopamine theory”);⁶⁹ or (2) the relationship between an individual and the behavior looks like the relationship between an individual and a drug because both involve craving, excessive use, withdrawal, tolerance, and continuation despite negative repercussions (the “looks-like-addiction theory”).⁷⁰

a. The Dopamine Theory

Much of the literature endorsing the concept of behavioral addictions cites the fact that the addictive behavior involves the same neural circuitry as drug use.⁷¹ Pleasurable or exciting behaviors, like gambling, sex, or shopping, increase the levels of dopamine and other neurotransmitters in the brain the same way that drugs do.⁷² The argument is that pleasurable activities can change the neural circuitry in ways that perpetuate the behavior.⁷³ The person then needs more and more of the activity in order to obtain the same “rush” from it.⁷⁴ This neuroadaptation then causes the person to invest increased amounts of time and resources into the activity, and to continue engaging in it despite negative consequences.⁷⁵

Although the dopamine theory of behavioral addictions is frequently proffered, little supporting research exists.⁷⁶ Neuroimaging studies have been conducted on only one of the proposed behavioral addictions—pathological gambling—and those studies involved small samples⁷⁷ (for

68. *Id.* at 379.

69. *See, e.g.*, Jon E. Grant, Judson A. Brewer & Marc N. Potenza, *The Neurobiology of Substance and Behavioral Addictions*, 11 *CNS SPECTRUMS* 924, 925–26 (2006).

70. *See* Jerald J. Block, *Issues for DSM-V: Internet Addiction*, 165 *AM. J. PSYCHIATRY* 306, 306 (2008).

71. *See, e.g.*, Grant, Brewer & Potenza, *supra* note 69, at 925–26; Marc N. Potenza, *Should Addictive Disorders Include Non-Substance-Related Conditions?*, 101 *ADDICTION* 142, 145 (2006).

72. *See* Grant, Brewer & Potenza, *supra* note 69, at 925–26; Potenza, *supra* note 71, at 145–46.

73. *See* Holden, *supra* note 41, at 980.

74. *See id.* (describing compulsive gamblers’ need to escalate their betting).

75. *Id.*

76. Potenza, *supra* note 71, at 147 (finding that while substantial data exist for pathological gambling, less data are available for other impulse control disorders).

77. Marc N. Potenza, *The Neurobiology of Pathological Gambling and Drug Addiction: An Overview and New Findings*, 363 *PHIL. TRANSACTIONS ROYAL SOC’Y B* 3181, 3186 (2008) (“Most biological studies to date have involved small samples . . .”).

example, ten subjects),⁷⁸ and their findings were far from decisive.⁷⁹ For instance, one study used functional magnetic resonance imaging on individuals diagnosed with pathological gambling and on control subjects while both groups viewed various stimuli, including depictions of “happy” and “sad” scenarios, and of people gambling.⁸⁰ The resulting brain scans were then compared to a similar study involving subjects addicted to cocaine who were scanned while viewing depictions of cocaine use.⁸¹ Although some difference was observed between the pathological gamblers and the control group, the gamblers and the cocaine users showed opposite brain activity when viewing their respective disorder-related cues.⁸² The gamblers also showed decreased activity in the brain’s reward center while viewing gambling cues, which is the opposite of what the dopamine theory would predict.⁸³

b. The Looks-Like-Addiction Theory

Most of the support offered for classifying certain excessive behaviors as addictions is grounded on the fact that many of the criteria used to diagnose drug addiction—craving, excessive use, and continuance despite negative repercussions—conveniently apply to excessive behaviors as well.⁸⁴ For example, people who engage in excessive shopping describe cravings that can be relieved only by new purchases, spending excessive time and money on shopping, and continuing shopping binges despite crippling credit card debt and other negative consequences.⁸⁵ Often, new

78. E.g., Marc N. Potenza et al., *Gambling Urges in Pathological Gambling: A Functional Magnetic Resonance Imaging Study*, 60 ARCHIVES GEN. PSYCHIATRY 828, 828–29 (2003) [hereinafter Potenza et al., *Gambling Urges in Pathological Gambling*]. See also Marc N. Potenza et al., *An fMRI Stroop Task Study of Ventromedial Prefrontal Cortical Function in Pathological Gamblers*, 160 AM. J. PSYCHIATRY 1990, 1990 (2003) (thirteen subjects).

79. Jon E. Grant, Kyle A. Williams & Suck Won Kim, *Update on Pathological Gambling*, 8 CURRENT PSYCHIATRY REP. 53, 54–55 (2006) (reviewing the research to date and explaining that it is in the early stages); Potenza, *supra* note 77, at 3186 (explaining that findings to date are preliminary and that “substantial gaps remain” in our understanding).

80. See Potenza et al., *Gambling Urges in Pathological Gambling*, *supra* note 78, at 829.

81. *Id.* at 833.

82. *Id.* at 833–34; *id.* at 834 (“[T]he nature of the activity differences during this initial period of videotape viewing was different in [cocaine-dependent] and [pathological gambling] subjects.”).

83. *Id.* at 832.

84. See, e.g., Block, *supra* note 70, at 306 (applying the criteria to support a classification of “Internet addiction”); Mark D. Griffiths & Alex Meredith, *Videogame Addiction and Its Treatment*, 39 J. CONTEMP. PSYCHOTHERAPY 247, 248–49 (2009) (applying the criteria to support a classification of videogame addiction); Warner & Griffiths, *supra* note 56, at 14 (applying the criteria to support a classification of “exercise addiction”).

85. See, e.g., Raymond Krych, *Abnormal Consumer Behavior: A Model of Addictive Behaviors*, 16 ADVANCES CONSUMER RES. 745 (1989) (describing commonalities in various abnormal consumer behaviors and analogizing them to addictions).

behavioral addictions will also be described in terms that attempt to apply the classic indicia of addiction—tolerance and withdrawal. For example, an editorial published by the *American Journal of Psychiatry*, advocating the inclusion of Internet addiction in the upcoming DSM-V, reasoned that excessive Internet users exhibit symptoms characteristic of typical drug addiction.⁸⁶ These symptoms include withdrawal, in the form of “feelings of anger, tension, and/or depression” when unable to access a computer; tolerance, evinced by “the need for better computer equipment, more software, or more hours of use”; and negative repercussions, such as “arguments, lying, [and] poor achievement.”⁸⁷

The process by which Internet addiction gained (some) recognition as a disorder provides a good example of how existing addiction criteria are being adapted to create new categories of behavioral addiction disorders, often with strange results. In 1998, Kimberly S. Young took the criteria for pathological gambling defined by the DSM-IV and used them for the first definition of Internet addiction.⁸⁸ Young crafted eight criteria, of which five or more were necessary for a diagnosis of Internet addiction.⁸⁹ The criteria were distributed as a diagnostic questionnaire, with questions such as

1. Do you feel preoccupied with the Internet (think about previous on-line activity or anticipate next on-line session)?
2. Do you feel the need to use the Internet with increasing amounts of time in order to achieve satisfaction?
3. Have you repeatedly made unsuccessful efforts to control, cut back, or stop Internet use?
4. Do you feel restless, moody, depressed, or irritable when attempting to cut down or stop Internet use?⁹⁰

The questionnaire yielded 496 valid responses, of which 396 met the

86. Block, *supra* note 70.

87. *Id.*

88. Kimberly S. Young, *Internet Addiction: The Emergence of a New Clinical Disorder*, 1 *CYBERPSYCHOLOGY & BEHAV.* 237, 237–38 (1998). One year before Young published the first definition of Internet addiction, Ivan K. Goldberg, a psychiatrist in New York, decided to parody the DSM-IV by adapting its pathological gambling criteria to a new condition he called “Internet addiction disorder.” David Wallis, *Just Click No*, *NEW YORKER*, Jan. 13, 1997, at 28, 29. He posted the diagnostic criteria for his hoax condition on an online psychiatrist discussion group, with symptoms including “important social or occupational activities that are given up or reduced because of Internet use,” and “fantasies or dreams about the Internet.” *Id.* Now Young’s criteria are frequently cited in the research, and Goldberg “may be the first in his field to gain notoriety for naming a disease that he says doesn’t exist.” *Id.* at 28.

89. Young, *supra* note 88, at 238.

90. *Id.*

diagnosis of Internet addiction.⁹¹ In other words, adapting the DSM-IV criteria to the new category of excessive Internet use resulted in 80 percent of respondents being diagnosed with Internet addiction.⁹²

c. DSM-V and Behavioral Addictions

The controversy surrounding behavioral addictions may be coming to a head with the publication of the DSM-V, slated for May 2013.⁹³ Proposed revisions include changing the name of the category “Substance-Related Disorders” to “Addiction and Related Disorders.”⁹⁴ This section would include proposed behavioral addictions like pathological gambling and, possibly, Internet addiction and sex addiction.⁹⁵ Shopping addiction was in the running but seems to have fallen out of the latest proposed draft revisions.⁹⁶

The DSM is the authoritative text with respect to mental illnesses. It is psychiatry’s “diagnostic bible.”⁹⁷ It was created as part of the APA’s long-standing effort to count and classify mental disorders.⁹⁸ The introduction of the DSM-III in the 1980s signaled a “paradigm shift” in the field of psychiatric diagnosis, which resulted in greater reliance on empirical data and a more rigorous methodology through operational criteria sets and the multiaxial system.⁹⁹ This diagnostic system is supposed to provide greater reliability of diagnostic criteria and greater consistency among

91. *Id.* at 239. Note that in the original article, the number of total valid responses was mistakenly reported as 596. *See id.* A subsequent publication by Young clarifies that the correct number of valid responses was 496. *See* KIMBERLY S. YOUNG, CAUGHT IN THE NET: HOW TO RECOGNIZE THE SIGNS OF INTERNET ADDICTION—AND A WINNING STRATEGY FOR RECOVERY 5 (1998).

