

Punishment, Pharmacological Treatment, and Early Release

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ABSTRACT: Recent studies have shown that pharmacological treatment may have an impact on aggressive and impulsive behavior. Assuming that these results are correct, would it be morally acceptable to instigate violent criminals to accept pharmacological rehabilitation by offering this treatment in return for early release from prison? This paper examines three different reasons for being skeptical with regard to this sort of practice. The first reason concerns the acceptability of the treatment itself. The second reason concerns the ethical legitimacy of making offers under coercive conditions. The third relates to the acceptability of the fact that those criminals who accepted the treatment would be exempted from the punishment they rightly deserved. It is argued that none of these reasons succeeds in rejecting this sort of offer.

Whether psychopharmacological methods—or other methods affecting the central nervous system—should be used as an instrument to deal with behavior which is not pathologically remarkable but socially undesirable, constitutes an important question in modern bioethics. Studies in non-human species have shown that pharmacological manipulation may have an impact on aggressive and impulsive behavior. Similar results have been reached in more recent studies on humans. For instance, in one study made on criminals the authors found that aggressive and impulsive responses were suppressed in subjects assigned paroxetine treatment relative to subjects assigned placebo treatment.¹ Suppose that these results are correct. That is, more precisely, suppose that it is possible, by pharmacological or other neurotechnological methods, to regulate aggression and impulsivity in dangerous violent criminals and thereby to prevent (or at least significantly reduce the risk of) engagement in future violent conduct. Would this sort of treatment of criminals be morally acceptable?

Answering this question obviously presupposes initial clarification. In the following, I shall not be concerned with coercive treatment—an issue which so far has been discussed mainly in relation to sexual offenders or drug-addicted offenders—but focus instead on what appears to be a somewhat less controversial

issue, namely, whether it would be morally acceptable to instigate violent criminals to accept pharmacological treatment by offering this treatment in return for early release from prison. There is no doubt that early release would constitute a powerful incentive. Moreover, this offer would, if accepted, have several obvious advantages. First, a decrease in the number of violent crimes would be of benefit to those who would have been the victims of the crimes had they been committed. Second, such a decrease would in several ways constitute a benefit to the society at large.² And, finally, the treatment would be of benefit even to the criminal himself, in the simple sense that the treatment would reduce the risk of his being involved in future crimes and, consequently, increase the possibility of his avoiding re-conviction and re-punishment. Be that as it may, there are probably many who would still be skeptical about a practice of making this sort of instigating offer to violent criminals. As Farah has recently underlined “many people’s intuitions raise a flag here.”³

In the ensuing sections I shall examine three different reasons for being skeptical with regard to offering pharmacological treatment to criminals as a condition of early release. The first reason concerns the moral acceptability of this kind of treatment which, it might be held, is not a standard type of health-care treatment but rather a kind of mind enhancement. The second reason concerns the ethical legitimacy of making offers under coercive conditions. The third relates to the acceptability of the fact that those criminals who accepted the offered treatment would be exempted from the punishment they rightly deserved. What I shall argue is that none of these reasons succeeds in rejecting this sort of offer. That is, even if one feels that a flag should be raised, this feeling cannot—at least not on the ground of the reasons considered—stand closer scrutiny.⁴

1. THE ACCEPTABILITY OF THE TREATMENT

A first reason for being skeptical with regard to offering pharmacological treatment to criminals as a condition of early release may be that this sort of treatment is itself regarded as ethically dubious. Modern neuroethical discussions contain a large number of objections against mind-changing treatment; not least against what is regarded as mood or personality enhancement. In the following, I cannot provide a discussion of all arguments in this comprehensive debate.⁵ However, let us consider what seems to constitute two of the most influential objections, namely, that psychopharmacological treatment threatens authenticity and that it deprives the one who is treated of understanding or self-knowledge.

The first objection, concerning authenticity, has often been presented in relation to the use of pharmacological treatment of depression. Authenticity, roughly, consists in being true to oneself. It is, as Levy has put it, a question of finding “one’s way of life and one’s values within.”⁶ The authentic life is an expression of who we, most deeply, are. Now, statements of this kind obviously require clarification. As Bublitz and Merkel have recently pointed out, the main division among theories of authenticity is between essentialist views “in which authenticity is threatened by everything that makes people depart from who they truly are” and existentialist views in which “we create ourselves according to our own

ideals, and an authentic personality consists of self-defined and self-established characteristics."⁷ Thus, following the first interpretation it can be said that a pharmacological intervention threatens authenticity if it changes our personality.⁸ On the second interpretation, such an intervention threatens authenticity if it is not consistent with our basic values and the way we have formed ourselves. Without engaging in further considerations on how precisely these claims should be interpreted, are there any reasons to believe that pharmacological methods devised as a means to increasing aggressive impulse control would threaten the ideal of authenticity?

