

Addiction and Agency

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Introduction

It is often thought that there are certain sorts of causal factors that should mitigate attributions of blame or praise. For example, there may be psychological causes that lead one to act that would render typical punishments or rewards unfair, and require a different sort of moral response. A paradigmatic case is that of addiction, insofar as addicts are often seen as lacking full freedom resulting from their compulsive prioritization of using over all else. Often in the philosophical literature, as well as in popular media, the character of the addict is portrayed as compelled or “seduced” by their addiction, even as they are, in some sense, *deciding* when they act on it (Cummins 2014; Grim 2007, 191). For example, Gorski and Miller begin their text:

Addiction is distinguished from [mere heavy] drug use by the lack of freedom of choice. Using a mood-altering substance is a choice. Addiction is a condition that robs a person of choice and distates the frequency, the quantity, and the nature of use (1986, 39).¹

The paradigm of addiction is therefore useful for philosophers interested in thinking about free will and moral responsibility, but worried about the possible scope of mitigating causal histories (Berofsky 2005, Kane 2020, Levy 2011, Shatz 1988, Yaffe 2011). The compulsive prioritization of using, e.g., drugs over other goals is taken to indicate a difference in

¹ See Nadelhoffer 2010 and Pickard 2017 for perspectives on this narrative that are consonant with the argument to follow.

kind between the addict and the rest of us, and gives grounds for delineating exceptional cases from typical ones when it comes to assigning desert.

Helping ourselves to paradigmatic cases like addiction can give the illusion of progress in debates over moral responsibility. Facing a challenge over the mitigating potential of causal histories, for example, the believer in moral responsibility might claim that an individual is culpable when their action is intentional, counterfactually dependent on their intention, and not motivated by whatever kind of causes lead addicts to act as they do. Such an argument makes use of what we can call the *method of paradigms*, where a case about which intuitions are supposedly clear is used to guide reasoning about other cases. This method is prominent in the literature on moral responsibility for obvious reasons: it bypasses the problem of specifying what sort of causal history should be taken as exculpatory by ostension, through specifying a condition that is generally thought capable of mitigating moral responsibility and generalizing from there.

Let's consider three examples of addictive behavior. On the "folk philosophical view" each of these behaviors would count as morally mitigated (even if not exculpated).

Example 1: The cocaine addict who steals someone's TV to buy more cocaine.

Example 2: The gambling addict who gambles away his children's college fund.

Example 3: The sex addict who commits adultery.

Now consider analogs to (1) – (3). On the folk philosophical account, these would *not* count as morally mitigated.

*Example 1**: The non-cocaine-addict who steals someone's TV because he wants to indulge his habit of watching TV over dinner, but his own TV set is broken.

*Example 2**: The first-time gambler who gambles away his children's college fund because of careless probability judgments during a business trip to Las Vegas.

*Example 3**: The non-sex-addict who commits adultery to fulfill his self-image as a pickup artist.

How can we distinguish between (1) – (3) and (1)* -- (3)* with respect to moral responsibility?

The method of paradigms presumes that there is no way to fill in the details so that (1) and (1)*, (2) and (2)*, or (3) and (3)* both satisfy, or fail to satisfy, the conditions for responsible action.

But our question is this: on what grounds can we conclude that the circumstances of (1) – (3) are mitigating, while those of (1)* -- (3)* are not, *independent of the assumption that the non-addicts in (1)* -- (3)* differ from the addicts in (1)--(3) by being responsible?* Without an informative account of when a person's causal history is sufficiently like that of an addict, the method of paradigms seems to provide only question-begging grounds for making such determinations.

By appealing to a biomedical concept, it might seem one can avoid the question of what makes an addict's actions different – on the assumption that, since clinicians and researchers seem to know what addiction is, it must represent a distinct class, with underlying properties that can explain the unique ways in which addicts act. We will argue that, on the contrary, our best scientific theories of addiction suggest that its essential features can be found in other processes that are *not* intuitively mitigating. We discuss four prominent models of addiction, and show that all of them explain addiction in terms of psychological processes that in other contexts are *not* supposed to diminish one's responsibility. The upshot is that if addiction mitigates on

account of these features, then so too do other conditions that seem irrelevant for questions of responsibility.