92. Young, *supra* note 88, at 239.

93. AM. PSYCHIATRIC ASS’N, DSM-V, <http://www.dsm5.org/Pages/Default.aspx> (last visited Nov. 2, 2010).

94. *Substance-Related Disorders*, AM. PSYCHIATRIC ASS’N, DSM-V, <http://www.dsm5.org/ProposedRevisions/Pages/Substance-RelatedDisorders.aspx> (last visited Nov. 2, 2010).

95. *Id.*; Kafka, *supra* note 66.

96. Compare Eric Hollander & Bernardo Dell’Osso, *New Developments in an Evolving Field*, PSYCHIATRIC TIMES, July 1, 2005, at 17, available at <http://www.psychiatrictimes.com/dsm-v/content/article/10168/52531#> (discussing proposed changes to the DSM-V, including the addition of “impulsive-compulsive buying disorder”), with *Substance-Related Disorders*, *supra* note 94 (setting forth the latest draft revisions with no mention of a shopping or buying disorder).

97. *See, e.g.*, Rita Rubin, *Psychiatry’s Bible: Autism, Binge-Eating Updates Proposed for “DSM,”* USA TODAY, Feb. 9, 2010, http://www.usatoday.com/news/health/2010-02-10-dsm10_ST_N.htm.

98. Joseph P. McMenamin & Andrea D. Tiglio, *Not the Next Tobacco: Defenses to Obesity Claims*, 61 FOOD & DRUG L.J. 445, 489 (2006).

99. Allen Frances, *A Warning Sign on the Road to DSM-V: Beware of Its Unintended Consequences*, PSYCHIATRIC TIMES (June 26, 2009), <http://www.psychiatrictimes.com/dsm-5/content/article/10168/1425378?verify=0A>.

psychiatrists.¹⁰⁰

When legislators, judges, and the experts who testify before them need authoritative criteria for mental illnesses they turn to the DSM.¹⁰¹ Thus, whether the DSM recognizes a particular condition, and what criteria it uses to define the conditions it does recognize, have a significant effect on the law and legal process. A particularly pertinent example is pathological gambling. Courts historically ignored the arguments of defendants who claimed that they should not be held fully responsible for their acts because of gambling problems.¹⁰² Once the APA put its “imprimatur” on pathological gambling by including it in the DSM-III, however, courts began to accept the condition as partially exculpatory.¹⁰³

The DSM, however, has distinct limitations.¹⁰⁴ For this reason the DSM itself warns against using it for legal purposes because of the “significant risks that diagnostic information will be misused or misunderstood”¹⁰⁵ and the “imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis.”¹⁰⁶ Despite the arguments against using the DSM in the legal realm, the reality is that it is the closest thing we have to an authoritative text on mental disorders, and for this reason it will likely continue to be relied on by judges, legislators, and practitioners. Consequently, its classifications are of immense importance to the legal field.

III. BEHAVIORAL ADDICTIONS AND THE LAW

A. THE STIGMATIZING AND EXCULPATORY EFFECTS OF RECOGNIZING BEHAVIORAL ADDICTIONS

Recognizing behavioral addictions as bona fide mental disorders would have a significant impact on the law. This impact can be thought of

100. See ALAN A. STONE, *LAW, PSYCHIATRY, AND MORALITY* 80 (1984).

101. See *id.* (discussing the use of the DSM in court); McMenam & Tiglio, *supra* note 98, at 490 (same); 135 CONG. REC. 20,572 (1989) (statement of Sen. Armstrong) (“A private entity that wishes to know what the act might mean with respect to mental impairments would do well to turn to DSM-III-R because that is one reputable place where mental disorders are listed category-by-category, name-by-name.”).

102. See Gilbert Geis, *Pathological Gambling and Insanity, Diminished Capacity, Dischargeability, and Downward Sentencing Departures*, 8 GAMING L. REV. 347, 347 (2004).

103. *Id.*

104. See McMenam & Tiglio, *supra* note 98, at 490 (discussing the limitations of the DSM-IV-TR in both medical and legal contexts).

105. DSM-IV-TR, *supra* note 8, at xxxii–xxxiii.

106. *Id.* at xxxiii.

in terms of the stigmatizing and exculpatory effects that occur when a set of characteristics or behaviors is classified as a disease or disorder.

Designating a certain characteristic as a disorder entails a judgment that the characteristic is outside the normal range of variation.¹⁰⁷ For instance, there is a normal variation of alcoholic beverage intake, and it is generally accepted that people can drink with regularity and be normal. At a certain point, however, the level of drinking is outside the normal range of variation and we attach the label “alcoholic.” This label is a stigma. It serves to differentiate the problem drinker from the normal drinker and thus carries with it society’s frown.

Recognizing that something is a disorder can also serve to excuse the afflicted individual from behavior caused by the condition.¹⁰⁸ You might yell at grandpa for forgetting to lock the house if the television is stolen, but you would probably hold back if grandpa forgot because he suffers from Alzheimer’s disease. There is presently a push to classify alcoholism, and indeed all drug addiction, as a disease.¹⁰⁹ The idea is that drug and alcohol use “change[s] the brain’s structure” such that it has the biological basis of a disease.¹¹⁰ Proponents of this view also argue that calling drug addiction a disease may relieve some of the stigma that prevents users from seeking treatment.¹¹¹ Whether drug addiction is, in fact, a disease is beyond the purview of this Note. Analogous concepts, particularly changes in the brain’s structure, are put forth to support the recognition of behavioral addictions, so the implications of a “disease” label remain important.¹¹²

For the legal system, classifying behavioral addictions under the rubric of mental disorders would have stigmatizing and exculpatory effects on various areas of the existing jurisprudence. If there is a firm scientific basis for this classification and reliable and accurate means for diagnosing the disorders, the effects are justified and aligned with the existing legal framework. If the science does not support the classification, however, or

107. See Nancy M. Petry, *Should the Scope of Addictive Behaviors Be Broadened to Include Pathological Gambling?*, 101 ADDICTION (SUPP. 1) 152, 157 (2006) (“Including pathological gambling as an addictive disorder along with substance use disorders may increase stigmatization.”).

108. See, e.g., Geis, *supra* note 102 (describing how the recognition of pathological gambling has had an exculpatory effect, weighing against findings of bankruptcy fraud and leading to reduced criminal sentences).

109. See Sally Satel & Scott Lilienfeld, *Medical Misnomer: Addiction Isn’t a Brain Disease*, *Congress*, SLATE (July 25, 2007, 1:36 PM), <http://www.slate.com/id/2171131/> (describing the trend, including the “Recognizing Addiction As a Disease Act of 2007”).

110. *Id.*

111. See Shaffer, *supra* note 63.

112. See *id.* (“New evidence suggests that neuroadaptation also results from addictive behaviors . . .”).

reliable means of diagnosis do not exist, the stigmatizing and exculpatory effects are not justified and skew what would otherwise be the correct and just result within the existing framework.

The remainder of this part analyzes three areas of law in which the legal recognition of behavioral addictions would have the most pronounced consequences. Again, these consequences can be thought of in terms of their stigmatizing and exculpatory effects. In employment law, recognition of behavioral addictions could have an exculpatory effect, excusing an employee's behavior in light of a "disability." In family law, the effect is primarily stigmatizing, such as when, during a divorce or custody proceeding, one spouse is labeled as suffering from a "disorder" and is thus determined to be an unfit parent. In criminal law, the effect is potentially exculpatory—reducing the defendant's sentence because the behavioral addiction amounted to significantly reduced mental capacity.

B. EMPLOYMENT LAW

In the context of employment law, a behavioral addiction could arguably qualify as a "disability" entitled to protection under the Americans with Disabilities Act ("ADA"), which prohibits employers from "discriminat[ing] against a qualified individual with a disability on the basis of disability in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment."¹¹³

The prospects of success for a plaintiff asserting a behavioral addiction as a disability have increased recently in light of amendments to the ADA that broaden the category of qualified disabilities and signal a clear intent for liberal application of the Act's protection. In order to understand how behavioral addiction would fit into the disability analysis of the ADA, a fair amount of background on the Act is necessary.

