

1 Introduction: The Makings of a Responsible Addict

Jeffrey Poland and George Graham

A person drinks a glass of wine. Suppose this is an instance of recreational behavior. It is a minor part of dinner in a fancy restaurant with family and friends. If someone gave the person a good reason for not drinking that glass of wine, such as that it would interfere with her ability to drive home, the person would refrain.

Suppose a person sitting at a table next to the wine drinker is consuming a fifth glass of scotch within an hour. Suppose that because of this behavior, heavy drinking, which he engages in imprudently and often, he has lost his job, and his spouse has divorced him. Suppose also that the person cannot be persuaded to stop drinking the scotch. He has an “unhealthy” preference for the scotch. He is, in fact, addicted to alcohol. To his obvious detriment, he depends on it.

Consuming the scotch is not like shivering when one gets cold or grinding one’s teeth when one is asleep. It is in some manner voluntary, deliberate, or intentional. But it is not as voluntary, deliberate, or reflectively intentional as the behavior of drinking the wine. Some causal responsibility on the part of the addict is present. But it is not of the paradigmatic sort exhibited in enjoying wine with family and friends.

This volume is focused on the scotch, as it were, not on the wine. It is focused on addiction. It is also focused on the role or roles of responsibility in and for addiction. It explores how best to understand the nature of addiction and the responsibility of an addict, as well as of other persons, including those who care for or treat an addict. Our intention in this editorial introduction is to engage in some conceptual stage setting: to describe the various topics examined in the book, the multiple perspectives offered herein, and the profound significance that the book’s topics have for individuals and society. To encourage this fusion of multiplicity and

significance, the contributors to the volume reflect a variety of disciplinary orientations and have been given substantial freedom or latitude with respect to the focal orientation of each chapter. Each essay also is new and original with this volume.

Background: Issues and Themes

What Is Addiction?

There is, of course, no simple answer to this question, no definitive definition of the very idea of addiction. By themselves, of course, abstract definitions provide no substantial level of understanding; rather, what is required is a complex theoretical framework that encompasses many facets of the phenomena labeled "addiction." To begin, an adequate theoretical framework will need to make distinctions among the types of objects to which an individual might become addicted. Not all addictions are to substances, since a variety of so-called "process addictions" are also widely recognized (e.g., eating, sex, gambling, self-injury, the Internet). Whether there is a unitary phenomenon that takes multiple objects of various sorts or whether there are as many types of addiction as there are objects of addiction is an open question. Further, an adequate theory should clarify what is meant by "addicted" drug seeking or dependency and use. Does such a term refer to patterns of behavior or to the character of the causes of behavior or both? And, in any event, which patterns and which causes are involved? Perhaps more important than explicating the very notion of addiction are delineations of the phases and time course of addiction and differentiations among the processes associated with becoming addicted, addiction-related seeking and use, struggling to overcome an addiction, remission, and recovery. Such theoretical complexities are of major significance for research, clinical practice, and, most importantly, the personal experience of the individual addict.

Another related limitation of abstract definitions of "addiction" is that they mask a considerable amount of causal ambiguity, that is, the fact that superficially similar patterns of behavior are associated with considerable heterogeneity of causal and constitutive structures and processes. To resolve such ambiguity requires recognition and study of multiple perspectives, multiple levels of analysis, and multiple dimensions of the phenomena labeled as "addiction." Specifically, the first-, second-, and third-person

perspectives are all potentially relevant to understanding addiction, where each has its own particular modes of access to information of certain proprietary sorts. And, insofar as each perspective, while having access to its proprietary sorts of information, does not have access to information available from the other perspectives, how can any provide a complete understanding of addiction? How, for example, could a portrait of addiction that lays out one or another causal mechanism that explains patterns of addictive behavior provide any understanding of the experience of being an addict (or, of course, vice versa)? Authors in this volume vary considerably with respect to their focus on one or another of these broad types of perspective, although all are aware of the importance of each. A few have even been addicts themselves.