While our arguments do not pose a problem for clinicians or researchers (or philosophers) aiming to understand addiction, they do pose a problem for moral philosophers using the addict as a paradigmatic case. If similar problems plague appeals to other characters familiar from the responsibility literature, like “obsessive compulsives,” “sociopaths,” and Tourette Syndrome patients – as we expect they do – then our conclusions are of general significance.² Actions resulting from conditioned learning, faulty reasoning, unfortunate, undesirable, or unusual identities, or various personal histories, may all be like actions resulting from addiction. We conclude that, by so expanding the boundaries of moral responsibility, the method of paradigms tends to support a more general skepticism about moral responsibility.

What is an Addict?

We should start by noting that there is hardly an agreed-upon folk definition of addiction, much less a clinical one. The heroin user, the alcohol abuser, the sex addict, and so forth are generally taken to *choose* to use, drink, or cheat, but in a way that is in an important sense different from that of other intentional beings. Terms like “compulsive,” “irresistible need,” “persistent dependence,” and “loss of control” are employed to capture this difference; but there is little consensus among laypeople or experts about what they mean. After an extensive review of working definitions of addiction, a report commissioned by the European Monitoring Centre for Drugs and Drug Addiction concluded that “accumulated evidence indicates that impaired control, conflict, craving and so on are not necessary features of addiction even though they are

² We use these designations in quotation marks to indicate not only our suspicion that these labels do not refer to natural kinds but also to indicate our discomfort with arguments that make instrumental use of such caricatures.

frequently observed and have to be accounted for in any comprehensive theory” (West, 2013). Addicts can resist using for days or weeks on end when sufficiently motivated (Hart et al. 2000) and, as the report explains, common symptoms like craving, withdrawal, and increased tolerance are not universal features. Accordingly, its author, Robert West, defines addiction as “a repeated powerful motivation to engage in a purposeful behaviour that has no survival value, acquired as a result of engaging in that behaviour, with significant potential for unintended harm” (27).

While West resists specifying putative mechanisms that might more narrowly define “powerful motivation,” or even committing to the existence of such mechanisms, he acknowledges that addiction is widely viewed as a categorically distinct pathological state, even by constituencies who agree on little else. For example, advocates of the biomedical model have increasingly spoken of addiction as a “brain disease” (Leshner 1997, Volkow et al. 2016) since the *Diagnostic and Statistical Manual of Mental Disorders* first recognized it as a primary mental health disorder rather than just a symptom of underlying psychopathology (Robinson and Adinoff 2016). And while avoiding the biomedical model, addicts who adopt the tenets of Alcoholics Anonymous also defend the view that addiction is a disease, contrasting it with everyday cases of weakness of will and sinfulness.

The stakes of this question are high, as proclaimed in the title of Leshner’s “Addiction is a Brain Disease, and It Matters.” Here Leshner argues, “The gulf in implications between the ‘bad person’ view and the ‘chronic illness sufferer’ view is tremendous” (45). Like many advocates of the biomedical approach, he believes that seeing addiction as a disease of the brain will reduce social stigma and transform the way the addicts are treated by the public health and criminal justice systems. He suggests that recognizing that “an addict’s brain is different from a nonaddict’s brain” (46) could allow us to distinguish those with a disease from “weak or bad

people, unwilling to lead moral lives and to control their behavior or gratification” (45).

Additionally, “Elucidation of the biology underlying the metaphorical switch is key to the development of more effective treatments, particularly antiaddiction medications” (46).

However, the demarcation criteria for what counts as a disease — that is, what would flip Leschner’s “switch” — are, as philosophers of medicine have long pointed out, disturbingly unclear (Bingham and Banner 2014, Stein et al. 2010). Indeed, the lack of a widely accepted conceptual analysis of the category of disease means that there is no easy answer as to whether addiction is or is not a disease, nor accordingly whether any individual who uses a substance has a disease or not. *Pace* Leschner, the problem is not solved by the fact that subjectively identified signs and symptoms have been discovered to have neurological correlates in the reward system, affective systems, or executive control system of the brain (which they have; for an overview see Volkow and Boyle, 2018). Variation is not pathology; understanding the mechanics of blood pressure is distinct from inventing a criterion for hypertension, as the latter results from taking a stand on what counts as too high a reading. Likewise, the discovery of recognizable mechanisms underlying impaired motivation does not answer the question of when motivation should be considered impaired. This problem will endure until a consensus forms around how *much* users need differ from non-addicts (who also, from time to time, display suboptimal functioning with respect to motivation, inhibition regulation, and compulsivity) before they are called an addict.