1. Background of the ADA

The ADA was enacted to extend protection from discrimination to individuals with disabilities.¹¹⁴ The ADA is a logical extension of the Civil

113. 42 U.S.C. § 12112(a) (Supp. II 2008). As discussed *infra* Part III.B.2, the ADA, originally enacted in 1990, was amended in 2008. *See* ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (codified in scattered sections of 28 and 42 U.S.C.).

114. Americans with Disabilities Act of 1990, Pub. L. No. 101-336, § 2(a), 104 Stat. 327, 328–29 (codified as amended at 42 U.S.C. § 12101(a) (2006)).

Rights Act of 1964,¹¹⁵ on which several of the ADA's titles were modeled.¹¹⁶ Underlying both acts is the notion that it is unjust to discriminate against an individual on the basis of a trait over which the individual has no control, whether that trait be one related to "race, color, religion, sex or national origin,"¹¹⁷ or one related to a "physical or mental impairment."¹¹⁸

The predecessor to the ADA was the Rehabilitation Act of 1973.¹¹⁹ The Rehabilitation Act was Congress's first attempt to extend civil rights protections to the disabled. Congress soon realized, however, that providing protection for individuals with disabilities was more complicated than protecting individuals of different races, genders, and national origins. Unlike the categories of race or sex, which have readily apparent defining characteristics,¹²⁰ the category of disability would require an operational definition. Congress chose to define a "handicapped individual" as "any individual who . . . has a physical or mental disability which for such individual constitutes or results in a substantial handicap to employment."¹²¹

The Rehabilitation Act, however, was hobbled by a provision limiting its reach to only those employers "receiving Federal financial assistance."¹²² The ADA was enacted to remove this limitation and cover private as well as public employers.¹²³ Nevertheless, the Rehabilitation Act is of continued importance because it served as the model for the ADA, and cases that were decided under the Rehabilitation Act are persuasive authority for interpreting the ADA.¹²⁴ Also, the ADA's definition of disability is taken essentially verbatim from the Rehabilitation Act, as amended in 1974.¹²⁵ The ADA defines "disability" as "(A) a physical or

115. Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241 (codified as amended in scattered sections of 28 and 42 U.S.C.).

116. RUTH COLKER, *THE DISABILITY PENDULUM: THE FIRST DECADE OF THE AMERICANS WITH DISABILITIES ACT 6* (2005).

117. 42 U.S.C. § 2000e-2(a)(1).

118. 42 U.S.C. § 12102(1)(A) (Supp. II 2008).

119. Rehabilitation Act of 1973, Pub. L. No. 93-112, 87 Stat. 355 (codified as amended in scattered sections of 29 U.S.C.).

120. *But cf.* *Ulane v. E. Airlines, Inc.*, 742 F.2d 1081, 1084 (7th Cir. 1984) (considering whether the prohibition of discrimination because of "sex" under Title VII of the Civil Rights Act, 42 U.S.C. §§ 2000e-2000e17, reaches transsexuals, and holding that it does not).

121. Rehabilitation Act § 7(6).

122. *Id.* § 504.

123. See 42 U.S.C. § 12111(5)(A) (2006) ("The term 'employer' means a person engaged in an industry affecting commerce who has 15 or more employees . . .").

124. See COLKER, *supra* note 116, at 16.

125. See Rehabilitation Act Amendments of 1974, Pub. L. No. 93-516, § 111(a), 88 Stat. 1617,

mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment.”¹²⁶ To establish a prima facie case of disability discrimination under the ADA, a plaintiff must show the following: (1) the employer is an entity covered by the ADA; (2) the plaintiff meets the definition of “disabled” under the ADA; (3) the plaintiff was otherwise qualified to perform the essential functions of his or her job, with or without reasonable accommodation; and (4) the plaintiff suffered adverse employment action on the basis of the disability.¹²⁷

2. *Toyota, Sutton*, and the ADA Amendments Act of 2008

In the years following enactment of the ADA, Equal Employment Opportunity Commission (“EEOC”) regulations and Supreme Court decisions constrained its application with a restrictive definition of what qualifies as a disability.¹²⁸ The EEOC defined the “substantially limits” language in the statute as “(i) [u]nable to perform a major life activity that the average person in the general population can perform; or (ii) [s]ignificantly restricted as to the condition, manner or duration under which an individual can perform a particular major life activity.”¹²⁹ In *Toyota Motor Manufacturing, Kentucky, Inc. v. Williams*, the Supreme Court looked to these EEOC regulations, as well as dictionary definitions, to find that in order for an impairment to be substantially limiting, it must “prevent[] or severely restrict[] the individual from doing activities that are of central importance to most people’s daily lives.”¹³⁰ The Court in *Sutton v. United Air Lines, Inc.* placed a similarly restrictive definition on the “regarded as” prong of the statutory language.¹³¹ There the Court interpreted that prong as requiring an ADA plaintiff to show that the

1619 (codified as amended in 29 U.S.C. § 705(9)) (defining a “handicapped individual” as “any person who (A) has a physical or mental impairment which substantially limits one or more of such person’s major life activities, (B) has a record of such an impairment, or (C) is regarded as having such an impairment.”); *Toyota Motor Mfg., Ky., Inc. v. Williams*, 534 U.S. 184, 193 (2002) (noting that the Rehabilitation Act is a “potential source of guidance for interpreting the terms of [the] definition [of disability under the ADA]”).

126. 42 U.S.C. § 12102(1) (Supp. II 2008).

127. *Sista v. CDC Ixis N. Am., Inc.*, 445 F.3d 161, 169 (2d Cir. 2006). *See also* 42 U.S.C. §§ 12102–12112 (2006 & Supp. II 2008).

128. Kate S. Arduini, *Why the Americans with Disabilities Act Amendments Act Is Destined to Fail: Lack of Protection for the “Truly” Disabled, Impracticability of Employer Compliance, and the Negative Impact It Will Have on Our Already Struggling Economy*, 2 DREXEL L. REV. 161, 168–72 (2009).

129. 29 C.F.R. § 1630.2(j)(1) (2010).

130. *Toyota Motor Mfg.*, 534 U.S. at 198.

131. *Sutton v. United Air Lines, Inc.*, 527 U.S. 471, 493 (1999).

employer regarded the plaintiff as having an impairment that substantially limited a major life function, as opposed to merely showing that the employer regarded the plaintiff as having an impairment.¹³² Case law interpreting the ADA had thus restricted the class of disabilities entitled to its protection.

In 2008, Congress responded with the ADA Amendments Act (“ADAAA”), which had the purpose of “restor[ing] the intent and protections of the Americans with Disabilities Act of 1990,”¹³³ because “the holdings of the Supreme Court [in *Sutton* and *Toyota*] have narrowed the broad scope of protection intended to be afforded by the ADA, thus eliminating protection for many individuals whom Congress intended to protect.”¹³⁴ The ADAAA amended various provisions of the ADA, with the intent of shifting the focus in ADA cases away from whether the plaintiff qualifies as an individual with a disability to whether discrimination against the plaintiff occurred.¹³⁵ The ADAAA explicitly rejected the restrictive requirements of *Sutton* and *Toyota* and reinstated an expansive definition of disability, which is to be “construed in favor of broad coverage of individuals under this Act, to the maximum extent permitted by the terms of this Act.”¹³⁶

3. Internet Addiction as a Disability Under the ADA

Although many of the proposed behavioral addictions could conceivably qualify as protected disabilities within the meaning of the ADA, Internet addiction has emerged as the leading contender. This section will analyze whether Internet addiction qualifies as a disability under the current framework and what would be the likely impact if it gained recognition as a mental disorder.

Although a plaintiff has yet to succeed on the theory that Internet addiction is a protected disability, ADA litigation is currently in a state of transition as courts implement the newly expanded definition of disability

132. *Id.*

133. ADA Amendments Act, Pub. L. No. 110-325, 122 Stat. 3553 (codified in scattered sections of 28 and 42 U.S.C.).

134. *Id.* § 2(a)(4).

135. *Id.* § 2(b)(5) (“The purposes of this Act are . . . to convey that the question of whether an individual’s impairment is a disability under the ADA should not demand extensive analysis.”). *See also* Regulations to Implement the Equal Employment Provisions of the Americans with Disabilities Act, as Amended, 74 Fed. Reg. 48,431, 48,440 (Sept. 23, 2009) (to be codified at 29 C.F.R. pt. 1630) (proposing new rules for the EEOC that would emphasize that “the focus of an ADA case should be on whether discrimination occurred, not on whether an individual meets the definition of ‘disability’”).