The first thing worth noting is that the worries, that some may have with regard to inauthenticity, hardly amount to a rejection of all kinds of treatment that compromises authenticity. That is, more precisely, it is hard to imagine that there should be a constraint against any kind of treatment that threatens authenticity. It seems to be a fact that our personalities change over time. Sometimes we even believe that there is a duty to try to change certain traits of our personality. Thus, it is hard to believe that a general constraint against authenticity-threatening treatment can be convincingly sustained.⁹ However, and more importantly, even if we *arguendo* assume that there is such a constraint and concede that pharmacological treatment may sometimes make a person lead an inauthentic life or act in a way that does not accord with who this person really is (in the same way as we sometimes claim that a person's behavior does not reflect his true self when he is drunk), this does not seem relevant when we are considering regulation of impulsivity. On the contrary, what is usually held to characterize impulsive behavior is that the individual experiences having very little control over the way he behaves.¹⁰ The behavior is not premeditated or considered in advance. But this seems to imply that it is difficult to adjust this type of behavior into expressing who one really is or wishes to be. Some proponents of authenticity objections have had hard times dealing with the fact that antidepressants — such as Prozac — are sometimes held, by those who use it, to make them feel *more* like themselves. They tend to regard their former state as an aberration from who they really are and now find themselves to be more in harmony with their true selves. It seems to me that this kind of view makes even more sense when we are considering pharmacological regulation of impulsivity. By improving a person's possibility of regulating his behaviour what happens is that the person gets more control over his life. Thus, it seems that in this case, rather than threatening authenticity, a more appropriate description is that the treatment actually helps the person lead a more authentic life or prevent behavior that could be accused of inauthenticity.¹¹ In my view, this suffices to indicate that, in relation to neurotechnological methods of increasing impulse control, authenticity-based objections have very little bite.

The second objection, concerning understanding or self-knowledge, also constitutes a frequently presented worry in relation to the use of psychopharmacological treatment. Roughly put, the idea is that pharmacological treatment constitutes a mechanical manipulation of the brain. That is, it is a type of intervention that simply bypasses the treated person's rational capacities. For instance, a person who is taking antidepressants is not provided with *reasons* to be happier. As Kass has put it, the person "can at best feel their effects without understanding their

meaning in human terms."¹² Thus, the worry is that pharmacological treatment acts directly on the human body and thereby deprives us of the opportunity of understanding the causes of a mental problem, of increasing our self-knowledge and, as it has been put, of personal growth.¹³ Does this type of worry provide a reason to object to treatment that modifies aggressive impulsive behavior?

An objection along these lines raises several questions. For instance, why precisely should we regard insight into causes, or self-knowledge, as valuable? And what does it mean to obtain understanding? If the actual cause of problems concerning impulse control is an imbalance in levels of serotonin and dopamine in the brain, could insight into this condition not be regarded as constituting a kind of understanding? And if this does not count as a proper sort of understanding, what would be—and why? Unfortunately, there is no room here to enter into a full discussion of these questions. However, a few things should be underlined.

First, the outlined considerations on understanding and self-knowledge cannot plausibly be held to establish that it is ethically impermissible to use interventions which do not provide proper understanding. Almost all sorts of traditional somatic problems are dealt with by treatment that acts directly on the body without providing any kind of understanding. And it is hard to see why a mind-affecting treatment, which has desirable consequences for the person who is treated, should be regarded as impermissible simply because it is not accompanied by a gain in terms of self-knowledge or understanding. Thus, as is the case with regard to considerations on authenticity, the worries concerning lack of understanding should not be interpreted as suggesting ethical prohibitions of particular types of treatment. A much more reasonable interpretation is that the idea is to identify *reasons* that should be taken into account, for instance, in comparative considerations of whether one type of treatment should be regarded as preferable to another (say, for instance, whether psychotherapeutic treatment is preferable to psychopharmaceutical drugs).¹⁴