Further, the resolution of causal and constitutive ambiguity associated with addiction depends crucially on investigation at distinct levels of analysis, including genetic, neurophysiological, neurocognitive, neuroaffective, higher-level cognitive, phenomenological, behavioral, social, and cultural levels. And as research is making abundantly clear, the relationships among variables at the same and different levels of such analysis are typically dynamic and nonlinear, making research and the models and findings they produce more and more complicated. Authors in this volume have collectively succeeded in laying out a variety of (partial) models of addiction-related phenomena. These include the incentive-sensitization theory (Berridge & Robinson), the ego-depletion theory (Levy), behavioral learning theories (Petry, Alessi, & Rash), pathological affect theory (Charland), a learning-impairment theory (Yaffe), and a theory based on hyperbolic discounting and recursive self-prediction (Ainslie). Such theories and models do perhaps conflict in certain individual ways, but they also may be better seen as potentially complementary forms of causal analysis that may or may not be integrated into a unified framework. Further, the dual questions of how such causal analyses are related to the subjective experience of the individual addict and whether such analyses are compatible with a more or less robust conception of human agency and responsibility loom large for anyone attempting to develop an integrated theory of addiction.

The multiple levels of investigation involved in addiction research raise and potentially address a number of traditional philosophical problems. Most notably the following problems are touched on in one way or another

in this volume: the mind-body problem, the problem of other minds, the free will problem, and problems both of human agency and responsibility. That any of these problems is “solved” is unlikely, although interesting observations and suggestions are presented in the chapters by Ainslie (free will and agency), Flanagan (mind-body and other minds), Morse (agency and free will), Levy (agency and responsibility), Yaffe (agency and responsibility), Charland (agency and responsibility), and Berridge and Robinson (mind body, free will, agency and responsibility). Those who come at the issues from the framework of the sciences are typically involved in problems of integrating findings from disparate research programs at different levels of analysis, and this inevitably brings them into contact with questions concerning relations between the mental and the physical. Those who are focused more on issues arising from within a first-person perspective, but who also take the third-person perspective of the sciences very seriously, are further engaged in how to integrate the findings of a phenomenological description or analysis and the findings of the sciences. In his chapter, for instance, Owen Flanagan brings to bear what he calls the “expanded natural method” to provide a framework for research into such integration. As alluded to above, that the various models and findings gleaned from various research programs and perspectives do not fit neatly and coherently into a single unifying framework is also a possibility, but it is one that does not necessarily compromise the value of each.

A further complication in comprehending and studying addiction-related phenomena concerns what may be described as the metaphysical status of addiction. Is addiction a brain disease, a moral failing, or something else, perhaps some sort of rational preference? The limited and evidently false dichotomy, brain disease or moral failing, fuels many ill-conceived debates, raises very difficult-to-resolve controversies over the proper analysis of the concepts of disease and moral failing, and masks deep-seated interests unrelated to the substance of questions concerning the nature of addiction (e.g., such interests may concern issues of access to health care or proprietary guild interests). As Morse discusses in his chapter, “status” questions are typically not probative in questions of legal responsibility, and we would add that they are not clearly probative with respect to most scientific and philosophical questions concerning addiction either.

This is especially the case with respect to whether addiction is a “mental disorder,” perhaps as conceived within the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Putting aside the widely recognized problems with psychiatric classification as presented in the DSM, the lack of clarity concerning how to conceive of “mental disorder” that is manifest in the field of psychiatry creates suspicion over the value of categorizing addiction as a mental disorder. In addition, a variety of “disease”-related inferences are highly suspect, although also quite prevalent. Here are three:

1. The brains of addicted individuals are different from the brains of non-addicted individuals; therefore, addiction to a substance is a brain disease.
2. X has difficulty controlling certain types of harmful behavior; therefore, X has a brain disease.
3. X has a brain disease; therefore, X is not responsible for behavior related to that disease.

Under close critical scrutiny such patterns of inference are clearly unsound, and they obscure important issues and confuse numerous discussions of addiction. Each is enthymematic, and when they are fleshed out, highly questionable premises come into view. For example, with respect to inference 3, candidate-intervening premises might be: if X has a brain disease, then X cannot control X's behavior, and if X cannot control X's behavior then X is not responsible for that behavior. But, the former premise is questionable, as Morse discusses in his chapter.

In lieu of substantial progress on such matters concerning the concepts of disease and disorder, it is probably best to focus on particular questions of interest concerning individuals in specific contexts (e.g., Was X responsible for committing a crime? or Should X be permitted access to health care resources? or Why does X exhibit certain patterns of behavior?). In all such cases disease or disorder status masks the genuinely relevant considerations and clouds engagement with the real issues of consequence.