136. ADA Amendments Act § 3(4)(A).

established by the ADAAA. The full impact of the ADAAA, which became effective January 1, 2009, remains to be seen.¹³⁷ Clues to the future course of ADA litigation, however, can be found in the new regulations proposed by the EEOC to implement the ADAAA.¹³⁸

The proposed regulations list several examples of impairments that “will consistently meet the definition of disability.”¹³⁹ Along with cancer, diabetes, and autism, these impairments include “[m]ajor depression, bipolar disorder, [and] post-traumatic stress disorder.”¹⁴⁰ Under a list of examples that “may be disabling to some individuals but not for others,” the regulations list “psychiatric impairment” that substantially limits an individual, as indicated by “diminished capacity to effectively interact with others” or “the length or quality of sleep the individual gets.”¹⁴¹ In addition, courts have held that a mental health condition can qualify as an “‘impairment’ under the ADA once it has been ‘diagnosed by a health professional.’”¹⁴²

Under this permissive framework, Internet addiction could very well qualify as a protected disability under the ADA.¹⁴³ An ADA plaintiff would undoubtedly have no trouble finding an expert to diagnose Internet addiction and testify that Internet addiction is a psychiatric impairment that substantially limits the plaintiff, as indicated by loss of sleep due to long nights spent logged on to the computer, as well as a diminished capacity to interact with others as a result of prolonged periods of time spent surfing the Web in isolation.¹⁴⁴ Another way in which an ADA plaintiff could

137. The ADAAA has been held not to apply retroactively. *See Lytes v. DC Water & Sewer Auth.*, 572 F.3d 936, 940 (D.C. Cir. 2009); *Ekstrand v. Sch. Dist. of Somerset*, 603 F. Supp. 2d 1196, 1205 (W.D. Wis.), *aff'd in part, rev'd in part*, 583 F.3d 972 (7th Cir. 2009). Thus, we will not see case law interpreting the ADAAA until conduct occurring on or after January 1, 2009 has been fully litigated.

138. Regulations to Implement the Equal Employment Provisions of the Americans With Disabilities Act, as Amended, 74 Fed. Reg. at 48,431–42.

139. *Id.* at 48,441.

140. *Id.*

141. *Id.* at 48,442.

142. *Ekstrand*, 603 F. Supp. 2d at 1206 (quoting *Krocka v. City of Chi.*, 203 F.3d 507, 512 (7th Cir. 2000)).

143. *See generally* Blake R. Bertagna, *The Internet—Disability or Distraction? An Analysis of Whether “Internet Addiction” Can Qualify as a Disability Under the Americans with Disabilities Act*, 25 HOFSTRA LAB. & EMP. L.J. 419 (2008) (providing an extensive analysis of Internet addiction’s potential to qualify as a disability and concluding that such a claim is colorable).

144. The supply of experts available to diagnose Internet addiction and testify about the disorder in court is already well established. One Web site, “The Center for Internet Addiction,” promotes its qualified expert in the following manner: “Dr. Kimberly Young is a qualified expert and . . . provides assessment and forensic consultation in the following ways: Conducting forensic evaluations for clients suspected of being addicted to the Internet[; and p]roviding written affidavits to support the validity of

bring a claim based on Internet addiction is to do so indirectly through a more established disorder like posttraumatic stress disorder (“PTSD”) or depression.¹⁴⁵ Through artful pleading, the plaintiff could allege that the established disorder is the disability entitled to protection, but this disorder also “manifests itself” through addictive behavior such as Internet addiction.¹⁴⁶

The case *Pacenza v. IBM Corp.* shows how this technique has been attempted by one ADA litigant.¹⁴⁷ *Pacenza* also illustrates the sizeable impact legal recognition of behavioral addictions could have on ADA cases. James Pacenza was an employee of IBM for nineteen years, most recently in one of IBM’s semiconductor facilities manufacturing computer chips.¹⁴⁸ Pacenza operated a tool that checked silicon wafers for the correct thickness. This task was performed via computer and required no input by Pacenza for five to ten minutes at a time. Therefore, Pacenza spent the majority of his day sitting at a computer, with Internet access, and nothing to do. One way Pacenza filled this time was by visiting sexually-explicit chat rooms on his computer. After getting caught and receiving a warning, Pacenza informed his supervisor of his “long-standing Internet sexual addiction.”¹⁴⁹ Approximately five months later Pacenza was caught again and subsequently terminated.¹⁵⁰

Pacenza filed an action claiming that IBM discriminated against him on the basis of his disability, which allegedly consisted of PTSD¹⁵¹ manifested through various addictive behaviors including “Internet sex addiction.”¹⁵² In granting IBM’s motion for summary judgment, the U.S.

Internet addiction and explain the nature of online behavior.” *Assessments*, NETADDICTION.COM, http://www.netaddiction.com/index.php?option=com_content&view=article&id=58&Itemid=81 (last visited Nov. 5, 2010). For an example of the sort of testimony these experts may offer, see Expert Report of John DeRosalia at 2, *Pacenza v. IBM Corp.*, No. 04 Civ. 5831 (PGG) (S.D.N.Y. Jan. 19, 2007) (“[Plaintiff’s Internet addiction] has strained and almost destroyed his relationship with his wife, and severely strained his relationship with his children. As such, it has substantially impaired the major life activity of interpersonal relations and relationships with both males and females. It also reveals itself by the fact that Plaintiff has few, if any, genuinely close friends.”).

145. See Potenza, *supra* note 71, at 144–45 (noting the high rate of cooccurrence between behavioral addictions and other mental health disorders).

146. See *Pacenza v. IBM Corp.*, No. 04 Civ. 5831 (PGG), 2009 U.S. Dist. LEXIS 29778, at *2 (S.D.N.Y. Apr. 2, 2009); *id.* at *3 (“Pacenza claims that he developed addictive tendencies as a result of his PTSD including alcoholism, food addiction, and, most recently, sex addiction.”).

147. See *id.* at *3.

148. *Id.* at *5.

149. *Id.* at *9.

150. *Id.* at *17.

151. Pacenza had a history of mental health problems stemming from his service in Vietnam and sexual abuse he suffered as a child. *Id.* at *3.

152. *Id.* at *30.

District Court for the Southern District of New York relied on the fact that Pacenza's supervisor had no knowledge of the alleged PTSD and therefore could not have discriminated on the basis of it.¹⁵³ Since the supervisor did know about Pacenza's long-standing Internet sex addiction, the court was careful to clarify that Pacenza was not alleging that condition constituted a disability within the meaning of the ADA.¹⁵⁴

The reason Pacenza (and the court) had to dance around the concept of Internet sex addiction is that the ADA explicitly excludes certain conditions from qualifying as disabilities: "(1) transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders; (2) compulsive gambling, kleptomania, or pyromania; or (3) psychoactive substance use disorders resulting from current illegal use of drugs."¹⁵⁵

This group of statutory exclusions is an obstacle to an ADA plaintiff claiming Internet addiction in three ways. First, the exclusions likely bar suits by many plaintiffs who, like Pacenza, claim their Internet addiction is tied to a sex addiction.¹⁵⁶ The exclusionary language, especially with respect to "other sexual behavior disorders," would seem to bar much sexual activity from the realm of disability. Second, the statutory exclusions categorically bar compulsive gambling and substance use disorders from qualifying as disabilities. Compulsive gambling was the only disorder close to a behavioral addiction recognized at the time the ADA was enacted, and it was expressly excluded from the Act's coverage. Further, substance use disorders are the classic examples of addiction. Given that the proposed behavioral addictions were created by close analogy to substance use disorders, the exclusion of substance use disorders suggests behavioral addictions should be excluded as well. Third, the legislative history of the exclusionary language reveals an intent to preempt just the sort of claims that behavioral addictions would generate.¹⁵⁷ Senator William T. Armstrong, author of the exclusionary provision, explained that it was intended to exclude some of "the more egregious lawsuits" and prevent the judiciary from being "swamped with mental disability litigation."¹⁵⁸ In his testimony before Congress, Senator Armstrong

153. *Id.* at *28–29.

154. *Id.* at *31 n.12.

155. 42 U.S.C. § 12211(b) (2006).

156. *Pacenza*, 2009 U.S. Dist. LEXIS 29778, at *31 n.12.

157. See 135 CONG. REC. 20,574 (1989) (statement of Sen. Armstrong).

158. *Id.*

referenced a number of these “egregious lawsuits” the amendment was intended to prevent.¹⁵⁹ One such case, *Majors v. Housing Authority of the County of DeKalb Georgia*, decided under the Rehabilitation Act, involved a plaintiff who was evicted for violating a “no pet” rule.¹⁶⁰ The district court allowed the case to proceed to trial, recognizing the possibility that the plaintiff had a valid disability in that she had a “psychological and emotional dependence upon her pet dog, Sparky.”¹⁶¹ Dog addiction!

Although the ADA’s legislative history and the conditions it expressly excludes weigh against behavioral addictions qualifying as disabilities, they do not preclude that result. The trend toward recognizing Internet addiction as a genuine psychological disorder in particular has the potential to expose employers to massive liability.¹⁶² The prevalence of Internet use in the workplace has made terminations and sanctions for misuse of the Internet very common.¹⁶³ Whether these adverse employment actions will support claims under the ADA is likely ultimately to turn on whether Internet addiction gains recognition as a mental disorder.¹⁶⁴

C. FAMILY LAW

Another area in which legal recognition of behavioral addictions would have a significant impact is family law, particularly divorce and child custody actions. Frequently, one spouse will claim that the other is addicted to the Internet, or sex, or both.¹⁶⁵ These allegations arise because of the nature of the rules and standards by which these disputes are decided. In child custody disputes, the overriding rule is that the best

159. *See id.* at 20,572–74.