Second, suppose therefore that we interpret the argument comparatively as suggesting that it is wrong to offer pharmacological treatment to criminals if other sorts of treatment, not operating directly on the human body, are available. How strong would this argument be? The first thing that should be noted is that, even though there exist alternatives to pharmacological treatment such as, for instance, various forms of CBT (cognitive behavioral therapy) which has been shown to be effective even with violent high-risk criminals, this does not in itself imply that these alternatives provide the sought-for kind of understanding. Thus, what an exponent of the argument would have to show is that these types of psychotherapeutic treatment do in fact provide the relevant kind of understanding of causes or constitute a proper source of self-knowledge. At the end of the day, this is of course an empirical question. The second thing to be noted is that a full exposition of the argument would have to make more clear what is meant by interpreting the argument in comparative terms. Suppose, for instance, that this is held to mean that *ceteris paribus* one should prefer one type of treatment that provides understanding and self-knowledge to another treatment that operates directly on the body. What then, if it turns out that everything else is not equal? That is, what if pharmacological treatment constitutes a much more efficient way of reducing

the risk of impulsive violence? To contend that in this case it would still be wrong to use methods that operate directly on the body would, I believe, require further theoretical underpinning. However, be that as it may, the most important problem facing the comparative interpretation of the argument is, of course, that the objection is relevant only in so far as there actually exist alternatives to pharmacological interventions. If there are *some* cases where psychotherapeutic treatment for one reason or another does not work (or if we simply imagine a situation in which a criminal rejects taking part in psychotherapeutic treatment) then, in these cases, the comparative interpretation of the objection is devoid of force.

In sum, what we have seen is that objections based on authenticity or lack of understanding and self-knowledge do not seem to have force as in-principle objections to pharmacological treatment. As already underlined, much more can of course be said on the matter. However, I believe that sufficient has been said to indicate that, in so far as there is a problem in offering pharmacological treatment of aggressive impulsivity to criminals as a condition of early release, this has nothing to do with the ethical unacceptability of this kind of treatment itself. Further support for this conclusion is given by considering the following simple question. Suppose a person has strong reasons to believe that in the future he will, due to lack of impulse control, commit a serious violent crime. And that this could be prevented by offering the person a pharmaceutical drug. Would it be wrong to make this offer to the person, or for the person to decide to take this drug? In the case where one agrees that it is hard to see that the answer should be in the positive, it also seems reasonable to conclude that, in so far as there is a reason to “raise a flag” when it comes to offering pharmacological treatment to criminals as a condition of early release, the problem is not the treatment itself.

2. THE APPROPRIATENESS OF THE OFFER

If the use of pharmacological methods does not itself constitute a moral problem, then what is it that constitutes the background for hesitation if one regards it as morally dubious to offer pharmaceutical drugs to inmates? According to Farah, what triggers the flag may have to do with the alternative to the treatment. Sentencing alternatives, she underlines, “are rarely appealing options, introducing implicit coercion.”¹⁵ In other words, the moral problem, if there is one, may have to do with the fact that the treatment, though not itself problematic, is offered under what seems to be coercive circumstances. Does this fact constitute a moral problem? Farah does not herself elaborate on such a view. However, a more thorough discussion of this view, as well as an argument based on an analysis of the appropriateness of offers, has recently been presented by Bomann-Larsen.¹⁶

The fact that the decision to accept or reject pharmacological treatment as an alternative to continued imprisonment is taken under coercive circumstances naturally prompts the question as to whether reasonable requirements for a consent to be valid are satisfied. According to Bomann-Larsen, the answer to this question depends on two further questions. The first is whether the formal criterion for consent—that the subject is free to accept the proposal—is satisfied. The second, whether the offer, even if the formal criteria are satisfied, constitutes an

appropriate offer in the first place. Let us briefly consider both questions. As we shall see, Bomann-Larsen's reluctance—and thus her suggestion as to how offers of treatment should be constrained—relates to the second question.