Another issue is raised by the possibility that addiction is not anything at all: there is no “it” that is an addiction to some substance or activity; there is no objectively real status that one has as an addict or as someone with a disease, and so forth. Rather, there are only narratives or stories, with no reliable ways of constraining their content, that we tell about ourselves or that others tell about us or that attach to us as we enter into some institution. Such narratives might include that of “the chronic

relapsing brain disease” or that of “the morally weak person who, although able to, does not resist temptation” or that of “one who has a bad habit that is difficult to break” or that of “the person who has lost control over his behavior and his life” or. . . . Such narratives bear directly not just on providing an understanding of how a person arrived at his current condition and situation but on how to understand those current conditions and situations, as well as what the future is likely to hold in store. All such attributions about the past, present, and future can have a decidedly powerful impact on what future course the person actually follows.

These issues of attributions and their impact arise acutely in the context of widely endorsed efforts at *destigmatizing* addiction and mental illness by advocating and teaching the idea that such conditions are brain diseases beyond a person’s voluntary control and, hence, that they are conditions for which the person should not be blamed. In addition to its not being clearly the case that a brain disease is involved, such attributions are not clearly effective in reducing social stigma, and they pose a serious likelihood of introducing toxic first-person self-pathologizing or medicalizing attributions that may undermine a person’s efforts to overcome her problems. There is much allure to medicalization, and it may well be appropriate to “medicalize” some conditions and, thereby, enable access for individuals to healthcare resources and insurance reimbursement, attract funding for research, and engender appropriate reactive attitudes in others. However, not all conditions warrant a “sick role,” and, in some cases adopting such a stance is harmful to the interests and rights of the individual who is inappropriately cast into such a role.

In her chapter, Potter draws special attention to the variety of narratives that can be constructed concerning an individual, the ways in which such narratives can serve various interests and purposes, and the likelihood that some narratives might better serve the interests of particular individuals in their particular life context than others, which might, for example, be narratives informed by institutional authorities or conventional forms of understanding. Here the tension between first-person and third-person perspectives is manifest when the “best” narrative from the point of view of an individual might conflict with an institutional or conventional social narrative designed to serve other interests or to promote stigmatizing social stereotypes. Along these lines it is important to keep in mind that there are many “truths” concerning a particular person (addicted or otherwise)

in his particular context, and which truths should be selected and identified as relevant in understanding that person will depend on a variety of pragmatic considerations (e.g., goals, interests, purposes, saliencies). If there is but one Ultimate Truth about us as persons, it embraces a multiplicity of contrasting aspects; if there are many truths about us, the set of them all is only very loosely "One." And in any event, different bodies of truth can have very different types of significance.

One special case concerning types of narrative is related to the focal issue of responsibility. Certainly an imaginative story teller can tell a story of a rock or a rat. But unlike the story of a human being, these tales are not narratives in a proper sense; rocks and rats harbor no responsibility for the "dramatic" episodes of their existence. They do not sculpt or author the conditions of their persistence, and, of course, they harbor neither moral nor legal responsibility for their circumstances or behavior. As we see below, there are various plausible ways of specifying the concepts of responsibility appropriate in discussions of addiction, and different conceptions will be more or less well suited to the demands of various contexts.

Another special case in which the choice among possible truths to focus on and narratives to tell arises in the context of what we will call "coping with addiction," something that can be understood from the first-person perspective of a person struggling with and attempting to overcome her addiction (with or without help) or from the third-person perspective of a clinician or other party concerned to help an individual overcome her addiction through some form of intervention. Certainly one important aspect of understanding what addiction is comes from an understanding of what might be involved in coping with addiction from either of these perspectives. Whether it is pharmacology-based therapy or behavioral rehabilitation or will power or a 12-step program or some other form of cognitive restructuring or social support, the question of which approach to overcoming and intervening is optimal presupposes important facts and values that may vary widely from case to case and from perspective to perspective.