160. *Majors v. Hous. Auth. of the Cnty. of DeKalb Ga.*, 652 F.2d 454, 455 (5th Cir. 1981).

161. *Id.*

162. *See* Lynn P. Hendrix, *Intellectual Property Assessment and Risk Management*, [2008] 4 MIN. L. SERIES: ROCKY MTN. MIN. L. FOUND. pt. 5, at 5-33 (“As Internet usage increases exponentially, more and more employers are confronted with the employees who claim themselves to be addicted to the Internet.”).

163. *See* Nancy Gohring, *Over 50% of Companies Fire Workers for E-Mail, “Net Abuse,”* ITWORLD (Feb. 28, 2008, 7:53 PM), <http://www.itworld.com/companies-fire-employees-email-080228> (“A new survey found that more than a quarter of employers have fired workers for misusing e-mail and one third have fired workers for misusing the Internet on the job.”).

164. *See* Catherine Holahan, *Virtually Addicted*, BUS. WK. (Dec. 14, 2006, 12:00 AM), http://www.businessweek.com/technology/content/dec2006/tc20061214_422859.htm (“Attorneys say recognition by a court—whether in this or some future litigation—that Internet abuse is an uncontrollable addiction, and not just a bad habit, could redefine the condition as a psychological impairment worthy of protection under the Americans with Disabilities Act . . .”).

165. *See* William S. Friedlander, *Exploring the Net Impact on Family Law*, TRIAL, June 2002, at 56 (examining the various ways issues regarding the Internet arise in family law disputes).

interest of the child determines which parent wins custody.¹⁶⁶ Some of the factors weighing on this determination include the willingness and capacity of each parent to provide primary child care, the physical and mental health of each parent, the moral fitness of each parent, and the stability of the home environment that each parent is able to provide.¹⁶⁷

Bower v. Bower provides a good illustration of how behavioral addictions can play a role in these types of disputes.¹⁶⁸ At the divorce proceeding of Cindy and Robert Bower, Robert claimed that Cindy was addicted to the Internet, spending a “tremendous” amount of time online.¹⁶⁹ Robert introduced a licensed professional counselor to testify as an expert in the area of “Internet addiction and Internet pornography.”¹⁷⁰

In assessing “[w]hich parent has the best parenting skills and willingness and capacity to provide primary care,” the lower court noted that “Cindy spent much of her time on the Internet.”¹⁷¹ Similarly, the lower court found that the “physical and mental health” factor weighed in favor of Robert because Cindy “spent enormous amounts of time on the Internet talking to strange men.”¹⁷² On appeal, Cindy claimed error, contending that the lower court’s findings of fact and application of the custody factors “were congested with references to Internet addiction and were obviously influenced by” the testimony of the Internet addiction expert.¹⁷³ The Supreme Court of Mississippi upheld the lower court’s award of custody to Robert, a finding that relied heavily on Cindy’s excessive Internet use.¹⁷⁴

Here, in the family law context, legal recognition of behavioral addictions potentially has a stigmatizing effect. Whereas before, a spouse could merely offer factual testimony about the other spouse’s excessive Internet use, now, a spouse can introduce a psychiatrist and Internet addiction expert to testify that Internet addiction is a genuine mental disorder. Whether this stigma is justified, however, depends on whether excessive Internet use warrants recognition as a mental disorder.

166. *Bower v. Bower*, 758 So. 2d 405, 409–10 (Miss. 2000) (citing *Albright v. Albright*, 437 So. 2d 1003, 1005 (Miss. 1983)).

167. *Id.* at 410 (citing *Albright*, 437 So. 2d at 1005).

168. *See id.* at 411–14.

169. *Id.* at 407.

170. *Id.* at 413.

171. *Id.* at 411.

172. *Id.*

173. *Id.* at 413.

174. *Id.* The court refused to reverse the case on any evidentiary issues, holding that the chancellor committed error by admitting Robert’s Internet addiction expert as a lay witness, but that this error was harmless because there was sufficient other evidence that demonstrated Cindy’s excessive Internet use. *Id.* at 413–14. Why the chancellor admitted an expert as a lay witness remains a mystery.

D. CRIMINAL SENTENCING

A third area of law potentially affected by the recognition of behavioral addictions is criminal sentencing. The United States Sentencing Guidelines (“USSG”) allow for a reduced sentence if the defendant “committed the offense while suffering from a significantly reduced mental capacity.”¹⁷⁵ The definition of “significantly reduced mental capacity” encompasses a “significantly impaired ability to . . . control behavior that the defendant knows is wrongful.”¹⁷⁶ A number of defendants have argued that their gambling addiction, and more recently, shopping addiction, qualifies as a significantly reduced mental capacity that warrants a reduced sentence under the USSG.¹⁷⁷

1. United States Sentencing Guidelines

The USSG determines the sentencing of criminal defendants in federal court.¹⁷⁸ The USSG uses a point system based on the severity of the crime and various attendant circumstances.¹⁷⁹ The resulting point total dictates a recommended sentence, from which the judge has discretion to depart under certain limited circumstances in which aggravating and mitigating factors exist.¹⁸⁰

One of the circumstances in which the judge may impose a reduced sentence is if “the defendant committed the offense while suffering from a significantly reduced mental capacity; and . . . the significantly reduced mental capacity contributed substantially to the commission of the offense.”¹⁸¹ The meaning of “significantly reduced mental capacity” embraces cognitive impairments and volitional impairments.¹⁸² A cognitive impairment is one in which the defendant has a significantly impaired ability to “understand the wrongfulness of the behavior comprising the offense or to exercise the power of reason,” whereas a volitional impairment is a significantly impaired ability to “control behavior that the

175. U.S. SENTENCING GUIDELINES MANUAL § 5K2.13 (2010).

176. *Id.* § 5K2.13 cmt. n.1.

177. *See infra* text accompanying notes 209–14.

178. *See* U.S. SENTENCING GUIDELINES MANUAL ch. 1, pt. A, introductory cmt. After *United States v. Booker*, 543 U.S. 220 (2005), the USSG is no longer mandatory, but it continues to play a central role in the sentencing determination. U.S. SENTENCING GUIDELINES MANUAL ch. 1, pt. A, introductory cmt.

179. U.S. SENTENCING GUIDELINES MANUAL ch. 5, pt. A, introductory cmt.

180. *Id.* § 5K2.0.

181. *Id.* § 5K2.13.

182. *See id.* § 5K2.13 cmt. n.1.

defendant knows is wrongful.”¹⁸³

The USSG prohibits judges from considering certain factors related to characteristics of the defendant because they are deemed not relevant to sentencing.¹⁸⁴ These prohibited factors include, for example, the individual’s race, sex, national origin, and religion,¹⁸⁵ “[l]ack of guidance as a youth,”¹⁸⁶ “drug or alcohol dependence,”¹⁸⁷ and “[a]ddiction to gambling.”¹⁸⁸

This section of the USSG formerly limited the consideration of mental and emotional conditions as well, stating that “mental and emotional conditions are not ordinarily relevant” to the sentencing determination, except as indicated in the “significantly reduced mental capacity” provision.¹⁸⁹ Effective November 1, 2010, however, these conditions “may be relevant” if they “are present to an unusual degree and distinguish the case from the typical cases.”¹⁹⁰ Section 3553 of Title 18 of the United States Code, which sets forth factors that courts shall consider in imposing a sentence, reflects a similar policy by requiring consideration of “the need to avoid unwarranted sentence disparities among defendants with similar records who have been found guilty of similar conduct.”¹⁹¹

2. Compulsive Shopping and *Roach*

If behavioral addictions are mental disorders, under the USSG a defendant who committed a crime while suffering from a behavioral addiction should likely be allowed a downward departure on the grounds that the offense was committed while the defendant was “suffering from a significantly reduced mental capacity.”¹⁹² This argument seems especially pertinent under the volitional impairment prong, which allows for a downward departure where the defendant had a significantly impaired

183. *Id.*

184. *Id.* ch. 5, pt. H, introductory cmt.

185. *Id.* § 5H1.10.

186. *Id.* § 5H1.12.

187. *Id.* § 5H1.4.

188. *Id.*

189. U.S. SENTENCING GUIDELINES MANUAL § 5H1.3 (2009).

190. U.S. SENTENCING GUIDELINES MANUAL § 5H1.3 (2010). This change may give judges greater leeway to consider the defendant’s alleged behavioral addiction as a mental or emotional condition. Given that the amendment became effective just prior to the publication of this Note and has yet to appear in any court decisions, as well as the fact that section 5H1.3 is not a stand-alone ground for departure, this Note will focus on the diminished capacity ground for departure in section 5K2.13.

191. 18 U.S.C. § 3553(a)(6) (2006).