Does the fact that the treatment is offered under constraining circumstances represented by the threat of incarceration undermine the validity of the consent? Is the inmate not in a position to make a free choice? The first thing that should be noted is that the fact that pharmacological treatment operates directly on the brain is not important here. Farah's objection is that, in relation to anger-management classes, a person is free to think "This is stupid. No way I am going to use these methods" while the mechanism by which "Prozac curbs impulsive violence cannot be accepted or resisted in the same way."¹⁷ However, the mere fact that one, once a decision has been taken, reaches a point of no return at which the decision can no longer be changed obviously does not show that the decision was not freely taken in the first place. In fact, this is the case in relation to many types of offer to which one may validly consent (e.g., it is no problem to consent to undergo a big operation even though one can no longer change the decision once it is being carried out). Thus, the fact that pharmacology works directly on the brain does not undermine consent to this sort of treatment. The second point that should be underlined is that neither does the implicit coercion in the situation seem to undermine the validity of consent. The mere fact that neither of the two alternatives between which the inmate has to choose—continued incarceration or pharmacological treatment—are regarded as desirable compared to what the inmate would ideally prefer, presumably to be released, does not imply that the inmate is bound in a way that undermines consent. By analogy, it would be absurd to hold that a person who is suffering from a serious disease and who is offered a risky operation cannot validly consent to this simply because he would ideally prefer not to suffer from the disease at all. A requirement along these lines would probably undermine most cases of what seems to constitute valid instances of consent. Thus, all in all, Bomann-Larsen seems to be justified in holding that the formal criteria for consent are not violated when inmates are offered pharmacological treatment as a condition of release. The reason she believes that there are, nevertheless, reasons why this kind of offer should be constrained has to do with the nature of the offer itself.

According to Bomann-Larsen, there are some offers which are wrong in themselves. And if an offer is wrong it is no longer possible to validly consent to it. The usual function of consent—that it takes the wrongness out of an act—is no longer upheld if the offer is wrong. On the contrary, the person to whom this kind of offer is made is already wronged when the offer is presented by the offer-giver. More precisely, Bomann-Larsen suggests that some offers are wrong in a relative sense, which means that while it may be wrong for A to offer some options to B, it is not wrong of C to offer such options to D. For instance, the offer "I'll pay your bill (at this expensive restaurant) if you help in cleaning my apartment" may be highly inappropriate if made by a person to a business associate but fully acceptable (even kind) if made by a person to a student in need of extra money. Furthermore, Bomann-Larsen holds that there are some offers—such as "I will pay for medical help for your (otherwise dying) child if I get to have sex

with you" — which are wrong *tout court* because no-one can ever be in the right normative position to make them.¹⁸ Now, if there are offers which are—either relatively or non-relatively—wrong in themselves, what does this imply for our discussion of whether it is acceptable to offer pharmacological treatment to an inmate instead of continued incarceration?

The first question is whether it is at all plausible to hold that there are offers which are non-relatively wrong, that is, which are always wrong to make. This seems to me a dubious view. Admittedly, we would all usually agree that it would be wrong to offer assistance to a dying child in return for sex. However, without engaging in a detailed analysis of the wrongness of offers, it seems to me that the main reason why this offer is wrong is that there is another option open to the offer-giver—an option which he or she ought to choose—namely, to assist the child without requiring anything in return. But if this explanation is correct, then it seems that even the suggested offer might be drained of wrongness if the morally preferable way of acting is excluded as an option. Suppose that the offer-giver's only motive is to assist the dying child, that the only way he or she can provide money to do so is by having sex with the parent (because some perverted person has offered money if someone has sex with the parent), and that for some reason it is not possible for the offer-giver to explain this to the parent. Would it then still be wrong to offer to assist the child in return for sex? If, as assumed, this is the only way the child can be assisted, then it seems to me that the answer is in the negative. In fact, I tend to believe that it would be wrong *not* to make the offer and thereby let the child die. In my view, this sort of consideration indicates that it is questionable to hold, as Bomann-Larsen does, that there are offers which are non-relatively wrong, that is, which are always wrong to make.¹⁹ Be that as it may, if it is correct that there are offers which are sometimes wrong to make, this may still be sufficient to question the offer of pharmacological treatment to inmates as a condition of early release.

What Bomann-Larsen suggests is not that offers of this kind of treatment are wrong. Rather her view is that such offers should be pretty narrowly constrained in order to be morally acceptable. The proposal is that the offered treatment "should not go beyond what is necessary in order to correct the behavior for which the criminal is imprisoned."²⁰ Why should the offer, in order to be acceptable, be so narrowly constrained? What Bomann-Larsen contends is that there are some acts for which we as citizens are responsible to the state and must answer for to the state and that "what citizens are answerable for to the state determines the scope of behavioral conditions for which the state can appropriately offer convicts treatment."²¹ This constitutes the reason as to why the state should only offer treatment of the behavior for which a criminal is convicted. As she also underlines, not all wrongs are "public wrongs" and "not all socially undesirable behaviors are the state's concern."²² However, this view prompts an obvious question. Even if one accepts that the scope of the sort of behavior for which the state can legitimately offer treatment must be classed under "public wrongs" and not just any kind of socially undesirable behavior, it is very hard to understand why an appropriate offer should be limited to treatment of "the behavior for which the agent is convicted."²³ Suppose that a criminal is convicted for crime C_1 but we have strong

reasons to believe that he or she will in the near future commit crime C_2 . Why then is it only acceptable to offer treatment that would prevent a future instance of C_1 but not acceptable to offer treatment targeted at preventing C_2 ? Surely, it cannot be held that C_2 is not the “state’s concern.” Thus, Bomann-Larsen’s analysis of offers has not provided reasons as to why the treatment offered to criminals should be limited as narrowly as she suggests.