Several authors in this volume have focused on just such questions about narrativity and coping, each from a somewhat different perspective. Whereas Potter focuses on the importance of the narrative that an individual embraces as her own, Petry and colleagues place heavy emphasis

on the demonstrated efficacy of empirically grounded contingency-management techniques based on learning theory. And whereas both Garrett and Flanagan depict the exquisitely detailed individual character of their respective struggles with addiction, Garrett articulates and endorses the value of a framework of cognitive-affective restructuring grounded in ideas drawn from a variety of moral and religious traditions, whereas Flanagan emphasizes the importance of identifying “zones of control” and of social support that were of value to him. In the context of the present volume such approaches to understanding how addiction might be overcome bear directly on certain questions of responsibility, as the authors bring out, and we now touch on briefly.

What Is Responsibility?

Of primary importance for addressing the question of how addiction might bear on responsibility is to clarify how responsibility is to be conceived. In addition to “moral responsibility,” which is generally conceived of as applying in all contexts of human activity, there are several more specific contexts in which questions concerning responsibility arise; and such contexts carry with them different standards and criteria for understanding and making determinations about the specific forms of responsibility appropriate to those contexts. Each of these more specific conceptions is tuned to the purposes, values, interests, relevant truths, limitations, and traditions of the corresponding context. Thus, as Morse outlines in detail in his chapter, “legal responsibility” reflects standards operating within the judicial system and involves such conditions as rationality and freedom from compulsion and duress. Charland, on the other hand, is concerned with questions of responsibility arising in health care and research contexts; the idea of responsibility for making health care decisions or decisions to participate in research is tightly associated with the requirements of informed consent and the types of condition that are required for giving such consent (e.g., factual understanding and adequate decision-making capacity).

Necessary conditions for moral responsibility have been conceptualized in various ways; possibilities include, X is responsible for A only if:

- A is an action that is intentional, voluntary, and free.
- A is an action that is rational and not the result of compulsion or duress.
- A is an action that is the result of X’s capacity for “guidance control.”

This latter conception of “guidance control” is a widely accepted concept developed by John Fisher and Mark Ravizza and concerns a certain sort of counterfactual sensitivity to reasons, understood partly in terms of the notions of “reasons responsiveness” and “reasons reactivity”:

Reasons responsiveness Were X presented with a sufficient reason to act in a different way (from A), X would be capable of recognizing it as a sufficient reason.

Reasons reactivity X’s mechanism that produces A would actually cause X to act otherwise in response to at least some sufficient reasons to do otherwise, if it is allowed to act unhindered.

In their chapters, Yaffe and Levy deploy this approach to understanding moral responsibility in their arguments.

Closely affiliated with conceptions of responsibility, whether they are general conceptions of moral responsibility or more context-specific conceptions, are conceptions of excuse from responsibility or of diminished responsibility. An excuse is, roughly, some condition that drives a wedge between a person and the wrongfulness (or rightfulness) of his act and is often associated with matters of knowledge, control, influence, and cognitive process. A person might be eligible for an excuse from responsibility (or a diminution of responsibility) if his act were a result of any of the following: loss of motor control, coercion, duress, ignorance, accident, mistake, lack of appreciation, irrationality of belief or of reasoning process. Several authors in this volume (Morse, Yaffee, Levy, Charland, Berridge and Robinson, Ainslie) discuss various features of addiction that are candidates for being excusing conditions, although these authors vary in the conclusions that they draw. Whereas some demur from reaching a definitive conclusion, others address directly the question of whether those suffering from an addiction are appropriately viewed as having diminished responsibility at least some of the time.

Other issues concerning responsibility come into view when we shift attention away from the person who may or may not be excused from responsibility for a wrongful act and toward other people who are in the person’s life or who are part of the social landscape in which the person lives. Wrongful acts do not occur in a social vacuum, so it is appropriate to ask what roles and responsibilities others might have with respect to either the actions themselves or the agents who commit them. For example,

do other people or institutions share in the responsibility for a person's addiction-related wrongful actions? Or, if not, do other people or institutions have responsibilities to change the social landscape in which such wrongful actions occur in order to make them less likely? Or, do other people or institutions have responsibilities to treat or rehabilitate, or to show compassion for, those who engage in such wrongful acts? In this volume, although the primary focus of attention is on the individual responsibility of those who suffer from an addiction, some attention is given to these broader questions concerning the responsibilities of others.

How Does Addiction Bear on Questions of Responsibility?