192. U.S. SENTENCING GUIDELINES MANUAL § 5K2.13.

ability to “control behavior that the defendant knows is wrongful,”¹⁹³ because “loss of control” is often the chief defining condition of a behavioral addiction.¹⁹⁴ The first defendants to employ this argument sought sentence reductions on the ground that they suffered from compulsive gambling, and they initially met with some success.¹⁹⁵ The next logical step was to bring this argument in relation to the behavioral addictions that arose through analogy to compulsive gambling, which is exactly what occurred in *United States v. Roach*.¹⁹⁶

Elizabeth Roach was an associate partner at Andersen Consulting.¹⁹⁷ She and her husband had a combined annual income of more than \$300,000, and they owned a condominium in “one of Chicago’s most fashionable neighborhoods.”¹⁹⁸ Roach suffered from chronic depression for which she underwent psychiatric therapy for most of her adult life.¹⁹⁹ In an effort to “self-medicate[]”²⁰⁰ her depression, Roach engaged in shopping binges in which she purchased excessive amounts of jewelry and clothing at upscale stores like Neiman Marcus and Barneys New York.²⁰¹ On one such binge, Roach entered a department store, obtained a credit card, and then charged \$10,000 that same day.²⁰² This excessive shopping had begun during her years in college, and it continued until the time of her arrest.²⁰³

In 1996, Roach was carrying approximately \$60,000 in credit card

193. *Id.* § 5K2.13 cmt. n.1.

194. *See* Holden, *supra* note 41, at 980 (explaining that behavioral addictions are “all related to loss of voluntary control”).

195. *See, e.g.,* *United States v. Sadolsky*, 234 F.3d 938, 945 (6th Cir. 2000) (upholding a two-level downward departure under the pre-2010 amended USSG based on the defendant’s compulsive gambling). *Cf.* *United States v. Carucci*, 33 F. Supp. 2d 302, 302 (S.D.N.Y. 1999) (recognizing that gambling addiction may be sufficient to make a colorable diminished capacity departure claim but denying downward departure for a defendant convicted of unlawful securities trading because “a compulsive gambler is not, *a fortiori*, a compulsive illegal trader”). Note that these cases arose before the 2003 amendments to the USSG, which prohibited “gambling addiction” from being a relevant factor. *See* U.S. SENTENCING GUIDELINES MANUAL § 5H1.4 (2003). After *Booker*, however, the USSG is no longer mandatory authority, thus courts may not be prohibited from considering gambling addiction during the sentencing determination. *See* *United States v. Booker*, 543 U.S. 220, 245 (2005).

196. *United States v. Roach*, No. 00 CR 411, 2001 U.S. Dist. LEXIS 8454 (N.D. Ill. June 4, 2001).

197. *Id.* at *1.

198. *United States v. Roach*, 296 F.3d 565, 566 (7th Cir. 2002).

199. *Id.*

200. *Id.* at 572.

201. *Id.* at 566.

202. *Id.*

203. *United States v. Roach*, No. 00 CR 411, 2001 U.S. Dist. LEXIS 8454, at *3 (N.D. Ill. June 4, 2001).

debt.²⁰⁴ One day she submitted an expense report to Andersen seeking reimbursement for conference registration fees.²⁰⁵ She was unable to attend the conference, but by this time she had already been reimbursed for it by Andersen. Roach kept the money. From there, she embarked on a three-year enterprise in which she embezzled more than \$240,000 from Andersen through padded expenses, phony airfares, and imaginary conferences. Roach was caught in 1999 and pleaded guilty to one count of wire fraud.²⁰⁶ Pursuant to the USSG, points were added to Roach's offense level because the fraud involved over \$200,000 and more than minimal planning, and points were subtracted because she accepted responsibility and had little criminal history. The resulting point total prescribed a sentencing range of twelve to eighteen months' imprisonment.²⁰⁷

Roach moved for a downward departure on the grounds that she committed the offense while suffering from a significantly reduced mental capacity pursuant to section 5K2.13.²⁰⁸ The court reviewed Roach's history of depression and other mental problems, including the psychotherapy and medication she had received.²⁰⁹ It then recounted the testimony of a psychiatrist retained as an expert witness for the defense, who opined that compulsive shopping is a way that people suffering from depression attempt to self medicate their disorder, and that it "temporarily increases the person's available level of serotonin," the same neurotransmitter involved in depression.²¹⁰ Further, the court explained, a person engaging in compulsive shopping is in a "dissociative state" in which information that would normally restrain the excessive behavior is not available to the person.²¹¹ The court found that "[Roach] was not in any real way able to control [her compulsive shopping] behavior."²¹² This, in turn, led to an "equally compelling" need for her to engage in activity to conceal and facilitate her compulsive shopping, which was the motivation behind her embezzling over \$240,000 from Andersen.²¹³ Consequently, the district

204. *Id.* at *4.

205. *Roach*, 296 F.3d at 567.

206. *Id.*

207. *Id.*

208. *Id.*

209. *Roach*, 2001 U.S. Dist. LEXIS 8454, at *3-4.

210. *Id.* at *5.

211. *Id.*

212. *Id.* at *12. For a comprehensive review of *Roach* and an endorsement of the district court's finding, see Jeffrey Michael Goldman, Note, *Addicted to Prada?: United States v. Roach Shopping Addiction, Significantly Reduced Mental Capacity, and United States Sentencing Guideline § 5K2.13*, 39 GONZ. L. REV. 197 (2003-2004).

213. *Roach*, 2001 U.S. Dist. LEXIS 8454, at *12. Though based on a similar claim of an underlying compulsion motivating the defendant's illegal behavior, in *United States v. Vitale*, 159 F.3d

court granted Roach's motion for a downward departure from the applicable sentencing range of twelve to eighteen months' imprisonment and sentenced her to five years' probation without any prison time.²¹⁴ Whether such a downward departure is warranted, however, hinges on whether excessive shopping or other behavioral addictions are recognized as mental disorders.

IV. THE LAW SHOULD NOT RECOGNIZE BEHAVIORAL ADDICTIONS

The study of addiction is one of the most contentious and least settled fields in science.²¹⁵ A growing number of commentators are pushing to expand the concept of addiction disorders to encompass excessive behaviors. This expansion may or may not be useful in the mental health field, but it is likely to have an unjustified distorting effect on the law; therefore, behavioral addictions should not be recognized for purposes of legal analysis.

First, recognizing a category of behavioral addictions would have a distorting effect on the law because once a group of characteristics is classified as a disorder, it increases the perceived severity of the condition. Second, this distortion is unjustified in the case of behavioral addictions because there is nothing sufficiently distinctive about patterns of overindulgent behavior to warrant categorization as disorders. The current state of neuroscience research reveals little empirical evidence for classifying excessive behaviors as disorders, nor does it reveal anything about such behaviors that is relevant or helpful for legal analysis. Third,

810, 816 (3d Cir. 1998), the Third Circuit Court of Appeals chose not to disturb the district court's decision to deny a downward departure for a defendant who embezzled approximately \$12 million to feed his "compulsion to purchase antique clocks."

214. *United States v. Roach*, 296 F.3d 565, 567–68 (7th Cir. 2002). The sentence also included six months of work release and home confinement, restitution, and a prohibition against Roach's obtaining new credit cards. *Id.* The Seventh Circuit vacated the sentence and remanded the case because the evidence did not support a finding that Roach committed the wire fraud while suffering from a "significantly impaired ability to control her behavior." *Id.* at 573. The Seventh Circuit reasoned that Roach had shopped compulsively for over ten years without turning to criminal activity and that she stumbled on the extra source of fraudulent money only accidentally; thus, the "analytic leap" to a finding that she was unable to control fraudulent conduct spanning three years was too great and unsupported by the evidence. *Id.* at 572. Subsequently, however, while Roach's certiorari petition was still pending, the Supreme Court held in *United States v. Booker*, 543 U.S. 220 (2005), that the USSG was no longer mandatory authority. As a result, the Court vacated the judgment and remanded the case for reconsideration in light of *Booker*. The Seventh Circuit remanded Roach's case to the district court and allowed it to impose the same sentence it chose originally. *See United States v. Roach*, 140 Fed. Appx. 619, 620 (7th Cir. 2005).

215. *See, e.g., Shaffer, supra note 7.*

and especially important for legal consideration, classifying behavioral addictions as disorders leads to the conclusion that an individual diagnosed with the disorder was *unable* to control his or her behavior. But there is no reliable way to distinguish such an individual from one who merely *did not* control his or her behavior. Therefore, presently, behavioral addictions should not be recognized for the purposes of legal analysis.²¹⁶

A. “DISORDER” LABELS INCREASE SALIENCE

One harm that recognizing behavioral addictions would cause stems from the effects of affixing “disorder” labels to such conditions. When a certain behavior or set of characteristics is “medicalized”—that is, when medical terms and disease-sounding labels are used to describe it—people perceive that condition to be more serious, more representative of a disease, and more rare.²¹⁷ Medicalizing the excessive-behavior patterns that constitute the proposed behavioral addictions could have significant effects in the legal field.