More generally, and importantly, it is hard to imagine that reasons can be provided for the wrongness of offering treatment to criminals that will decrease the likelihood of future criminal conduct. Boman-Larsen has suggested that some offers are wrong because they do not treat the person to whom the offer is made as “an equal” or with proper respect. But it is hard to see how the offer of a treatment to a criminal, that would reduce the probability of future criminal conduct and thus perhaps of long-term future imprisonment, can plausibly be held not to treat the criminal as an equal. Moreover, suppose it is correct—as suggested in relation to the dying child example—that what makes a particular offer wrong is that there is another option—besides those that are offered—open to the offer-giver and that this option is the one which he or she ought to choose. This might imply that it would be wrong to offer pharmacological treatment to a criminal as a condition of early release if there is a better way of preventing the criminals from committing crimes in the future. However, as mentioned in the former section—and to which I shall return later—this does not imply that the offer is wrong if there exist no such preferable alternatives.

Thus, to sum up, it seems dubious to hold that there are some offers which are always wrong. Moreover, it is difficult to see why offers of treatment should—as Bomann-Larsen suggests—be limited only to the kind of behavior for which a criminal is convicted and, more generally, it is hard to imagine any other general arguments concerning the morality of offers which imply that the suggested kind of treatment of criminals should be ruled out because the offer per se is morally inappropriate. However, even if this conclusion is correct there may still be—as we shall now see—a reason why some would hesitate to accept treatment being offered to criminals.

3. THE PURPOSE OF THE SANCTION

Even if one accepts that pharmacological treatment is not in itself unacceptable and that the offer of this type of treatment, though coercive, should not be regarded as inappropriate, there may still be a reason to reject such treatment to criminals as a condition of early release, namely, that this practice is inconsistent with the idea of why punishment should be imposed in the first place.

As is often described in the literature, retributivist thinking has dominated the penal theoretical field over the last three or four decades. Retributivism has been defended in many different versions. Some retributivists—adhering to so-called negative retributivism—contend that what matters is that criminals are not punished more severely than they deserve, whereas punishing less severely is no problem in terms of justice. However, most retributivists favor positive retributivism, that is, the view that criminals should be punished as they deserve—neither more nor

less severely. On the ground of this view, retributivists have objected to various sorts of forward-directed approaches to criminal justice such as, for instance, treatment-based sentencing. For instance, “traditional rehabilitationism” as von Hirsch remarks “flouted proportionality blatantly, and this is one of the reasons for those schemes’ demise.”²⁴ However, there is no reason to hold that a modern treatment-based scheme operating in terms of offered pharmacological treatment should be assessed any differently. In other words, it might be objected that if a criminal accepts treatment he does not get the punishment he deserves—i.e., the punishment proportionate to the gravity of the crime committed—and that, even though this may have desirable consequences for the criminal and for society in general, it is morally unacceptable to let respects to future consequences overrule the requirement of justice. Therefore, pharmacological treatment may well be offered, but never in return for early release from prison.

The objection presupposes that positive retributivism is correct, that is, more precisely, that not only upward deviations from the proportionate punishment, but that also downward deviations are morally unacceptable. If one accepts certain types of relaxed retributivism or mixed penal theories, or simply subscribes to versions of consequentialist theories, the objection falls apart. However, what is more important is that it is not even clear that early release and treatment is inconsistent with positive retributivism. What matters for the retributivist is that the criminal receives a proportionate punishment. If the severity of the punishment is determined on the grounds of the degree of hard treatment or harm that is imposed on the criminal, then all one has to do to satisfy the proportionate punishment requirement is to ensure that the treatment is actually imposed as (part of) a punishment and that the two alternatives offered to the criminal—continued incarceration or earlier release and treatment—are equivalent in terms of inflicted harm. How could this be the case? From the outset there is—given the standard definitions—nothing that excludes the possibility that a treatment could serve as a punishment even though it, at the same time, has a future-directed function in the form of crime prevention.²⁵ But how should one ensure that proportionality is maintained? There are several possibilities. The first one is simple. If treatment by pharmacological means is unpleasant—for instance in terms of side-effects—then this sort of treatment could be offered to the criminal as part of the punishment. If an inmate chooses treatment, and if this takes place in prison prior to the early release, then this would increase the harm inflicted on the criminal (compared to the situation in which treatment was not accepted) which means that, even if the inmate is released at an earlier point than he would otherwise have been, the total amount of inflicted harm may be the same. Alternatively, if the treatment is effectuated in prison but goes on after the early release, or if it is started after release and then goes on for a longer period, then once again there is nothing that excludes the possibility that the total harm of the reduced prison term and the treatment could be made equivalent to the harm of the full prison term (without treatment). But what then if the treatment does not involve any inconveniency for the criminal? The second possibility would then be to somehow make the treatment inconvenient. This could be done either by adding other kinds of drug to the treatment or by applying some kind of probation or other means during the