With respect to the question of how addiction bears on individual responsibility, many of the distinctions surveyed above must be deployed: What context and conception of responsibility is involved (moral, legal, clinical, research)? What are the specifics concerning the individual's addiction, and what impact do they have on processes or conditions related to a person's responsibility for some condition or act? What specifically is an individual supposed to be responsible for? With respect to this last question, an individual might be responsible for (1) becoming addicted to some object of addiction, (2) seeking and using his specific object of addiction, (3) other behavior or consequences related to his addiction (e.g., criminal activity, impact on family, friends, or community, harm to himself, consent to participate in research or treatment), or (4) overcoming his addiction. Several of the authors in this volume deploy such distinctions to specifically address questions of moral responsibility (Levy, Yaffe, and Garrett), legal responsibility (Morse), and responsibility in health care and research settings (Charland) and reach definitive conclusions, one way or another.

In each case the strategy of argument is to identify a relevant standard for determining responsibility in the identified context, to identify critical features of addictive processes, and to assess, given the relevant standard, whether or not those features are sufficient for a determination of responsibility for some sort of behavior or condition (from among 1–4). Other authors (Ainslie, Berridge and Robinson, Petry et al., Flanagan, and Potter) identify important considerations relevant to such questions, but they do not reach definitive conclusions on specific questions of responsibility. Rather, they identify important dimensions of

the scientific, personal, cultural, and clinical background for addressing such questions.

With respect to the responsibilities of other individuals or institutions, there are at least three important areas to consider. First, in the context of health care, providers who are bound by standards of professional ethics have duties to secure informed consent before providing care or pursuing a research protocol, and this requires that they make determinations of whether an individual is capable of giving such consent. When clinicians fail in giving due diligence with respect to such determinations (either by ignoring a legitimate refusal or accepting an illegitimate consent), they fall short of their ethical obligations. In addition health care providers and institutions that are bound by standards of “evidence-based practice” and “best practice” have duties to identify and make available the best available therapies or rehabilitation interventions for those suffering from health problems; when such interventions exist but are ignored because of cognitive or interest-based biases, such providers and institutions again fall short of their ethical obligations. Social, professional, and institutional biases and stigmata associated with addiction and those who are addicted may lead to unethical conduct and inferior health care services that are not appropriately responsive to the health care needs of addicts and may ultimately promote addiction and its harmful consequences.

Second, with respect to the administration of the law and the meting out of punishment for criminal activity, the core question of whether addiction bears upon determinations of individual legal responsibility is addressed against a backdrop of law and social policy that may be relevant to the substantial prevalence of addiction and addiction-related criminal activity. As Morse argues in his chapter, the legal system is bound to administer the law as it is written, although he allows that current laws may be defective and that responsibilities might exist to replace such laws with better ones. Further, in the administration of the law, judges might show compassion during sentencing for those suffering from addiction, even as those individuals have been found guilty of criminal conduct. Whether such compassion rises to the level of a judicial responsibility is not clear, although such compassion might be the mark of a superior form of justice. Thus, a context constituted by legal or health care policies and practices that are harmfully flawed or biased raises the question of who is responsible for improving those policies and practices.

Finally, although not specifically addressed in this volume, a further feature of the cultural context in which questions of addiction and responsibility arise concerns business practices that may promote addictions of various sorts. Visible examples concern the practices of casino owners and the developers of casino gaming technologies, the manufacturers of tobacco products, and the manufacturers of legal drugs advertised for use in health care contexts. To the extent that such practices are designed to manipulate users of the related products in a way that leads to addiction in many cases, the question arises concerning whether such business entities or the individuals within them have obligations to reform such practices (e.g., by warning consumers or by ceasing in a deceptive and manipulative practice). Here again, the question of responsibility concerns those who are part of the context in which addiction occurs rather than the persons who suffer addictions.

Overview of the Chapters

We would now like to turn to each of the chapters in this volume. We will not highlight connections among the chapters; to some extent, we have already done that. Nor will we try to smooth over differences of perspectives that may exist among the chapters. As noted, differences among perspectives animate the heart of the contemporary literature on addiction and responsibility.