Modern society has been experiencing a shift toward greater use of medical terminology to describe conditions historically considered to fall outside the realm of disease.²¹⁸ This is sometimes accomplished through the use of Latin terms or their constructive derivatives (excessive sweating christened “Hyperhidrosis”) or through technical language connoting a special medical status (impotence christened “Erectile Dysfunction Disorder”).²¹⁹ A study on the role of medical language found that putting a medical-sounding name on a condition that was previously considered outside the realm of disease resulted in that condition’s being perceived as more severe, more likely to be a disease, and less prevalent in the population, compared to the same condition presented in its synonymous, lay-English name.²²⁰ A simple switch in labels caused the condition to be perceived as significantly more serious. This result remained even when the participants were also told the condition’s symptoms, indications of prevalence, fatality, and transmission vector.²²¹ The increased perception of severity depended on the medical label itself rather than any new

216. Nothing in this Note is intended to trivialize the mental health problems of those engaging in excessive, self-destructive behavior over which they feel no control.

217. Meredith E. Young, Geoffrey R. Norman & Karin R. Humphreys, *The Role of Medical Language in Changing Public Perceptions of Illness*, PLOS ONE, 1, 5 (Dec. 8, 2008), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2587237/pdf/pone.0003875.pdf>.

218. *Id.* at 1.

219. *Id.* at 3.

220. *Id.* at 5.

221. *Id.* at 2, 5.

information about the disorder or its symptoms.

The implications of this phenomenon in the legal realm are profound. Judges and juries are often called on to make difficult decisions, often in complex areas for which they must rely on expert witnesses.²²² When these decisions involve analyzing a party's mental state, including the extent to which the person truly lost control to an addiction, the decisionmaker has very little basis on which to make a decision. For instance, in *Roach* the judge had to decide the extent to which Roach's embezzlement resulted from a significant loss of control over her mind and actions due to her shopping habits.²²³ Consider the two alternatives. In the first scenario, the judge hears testimony of Roach's excessive shopping, her high levels of debt, and her history of mental health problems. In the second scenario, the judge hears the same testimony, but also testimony that Roach suffers from Compulsive Shopping Disorder which is evinced by increases of the neurotransmitter serotonin, and that this psychiatric impairment puts her in a "dissociative state,"²²⁴ unable to control her shopping binges.

The research on medical language discussed above suggests that the judge in the second scenario will perceive Roach's condition as more severe. This increased perception of seriousness will make the judge more likely to find that she suffered from a significantly reduced mental capacity within the meaning of section 5K2.13. The research also suggests that the judge in the second scenario will be more likely to perceive Roach's condition as representative of a disease. This notion finds support in the court's opinion in *Roach*. In granting Roach a reduced sentence, the court relied heavily on the fact that her compulsive shopping disorder was a "recognized psychiatric diagnosis"²²⁵ that constituted "a serious mental disorder."²²⁶ Lastly, the judge is more likely to perceive her condition as more rare. This perception could make the judge more likely to believe that Roach's is a special case; thus, reducing her sentence will not give rise to an "unwarranted sentence disparit[y]" under 18 U.S.C. § 3553(a)(6).²²⁷ This, too, is what the court found in *Roach*.²²⁸

222. See, e.g., *United States v. Roach*, 296 F.3d 565, 567–68, 571–72 (7th Cir. 2002) (noting the district court's reliance on expert testimony regarding the defendant's suffering from shopping addiction in reducing the defendant's sentence under the USSG).

223. See *United States v. Roach*, No. 00 CR 411, 2001 U.S. Dist. LEXIS 8454, at *10–12 (N.D. Ill. June 4, 2001).

224. *Id.* at *4.

225. *United States v. Roach*, No. 00 CR 411, 2005 WL 2035653, at *4 (N.D. Ill. Aug. 22, 2005).

226. *Id.* at *5.

227. 18 U.S.C. § 3553(a)(6) (2006).

228. *Roach*, 2005 WL 2035653, at *8.

The fact that a medical label increases the perceived seriousness of a condition, however, is not itself decisive. The increased perception of severity might be justified. For instance, Alzheimer's disease can be reliably diagnosed and differentiated from normal consequences of aging.²²⁹ The reliability of this diagnosis can be confirmed through postmortem examination of brain cells.²³⁰ Ascribing the disease moniker "Alzheimer's disease" justifiably creates an increased perception of severity. The question, therefore, is whether the proposed behavioral addictions can be diagnosed with a similar degree of reliability to justify classifying them with the labels of medical diseases.

B. DIFFICULTY DISTINGUISHING "LOSS OF CONTROL"

"[T]he line between an irresistible impulse and an impulse not resisted is probably no sharper than that between twilight and dusk."²³¹ The underlying characteristic of behavioral addictions is "loss of control."²³² Classifying behavioral addictions as discrete mental disorders presumes that a psychiatrist can reliably differentiate between a patient that lost control and one that simply did not control natural, appetitive urges. This determination is highly subjective and necessarily relies on self-reported mental experience. Having such a disorder category may or may not be beneficial for clinical therapy, but it does not provide reliable information on which to base legal decisions.

Moreover, implicit in the concept of behavioral addiction is the distinction between "excessive" and "normal" levels of an activity. The need for this distinction is what separates behavioral addictions from most currently recognized mental disorders. It is also what makes the classification of behavioral addictions as mental disorders particularly problematic. For instance, it is easier to acknowledge that kleptomania is a disorder because its defining characteristic, stealing, is easily and

229. See Kim A. Jobst, Lin P.D. Barnetson & Basil J. Shepstone, *Accurate Prediction of Histologically Confirmed Alzheimer's Disease and the Differential Diagnosis of Dementia: The Use of NINCDS-ADRDA and DSM-III-R Criteria, SPECT, X-Ray CT, and Apo E4 in Medial Temporal Lobe Dementias*, 10 INT'L PSYCHOGERIATRICS 271, 289, 291, 296-97 (1998).

230. See *id.* at 277-78, 291, 296.

231. Am. Psychiatric Ass'n, Position Statement on the Insanity Defense, available at http://archive.psych.org/edu/other_res/lib_archives/archives/198202.pdf. This quote comes from the APA's position statement on the insanity defense, which has since changed. See Am. Psychiatric Ass'n, Position Statement on the Insanity Defense, available at <http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/200703.aspx>.

232. Kafka, *supra* note 66, at 383. See also Gori, *supra* note 44, at S33; Shaffer, *supra* note 7, at 1577.

commonly considered wrong. There is no “normal” level of stealing, so if an individual steals obsessively (and the theft is not for financial gain) we have an easier time assuming that something is not normal with that individual. The same holds true for all the volitional, or impulse-control disorders: there is no normal level of fire setting, hair pulling, or aggressive assaults.²³³ Behavioral addictions, however, all involve activities that are inherently normal—sex, work, shopping—and thus require a diagnosis of excessive levels of behavior. The distinction appears descriptive, but it is inherently normative and value laden.

For instance, the article setting forth proposed diagnostic criteria for sex addiction in the DSM-V cites Alfred Kinsey’s survey of sexual behavior frequency from the 1940s, which used a measure called “total sexual outlet/week” (“TSO”), defined as the cumulative number of orgasms per week (achieved by any sexual behavior).²³⁴ The article reported that “[o]nly 7.6% of American males . . . had a mean TSO of 7 or more.”²³⁵ Where does one draw the line between normal levels of sexual behavior and excessive levels? More important, who gets to decide where that line is drawn?

One response may be that the diagnostic criteria for the proposed behavioral addictions require that the excessive behavior cause some significant personal distress or adverse consequences.²³⁶ This diagnostic requirement, however, is also hard to separate from the value judgment it requires. The article proposing a sex addiction disorder referenced one study that attempted to craft a measure to quantify these criteria.²³⁷ The study provided a composite measure for hypersexuality based on the tendency to engage in “impersonal sex” and an attitudinal preference toward a “casual sexual lifestyle.”²³⁸ The negative consequences observed in this group included that they were “less likely to feel satisfied with their

233. See DSM-IV-TR, *supra* note 8, at 663–77. Pathological gambling is the sole exception and most likely reflects moral objections to gambling. See Geis, *supra* note 102, at 359 (noting the “ideological and theological baggage” that accompanies the issue of gambling). This discussion is oversimplified for purposes of distinguishing the “normal” activities at issue in behavioral addictions. The “mania” disorders bring about their own difficulties with respect to the intersection of morality and mental illness, and the distinction between deviant behavior and mental disease. For a fascinating account of the historical evolution of the concept of pyromania as a psychiatric disorder, see Jeffrey L. Geller, Jonathon Erlen & Rosa Lynn Pinkus, *A Historical Appraisal of America’s Experience with “Pyromania”—A Diagnosis in Search of a Disorder*, 9 INT’L J.L. & PSYCHIATRY 201 (1986).

234. See Kafka, *supra* note 66, at 379.

235. *Id.*

236. *E.g., id.* at 380.

237. *Id.*

238. *Id.*

sexual life, had more relationship-associated problems, more [sexually transmitted diseases], and were more likely to have consulted professional help for sexuality-related issues.”²³⁹ Ultimately, a diagnosis of sex addiction would have to rest on a value judgment about how much and what type of sexual behavior is appropriate.