treatment if it takes place after release. Once again, there is nothing in principle that excludes the possibility of making the two alternatives with which the criminal is confronted equivalent in terms of hard treatment. And what is particularly noteworthy is that if treatment could function as a punishment then not only would it be acceptable to release a criminal, who accepts treatment, earlier than a person who does not, this would be required in terms of justice. In order not to end up imposing a disproportionate punishment on the criminal who accepts treatment—that is, in order not to punish too severely—early release is what positive retributivism would prescribe.²⁶

It is worth noting that these thoughts are not far from what some retributivists have themselves suggested. Several retributivists accept that punishment need not consist only in imprisonment or fines. There exist various sorts of intermediate sanctions—including, for instance, home detention, community service, and electronic monitoring—which should not be regarded merely as alternatives to punishment but rather as alternative punishments. But this means that one will have to be able to compare punishments of different type in terms of severity. Moreover, it has been suggested, for instance by von Hirsch, that substitution could to some extent be used between different types of punishment.²⁷ That is, as long as the “penal bite” is maintained one could substitute a punishment of one type with a punishment of another, for instance, if the latter type of punishment would have preferable consequences. In this way the retributivist could—to some extent—allow considerations of future consequences without violating the basic requirement of proportionality. Thus, the overall idea of comparing equivalents of punishments of different types is not foreign to modern positive retributivists. Be that as it may, the outlined answer as to why there need not be any inconsistency between retributivist proportionality requirements and the idea of offering inmates treatment as a condition of early release may nevertheless prompt a number of objections.

Firstly, it might be suggested that, even if it is correct that retributivists hold that it is possible to compare punishments of different types in terms of severity, it is another matter if one—as the above considerations imply—wishes to combine different types of punishment into one overall sanction. In other words, the idea of assessing the overall severity of the combination of imprisonment and treatment seems dubious. However, it is hard to see why there should, as a matter of principle, be a problem here. Suppose that for some reason one prison term was split up into two terms. First the criminal serves the first half and after some time he serves the second half. It would surely be absurd to hold that in this case it makes no sense to talk of the overall punishment which the criminal has received or that this split punishment cannot be compared in terms of severity to an uninterrupted period of incarceration. But if one, furthermore, accepts that a punishment of one type can be compared to a punishment of another in terms of severity, then it is hard to see why it should not be possible to compare a punishment which consists of incarceration and treatment to a punishment which consists only in incarceration. Thus, the suggestion that the punishment combined of incarceration and treatment does not really amount to one overall

punishment or that it—in so far as it is one punishment—is not comparable to a standard prison term does not seem plausible.

Secondly, it might be held that even though there is in purely theoretical terms no problem in constructing a punishment by combining different sources of harm or, for that matter, in comparing a punishment thus designed with standard types of punishment, there nevertheless is a simple practical problem: It becomes much more difficult to precisely mete out the proportionate punishment. However, though this is probably correct it should be recalled that—as mentioned—all retributivists accept that different types of punishment can be applied even though they are not in any easy way comparable. And, as retributivists have underlined, one cannot expect any actuarial or mathematical precision when it comes to the comparison of punishments in severity.²⁸ In order to block these considerations, it would have to be argued that the margin of error somehow becomes too large to be acceptable. However, no argument of this type has yet been presented and it is hard to imagine how it would go. Thus, this objection too is unconvincing.