In “Drug Addiction as Incentive Sensitization,” Kent Berridge and Terry Robinson lay out the main claims and implications of their “incentive sensitization” model of addiction. In so doing they outline evidence for the model as well as argue for its superiority relative to dual-process learning-theoretic approaches. They further identify various implications of the model for cognition, motivation, evaluation of behavioral outcomes, decision making, and behavior choice that are potentially relevant to determinations of responsibility. For example, they identify biases in attention, a distinction between wanting and liking, compulsive wanting/desire, irrational desire, unconscious desire, nonintentional desire, and impairments of executive control over behavior. Indeed, they take the core of addiction to be the combination of an impairment of executive control with incentive sensitization. Their research represents an example of integrative research that brings together behavioral, cognitive, and neuroscientific

findings in a coherent model that explains a substantial portion of the phenomena labeled “addiction.” And, it provides a significant factual backdrop for the assessment of responsibility in various contexts.

In “Free Will as Recursive Self-Prediction: Does a Deterministic Mechanism Reduce Responsibility?,” George Ainslie embeds a discussion of addiction and responsibility in the larger philosophical context of the classical problem of free will; he navigates toward a compatibilist approach in which ascriptions of freedom and responsibility do not require a rejection of strictly deterministic mechanisms as the causes of behavior. He further rejects cultural assumptions of the self as a unitary governor and the will as the self’s organ of selection. Rather, Ainslie develops a view of free will as involving unpredictability, initiative, and responsibility, a view of the self as a population of partially conflicting interests, and a view of the will as a property that emerges from these conflicts. Ainslie builds on research establishing the existence of a hyperbolic discounting function with respect to preferences in humans and the effectiveness of various strategies (e.g., early commitment, bundling of choices, recursive self-prediction) for managing the distortions this function introduces into human decision making (e.g., impulsiveness and preference reversals over time). He proposes a “marketplace model” of decision making in which the process of choice is analogous to an economic marketplace trading in a limited resource (viz., access to a limited channel of behavior) and in which self-control is an emergent property not requiring a central organ of the will.

In laying out the model, Ainslie identifies “recursive self-prediction” as a vital process by which current commitments and choices impact future commitments and choices; this process involves the building of cognitive resources that enable individuals to exercise self-control (e.g., keep to current commitments in the face of temptations to defect). In addition, these resources become diminished in the context of numerous defections (e.g., from a commitment to abstinence); this is a form of psychological damage that he refers to as “motivational bankruptcy.” Although he rejects the idea that diseases (or other abnormal causes) ipso facto provide an excuse, Ainslie allows that some addicts might be excused from responsibility when they reach this bankrupt condition. However, the setting of criteria for when bankruptcy occurs is a culture-bound matter, and there may well be no practical way of determining whether such a condition exists in individual cases; hence, the model may have limited pragmatic value

with respect to determinations of responsibility and excuse. Within this framework Ainslie also provides an understanding of self-blame and social blame, and he notes that regeneration of the will can occur as addicts reframe their choices.

In "Addiction, Responsibility, and Ego Depletion," Neil Levy explicates and deploys the ego-depletion hypothesis of addiction, according to which a certain form of loss of control over mental life is a significant feature in addictions. After rejecting both the medical model and the moral model of addiction, he argues further that strength of craving and aversiveness of withdrawal are not sufficient for making either proximal or distal addictive behavior compulsive and hence not reactive to reasons. Rather, he suggests that addictive behavior is similar to much of "normal" behavior and that both can be produced by mechanisms that render it not responsible. According to the ego-depletion hypothesis, addiction involves periodic failures of self-control due to vacillations in the individual's self-control reserves: when such reserves are strong, a preference for abstinence may result; whereas when they are weakened, the individual may experience a judgment shift and proceed to engage in drug-seeking or drug-consuming behavior. As a consequence, Levy contends that standard accounts of moral responsibility must be amended to add ego depletion (failure of control over one's mental life) to failures of reasons responsiveness and reactivity as conditions that undermine responsibility. He concludes that, although addicts are moderately reasons responsive, they cannot be expected to exercise greater self-control over their mental life than they do, and hence they are not to blame for their failures.