Therefore, given the impossibility of distinguishing genuine loss of control and the arbitrary line drawing required in determining how much behavior is excessive, we are currently not able to diagnose behavioral addictions with the degree of reliability necessary for them to be recognized as mental disorders in the eyes of the law.

C. EMPIRICAL SUPPORT FOR BEHAVIORAL ADDICTIONS IS LACKING

The science behind behavioral addictions is at a stage that can best be described as conjectural. It is vital that decisionmakers, particularly judges and legislators, be aware of the current fledgling state of research in support of behavioral addictions. Ultimately, there is no discernible scientific basis for creating a category of behavioral addictions. Neither of the two bases that have been put forth to support such a category—the dopamine theory and looks-like-addiction theory—find much, if any, support in the scientific research.

1. The Dopamine Theory Is Speculative

Nearly every proponent of behavioral addictions cites the changes such behaviors bring about on neurotransmitters, usually dopamine.²⁴⁰ This evidence is intuitively attractive—it supplies hard science to help with the vexing determination of what is going on in another’s mind. The invention of medical imaging technology has allowed researchers to attach chemical names and brain regions to processes that were heretofore described in common-sense terms.²⁴¹ Thus, where a subjective experience may previously have been self-described, “I shop because it makes me feel better when I’m sad,” now it can be described in terms of chemicals and physiological functions like a disease: “[Compulsive shopping] temporarily increases the person’s available level of serotonin, a neurotransmitter that, among other things, determines the extent and severity of depression.”²⁴²

239. *Id.*

240. *See supra* text accompanying notes 71–83.

241. *See* Potenza, *supra* note 71, at 145 (“A brain circuit central to addiction involves the dopaminergic mesolimbic pathway linking the ventral tegmental area to the nucleus accumbens (NAc) or ventral striatum.”).

242. *United States v. Roach*, No. 00 CR 411, 2001 U.S. Dist. LEXIS 8454, at *5 (N.D. Ill. June 4,

Unfortunately, this type of neurotransmitter reasoning extrapolates from existing neuroscience to a much greater degree than the data support.²⁴³ Although there is general consensus that dopamine plays some role in pleasure and reward, it also serves a diverse range of functions including a sensorimotor function.²⁴⁴ Dopamine is also released following aversive events. For instance, dopamine levels in rats increase after having their tails pinched.²⁴⁵ Even assuming that dopamine is related to pleasure, there is significant disagreement among researchers as to the nature and extent of its role in that complex process.²⁴⁶ The fact that some behaviors activate the same pathways or circuits in the brain as drugs tells us little in itself because many disorders and functions share brain circuitry.²⁴⁷ As Walter Kaye of the University of Pittsburg Medical Center notes, “stroke and Parkinson’s also involve the same pathway.”²⁴⁸

Second, and closely related to the dopamine fallacy, are the “neuroadaption” grounds for behavioral addiction.²⁴⁹ According to this theory, engaging in the behavior produces changes in neural circuitry that perpetuate the behavior, leading to addiction.²⁵⁰ Although saying that something “rewires the brain’s circuitry” sounds impressive, in effect everything a person does and experiences “rewires” the brain.²⁵¹ That in itself cannot make something addictive. The concept of addiction was developed to explain a certain class of psychoactive chemicals that mimic naturally occurring pleasure but produce a hedonic effect that would be impossible to achieve without the drug.²⁵² Although it is often said that an

2001).

243. For an introduction to neuroimaging geared toward the legal user, including a thorough discussion of the limits and pitfalls of using such data, see Owen D. Jones et al., *Brain Imaging for Legal Thinkers: A Guide for the Perplexed*, 2009 STAN. TECH. L. REV. 5.

244. Berridge & Robinson, *supra* note 40, at 311.

245. GENE M. HEYMAN, ADDICTION: A DISORDER OF CHOICE 143 (2009).

246. See Kent C. Berridge & Terry E. Robinson, *Parsing Reward*, 26 TRENDS NEUROSCIENCE 507, 509 (2003) (“[D]espite the popular view, dopamine is not after all a pleasure neurotransmitter in the sense of mediating immediate hedonic impact.”); Berridge & Robinson, *supra* note 40, at 312–13; *id.* at 313 (describing the “alternative hypotheses regarding the psychological function mediated by mesolimbic dopamine systems in reward”).

247. Holden, *supra* note 41, at 982.

248. *Id.*

249. *Id.* at 980.

250. *Id.*

251. See *Long-Term Changes in Experience Cause Neurons to Sprout New Long-Lasting Connections*, HOWARD HUGHES MED. INST. (June 22, 2006), <http://www.hhmi.org/news/svoboda20060622.html> (“[P]rocedural learning induces long-term rewiring of the brain. This type of learning is used in mastering skills such as riding a bicycle or typing on a computer.”).

252. See *supra* text accompanying notes 38–41.

addictive substance “hijacks” the brain’s circuitry,²⁵³ and some research has indicated that addictive drugs uniquely alter brain chemistry,²⁵⁴ there is simply no evidence that non-substance related activities have similar effects.²⁵⁵

2. The Looks-Like-Addiction Theory Is Illusory

The remaining justifications for a category of behavioral addictions rely on comparisons to the definitions of pathological gambling or substance use disorders in the DSM-IV-TR.²⁵⁶ The application of the substance use disorder definition to behavioral addiction reveals the incongruity such an approach entails. As described above, the criteria of tolerance and withdrawal are central to the concept of substance-use addiction.²⁵⁷ Cessation of addictive chemicals like alcohol or opiates results in real, demonstrable physiological withdrawal symptoms, which can range from hyperactivity, nausea, vomiting, and diarrhea, to seizures, delirium, and death.²⁵⁸

The incoherence that results from attempts to find withdrawal symptoms in behavioral addictions reveals much about the inappropriateness of a drug analogy. For example, Young sees “severe withdrawal symptoms” in child “video game addicts,” which consist of the children becoming “angry, violent, or depressed” when parents take their video games away.²⁵⁹ The author of *Mobile Phone Addiction* asserts that the findings of a recent study, in which 73 percent of Korean college students reported feeling “uncomfortable and irritated” when they did not have access to their mobile phones, show that the denial of mobile phones elicits withdrawal symptoms indicative of addiction.²⁶⁰ As previously mentioned, the Internet addict displays symptoms of tolerance consisting of “the need for better computer equipment, more software, or more hours of

253. See Holden, *supra* note 41, at 980.

254. See *supra* text accompanying notes 17–19.

255. See Donald W. Black, *A Review of Compulsive Buying Disorder*, 6 *WORLD PSYCHIATRY* 14, 16 (2007) (“There is currently no direct evidence to support the role of these neurotransmitter systems in the etiology of [compulsive buying disorder].”); Kafka, *supra* note 66, at 391 (“[N]europsychological studies and neuroimaging studies . . . [are] lacking to firmly support a specific ‘withdrawal’ state associated with the abrupt cessation of Hypersexual Behavior.”).

256. See *supra* text accompanying notes 84–92.

257. See DSM-IV-TR, *supra* note 8, at 197. The criteria are quoted *supra* note 10.

258. McKeown & West, *supra* note 17.

259. Sherry Raoh, *Video Game Addiction No Fun*, WEBMD, <http://www.webmd.com/mental-health/features/video-game-addiction-no-fun> (last visited Nov. 17, 2010) (quoting Kimberly Young).

260. Woong Ki Park, *Mobile Phone Addiction*, in *MOBILE COMMUNICATIONS: RE-NEGOTIATION OF THE SOCIAL SPHERE* 253, 254 (Rich Ling & Per E. Pederson eds., 2005).

use.”²⁶¹ Surely the fact that an individual becomes upset when the thing is taken away cannot qualify as withdrawal. Nor does buying more computer equipment conceptually fit the idea of tolerance—a drug addict’s upping the dosage to achieve the same high. Once the concepts of withdrawal and tolerance are divorced from substance use—that is, once they are applied to behaviors—they become functionally meaningless.

Therefore, because the two theories that have been put forth to support a category of behavioral addictions lack empirical support, it would be a mistake for the legal system to recognize behavioral addictions as mental disorders.

V. CONCLUSION AND RECOMMENDATION

Mental health standards evolve over time. If mental disorders are to have any meaning in the legal context, however, they must be grounded in empirical data and amenable to diagnosis with some measure of reliability. As cases like *Pacenza* and *Roach* demonstrate, using the addiction label for patterns of excessive, self-destructive behavior has the potential to create confusion and anomalous results in the legal system. Currently, there is little empirical data supporting the ascription of mental disorder status on behavioral addictions. In contrast, chemicals create the measurable withdrawal and tolerance effects that gave rise to the concept of addiction. Although these effects do not make the concept of addiction simple or clear cut, they at least provide a quantifiable basis on which to define the disorder. Therefore, this Note recommends that in the eyes of the law the concept of addiction be restricted to chemical substance dependence.

261. Block, *supra* note 70.