Thirdly, even if one accepts that the alternatives offered to the criminal are comparable in terms of the harm that is inflicted, some retributivists might still object that this is not sufficient. According to one of the dominant versions of modern retributivism, what matters in relation to punishment is not merely the infliction of hard treatment. Rather the punishment is perceived as a sort of communicative enterprise in which a condemnatory message is conveyed to the criminal. The hard treatment serves as a means of conveying the appropriate message to the criminal.²⁹ But if this is so, then it might be suggested that the pharmacological treatment cannot really serve the function of punishment. Even if it is, in fact, unpleasant (or if it is made unpleasant) it cannot really serve the function as a means of communication. Therefore, the two alternatives—continued imprisonment or early release and treatment—cannot be made equivalent in terms of severity. However, this objection presupposes that the unpleasantness or harm related to the treatment (or, as suggested above, added to it) cannot—even if imposed in the right way—serve as a means for communicating a condemnatory message. The problem is that it is very hard to see why this should be the case. If one believes that all standard types of punishment, including various sorts of intermediate punishment, can serve this function then it is hard to see why we have suddenly reached a sort of unpleasantness or harm which cannot serve this purpose. Thus, this objection in turn does not seem persuasive.

Finally, it might be objected that if the pharmacological treatment itself is unpleasant, or if some sort of harm is added to it in order to make the overall punishment equivalent to the proportionate prison term, then it becomes much less likely that this alternative will be chosen by the criminal to whom pharmacological treatment is offered. The answer to this comment of course is that such may well be the case. Certainly treatment becomes less attractive the more unpleasant it is. However, the main point here has not been to show that treatment is equally attractive under all penal schemes but to consider whether it would be morally acceptable to offer this sort of treatment to criminals as an alternative to a full prison term. And, as we have seen, this may be the case even if one

subscribes to a penal theory that does not allow for downward deviations from the proportionate punishment.

In sum, what I have argued is that even though a positive retributivist outlook will—in order to maintain proportionality—place constraints on how the pharmacological treatment should be carried out and on how early treated inmates should be released, this approach to punishment is not inconsistent with the idea of offering treatment as a condition of early release.

4. CONCLUSION

That the use of pharmacological treatment and other sorts of medical intervention as a means of dealing with anti-social behavior might “raise a flag” is not hard to understand if perceived from a historical perspective (e.g., think of the ways in which lobotomies or drugs have been used as a means of social control). However, obviously former cases of use or misuse of such interventions do not imply that treatment cannot be properly applied. In the foregoing, I have considered whether there are any in-principle reasons to reject the use of pharmacological treatment of criminals as a condition of early release from prison. What I have suggested is that the nature of the treatment itself, the character of the offer, the fact that it, if accepted by a criminal, would imply a reduction of the time spent in prison, none of these factors constitute sufficient reasons for rejected the offering of such treatment to violent criminals. This conclusion obviously does not imply that there should be no constraints on such offers. For instance, if the risk of future impulsive violence can be reduced in other ways that are preferable to the use of pharmacological treatment (e.g., different types of CBT) then the offer of this treatment becomes morally dubious.³⁰ Moreover, depending on the view one holds on mind-changing treatment or the penal theory to which one subscribes, there may—as we have seen—be other sorts of constraints on the ways in which such treatment should be carried out. Furthermore, it is clear that there is no simple or direct step from an in-principle acceptance of such treatment to the practical use of such offers to criminals. Practical application opens up a large number of pertinent challenges that have to be dealt with (how should the treatment be controlled; what are the risks of misuse; what are the risks that some inmates may force others to accept treatment against their will in order to use them for “jobs” once they have been released, etc.). In real life there is of course a myriad of such questions that have to be considered. However, if the conclusion of this paper is correct—that there is no reason to reject such treatment in principle—then we have a reason to engage in considerations on how these practical challenges should be dealt with.

Endnotes

1. D. R. Cherek et al., “Effects of Chronic Paroxetine Administration on Measures of Aggressive and Impulsive Responses of Adult Males with a History of Conduct Disorder,” *Psychopharmacology* 159 (2002): 266–74.

2. As the most obvious example, the society would save a lot of money in terms of the resources that would have been used on police work, court work, and incarceration.

3. M. J. Farah, "Emerging Ethical Issues in Neuroscience," in *Defining Right and Wrong in Brain Science*, ed. W. Glannon (New York: Dana Press, 2005), 28.

4. In the following, I shall not engage in considerations on the possible side-effects of the considered sort of pharmacological treatment. The studies that have been conducted so far do not report serious medical side-effects. Moreover, and more importantly, if one imagines that this treatment would have serious side-effects—for instance, that suppressing impulsive violent reactions would leave people in some sort of zombie-like state or cause serious diseases—then it becomes much less likely that anyone would accept the treatment. Thus, while such side-effects would be highly relevant if one considers the use of coercive treatment, they are less relevant when we are considering treatment that is offered to criminals.