In "Lowering the Bar for Addicts," Gideon Yaffe argues that addicts should be excused from certain things but not others, and he bases his argument on the claim that addicts should be excused, when they are, not because they are disabled but because they should not be expected to comply with a norm when it demands too high a cost. Specifically, he argues that, when the burdens of compensation for a deficit are too high, the person cannot be expected to carry them in order to comply with some relevant norm of conduct. In the case of addiction the deficit is a learning deficit that makes addicted individuals relatively ineffective in learning from their own mistakes about the values of actions and outcomes in a way that guides their behavior, and the burden of compensation is to have their behavior guided by a mechanism that does not involve the

individual's appreciating the reasons for the behavior (i.e., the burden is an abdication of individual autonomy). The hypothesized deficit (for which there is substantial evidence) is one that not only is associated with active use of a substance but also is present even when the addict is not using a substance. The bottom line is that addicts are responsible for whichever of their behavior is such that they could have avoided doing it without giving up their autonomy.

In "Decision-Making Capacity and Responsibility in Addiction," Louis Charland addresses the question of whether severely heroin-dependent individuals are responsible for their decision to consent to therapy or research protocols involving their drug of choice. By challenging the presumption of capacity when consent is provided and focusing on impairments of decision-making capacity found in many heroin-addicted individuals, he argues that such individuals are not fully responsible for their decisions to consent in these circumstances. The argument is premised on the hypothesis that pathological processes of valuation at the core of addiction-related cognition lead to a failure to appreciate the significance of various options and to a vacillation in the evaluation of options over time. Such vacillation and lack of appreciation diminish an individual's capacity to provide informed consent to participate in treatment and research protocols involving his drug of choice.

In "Addiction and Criminal Responsibility," Stephen Morse argues that addicts are, for the most part, responsible for becoming addicted and for their further drug-related activity. Specifically, those who are addicted are, most of the time, legally responsible for their drug-related criminal activity (e.g., behavior related to drug seeking and drug consumption). This is so, according to Morse, because most of the time addicts have sufficient capacity for action that is neither irrational nor compelled nor grounded in a hard choice (i.e., none of the relevant and recognized legal excuses are present). In the course of his discussion, he clears away a variety of false claims about addiction and responsibility and argues that metaphysical determinism is irrelevant to legal responsibility, that status as an addict or as mentally disordered is not an excuse, and that those who argue that addictive behavior is excused because it is caused by genetic, neurophysiological, social, or other nonintentional causal variables are guilty of what he calls "the fundamental psycholegal error." Addiction, disease, or any other causal variables are relevant to questions of responsibility only to

the extent that they cause a genuine excusing condition such as lack of rational capacity or compulsion. Nonetheless, despite contending that addicts are responsible agents most of the time, Morse suggests that contemporary law and public policy concerning addiction fail to measure up to the standards of a just society; vastly more treatment options for addicts should be available to help reduce their risk for criminal behavior; and doctrines of mitigation should be expanded to cover cases where addicts commit crimes that are not part of criminal use itself.

In "Grounding for Understanding Self-Injury as Addiction or (Bad) Habit," Nancy Potter explores the question of whether self-injurious behavior (SIB) is best understood as a form of addictive behavior and argues that it is not. More deeply, she also examines why this is an important question, raising issues about the nature of addiction as well as about habitual self-injury. Potter frames her discussion around the notion of a narrative (i.e., stories that are told about ourselves and each other to make sense of some event, state, activity, or condition and to guide responses to such events), and she notes that different narratives can be constructed from different perspectives and designed for various purposes. Conventional and culturally prevalent narratives (e.g., a medical disease model, a moral model) may capture some features of a condition, but they tend to lose a grip on the particularity of a person's identity and life context; and such conventional narratives may serve interests not aligned well with those of the individual. Other narratives generated by individual addicts may be toxic because of heavy emphasis on guilt, blame, and helplessness or because of the influence of prevalent cultural narrative themes. The question of which narrative is best for given purposes depends on pragmatic considerations that are sensitive to perspective and context, and, given the limitations of any perspective, multiple narratives may be necessary for an understanding of SIB and other patterns of addictive behavior. Potter advocates the importance of opening up space for alternative, patient-generated, and patient-friendly narratives tied to particular persons and their (frequently invisible to others) perspectives.