5. For an overview, see N. Levy, *Neuroethics: Challenges for the 21st Century* (Cambridge: Cambridge University Press, 2007), chaps. 2 and 3; N. Bostrom and R. Roache, "Human Enhancement" in *New Waves in Applied Ethics*, ed. J. Ryberg et al. (Basingstoke, NY: Palgrave Macmillan, 2007).

6. Levy, *Neuroethics*, 75.

7. J. A. Bublitz and R. Merkel, "Autonomy and Authenticity of Enhanced Personality Traits," *Bioethics* 23.6 (2009): 361.

8. See also Levy, *Neuroethics*, 73–6.

9. Theorists who have discussed the argument have often interpreted it as a comparative argument (i.e., as an argument to the effect that treatment that does not threaten authenticity should be preferred to treatment that does). See, for instance, Levy, *Neuroethics*, chaps. 2 and 3.

10. Admittedly, this is not always the case. In some emotional states, such as when overcome by anger, people are sometimes in much control of their behaviour though not of their emotion. But even when this is so, it is still far from clear that the way a person behaves in a state of anger can be said to properly express who this person really is or wishes to be. Quite often people will hold that a uncontrollable emotional state made them behave in a way in which they would not have behaved had they not been overcome by the emotion.

11. It might perhaps be objected that the impulsive self is the more genuine or true self. However, this certainly does not reflect the idea of authenticity as it has usually been defended and, pursuing this idea of authenticity as a guideline for what sort of treatment should be seen as morally acceptable, would have several pretty odd implications (though I cannot here engage in a closer scrutiny of these implications).

12. L. Kass, "Ageless Bodies, Happy Souls: Biotechnology and the Pursuit of Perfection," *The New Atlantis* Spring (2003): 22.

13. See Levy, *Neuroethics*, 76ff.

14. *Ibid.* chaps. 2 and 3.

15. Farah, "Emerging Ethical Issues in Neuroscience," 28.

16. L. Bomann-Larsen, "Voluntary Rehabilitation? On Neurotechnological Behavioural Treatment, Valid Consent and (In)appropriate Offers," *Neuroethics* (March 2011), online first. DOI: 10.1007/s12152-011-9105-9.

17. Farah, "Emerging Ethical Issues in Neuroscience," 28.

18. Bomann-Larsen, "Voluntary Rehabilitation?," 10.

19. For a more comprehensive discussion of Bomann-Larsen's position, see J. Ryberg and T. S. Petersen, "Neurotechnological Behavioural Treatment of Criminal Offenders—A

Comment on Bomann-Larsen," *Neuroethics* (December 2011), online first. DOI: 10.1007/s12152-011-9146-0.

20. Bomann-Larsen, "Voluntary Rehabilitation?," 11.

21. *Ibid.*, 10.

22. *Ibid.*

23. *Ibid.*, 10–1.

24. A. Von Hirsch and A. Ashworth, eds., *Principled Sentencing* (Oxford: Hart Publishing, 1998), 4.

25. The idea of the standard definitions of punishment—such as the Flew-Benn-Hart definitions—that punishment must be an evil or harm deliberately inflicted on someone who has violated the law might well be satisfied by a treatment.

26. At least if we *arguendo* assume that the prison term could not be made more lenient in other ways.

27. A. von Hirsch, M. Wasik, and J. Green, "Punishments in the Community and the Principles of Desert," *Rutgers Law Journal* 20.3 (1989): 595–618.

28. As von Hirsch, Wasik and Green contend, desert requirements are satisfied in cases of substitution if "the substitute penalty is required to be of approximately the same onerousness as the normally-prescribed grid sanction," *ibid.*, 604.

29. See, for instance, A. von Hirsch, *Censure and Sanctions* (Oxford: Oxford University Press, 1993); A. von Hirsch and A. Ashworth, *Proportionate Sentencing* (Oxford: Oxford University Press, 2005); and A. Duff, *Punishment, Communication, and Community* (Oxford: Oxford University Press, 2001).

30. For a meta-analysis showing that cognitive behavioral therapy significantly reduces recidivism even among high-risk criminals, see N. A. Landenberger and M. Lipsey, "The Positive Effects of Cognitive-behavioral Programs for Offenders: A Meta-analysis of Factors Associated with Effective Treatment," *Journal of Experimental Criminology* 1 (2005): 451–76.