In "Contingency Management Treatments of Drug and Alcohol Use Disorders," Nancy Petry, Sheila Alessi, and Carla Rash emphasize the importance of theoretical models of addiction for designing effective strategies and techniques for clinical intervention. After calling into question both disease and moral models, they suggest that behavioral models,

focusing on the role of environmental contingencies in establishing and maintaining addictive patterns of behavior, provide the basis for a useful clinical approach. Although such approaches have demonstrated efficacy, they are nevertheless not often employed in clinical settings as a result of practical barriers and philosophical biases and disputes. This discrepancy obviously raises questions about the responsibility of clinicians to provide evidence-based therapies as part of best practice. After outlining considerable clinical evidence establishing the clinical superiority of voucher-based and prize-based contingency management approaches over standard approaches, and the cost effectiveness of prize-based approaches, Petry et al. strongly suggest that obstacles and biases should be overcome and that such approaches ought to be in more widespread use.

In "Addiction, Paradox, and the Good That I Would," Richard Garrett is concerned with the question of what is necessary or at least helpful for overcoming addiction, and he addresses his own addiction to food and his personal struggle to overcome it. Conceiving of this struggle as a fundamentally moral and spiritual matter concerning what kind of life to live and what kind of person to be, Garrett approaches it as a process of cognitive-affective-behavioral restructuring, a process that is grounded in fundamental ethical principles (e.g., the Golden Principle, Buddha's Eightfold Path). Such restructuring consists, in part, in embracing certain attitudes and commitments to oneself and to others (e.g., the recognition of the dignity and worth of all persons, including oneself; an attitude of self-love and love of others; and a commitment to the welfare and well-being of oneself and all other persons). Further, the core strategy for overcoming addiction consists in identifying and engaging in behavior that is under the control of reason ("what one can do") for the purpose of bringing under such control behavior that is (currently) beyond the control of reason ("what one would do"). In laying out this framework, Garrett demonstrates the importance of the first-person perspective and associated narratives for understanding addiction, and he shows that a moral model need not consist of toxic and naive moralizing or of associated (and highly prevalent) guilt and blame narratives. Rather, a sophisticated moral understanding grasps the struggle with addiction in the context of an individual's particular life project and identifies key issues that all persons face and key normative principles that constitute a way to live a life and face life's struggles.

In “What Is It Like to Be an Addict?,” Owen Flanagan provides a personal narrative of his struggles with addiction as a basis for exploring issues ranging from the integration of forms of understanding developed from a variety of phenomenological and scientific perspectives to issues related to the nature of recovery from addiction. His phenomenological read out of what it is like to be an addict sets the stage for discussions of the limits of knowledge characteristic of both phenomenological and scientific perspectives, the importance of the particularity of an individual addict’s experience and situation, and the distinction between talking of an addiction as an entity and talking of an addict as a person living a life in the world. Further, emphasizing the distinction between two kinds of epistemic “capture” (i.e., one concerning explanation of cause and constitution of addictive brains, psychology, and behavior; another concerning first-person experience uniquely accessible to the individual), he outlines an “expanded natural method” that recognizes the importance of multiple phenomenological and scientific perspectives, gives priority to none, emphasizes a process of mutual coordination and constraint, and provides a context for moving among different levels and perspectives as required in particular contexts.

With respect to recovery, as comprehended via the phenomenology of agency, control, and responsibility, Flanagan allows that there are multiple narratives available to addicts that may be more or less useful to individuals at different stages of their addiction. In his own case, recovery was based on a view of addiction as a deep moral problem of who, what, and how he wanted to be in his life and on a process of establishing and leveraging zones of control that promoted a goal of reintegration and that was grounded in social support.

Concluding Comments

Besides drinking a fifth glass of scotch even knowing the damage it may do to him, our second restaurant patron may regret drinking the scotch, lamenting his weakness in consuming it. *That* is not the way he wants to behave. That is not the way he *should* have behaved.

The interplay between forward-looking and backward-looking beliefs, desires, and feelings in addiction is a complex process. Surely, though, the development of more consistent and prudent beliefs, desires, and feelings

may require (and certainly may encourage) the associated development of understanding the sources of addicted behavior and the modes, manners, and dimensions of responsibility for behavior. There is no point in regretting drinking the libation in the restaurant if one cannot refrain the next time one tries. A person has to identify the signs, learn the *why*, *when*, and *how* if change is to be produced in his very being. And that is precisely the sort of result we hope this collection encourages. In terms of associated phenomena, what else, other than addiction itself, is necessary for understanding the conundrum of addiction but the very multimodal responsibility for addiction—for when and why it occurs and for how it may be overcome or avoided.