However, for our purposes, what matters is not whether addiction is a disease per se, but whether it is a mitigating condition. Not all diseases — even all mental diseases — are mitigating. And some mental states are mitigating without being diseases. In the courtroom, for example, a diagnosis is less relevant for assessing culpability and for sentencing than the displaying of certain features, such as a floridly psychotic state at the time of the crime or

cognitive deficit like dementia or low IQ. From this perspective, addicts are exculpated not *for being addicts*, but rather for meeting some other measure. In that case, what would matter is whether non-addicts periodically meet that measure, too, rather than the extent to which they resemble addicts in other ways. Even if there were universal agreement about who counts as an addict, then, it would not solve our worries about the method of paradigms, without an accompanying theory of who is *like* an addict in the sense relevant for assessing desert.

Theories of Addiction

What are the most prominent scientific theories of addiction? In this section we will examine four, each of which would be a natural place for the philosopher to turn when looking to identify the mechanism whose presence can justify judging addicts differently. Ideally, one or more of these accounts would provide an explanation for addiction that could work in tandem with our best accounts of responsibility to explain the common intuition that addicts are less responsible for their actions than non-addicts. That explanation could guide other judgments about mitigation, ideally validating intuitions about what sort of histories matter for desert. If one or more account of addiction could do this work, we would be able to save the method of paradigms from an unpleasant dilemma: on the one hand, falling into a vicious circularity (anyone who is importantly like an addict has mitigated responsibility, and to be importantly like an addict is to have mitigated responsibility in the way as an addict does) or on the other, accidentally excusing more of the actions of non-addicts than many would be comfortable with.

First worth considering are those accounts of addiction that employ the terms of operant learning theory. For example, one influential model, the incentive-sensitization theory, posits that addicted behavior is caused by an increased sensitivity in the brain to the reward-value of

certain substances or behaviors, such that the brain learns to “want” drugs even if they are not (or are no longer) “liked.” Even if the opiate user no longer feels euphoria when taking a hit, they may still feel an intense craving when they see drug paraphernalia that will lead them to desire to use. Evidence for this account is drawn from animal models showing how reward cues are mediated by dopamine-related systems in the addicted brain: “addicted” animals are those who “have stronger cue-triggered urges and intensely ‘want’ to take drugs [...] addiction becomes compulsive when mesolimbic systems become sensitized and hyperactive to the incentive motivational properties of drug cues” (Berridge and Robinson 2016, 673). Berridge and Robinson concede that their theory does not demarcate the addict from the non-addict, but maintain that “incentive sensitization can make the temptations faced by addicts harder to resist than those most other people are called upon to face (675).” This justifies, in their view, calling addiction a “brain disease” (675).

A second approach to explaining why addicts struggle with motivation to abstain focuses on reflective choice. One example of such is the hyperbolic discounting model advocated by George Ainslie. In Ainslie’s picture, behavior that seems compulsive is not due to a weakness of the will or a failure of the individual to make a certain choice, but to the outcome of what Ainslie refers to as an intrapersonal “marketplace of reward,” in which different interests compete across timescales, producing effects like hyperbolic discounting, in which far-off goals lose their motivational power in favor of immediate gains. With respect to demarcating addiction, Ainslie is comfortable with the notion that his account might be revisionist: “If addiction is defined with a low threshold, half the people in America are addicted to something [...] Those of us who have avoided the named addictive diagnoses are nevertheless apt to suffer from habitual overvaluation of the present moment, as in chronic procrastination, overuse of credit, or

unrealistic future time commitment” (Ainslie 2018, 37). The question to answer about those we consider addicts is not what makes them struggle with cognitive effects like hyperbolic discounting, but what makes these problems so extreme for them, and what stops them from using the usual methods that non-addicts use to conform to social expectations around choosing. In other words, if addiction is a disease at all, it is “a disease of motivation, that is, one that does not bypass the mechanism of choice” (42).

A third theory sees addiction as due to the malformation of the identity of the addict, either due to social pressures and cues from the environment, individual traumas, or positive influences on identity, like group membership (Walters 1996). Wasmuth et al. have conceived of addiction as an occupation, that is, a self-organizing human activity that provides “meaning, temporal structure, roles, habits, routines, and volition to individuals” (Wasmuth et al. 2014, 605). Understanding addictions in this way allows the authors to explain the failures of abstinence to constitute recovery, in so far as it may “be profoundly distressing because of [...] not having or being able to participate in occupations that were once central to daily living” (607). Alcoholics Anonymous, Narcotics Anonymous, Sex Addicts Anonymous, and so forth address this by allowing for the renegotiation of an addict’s identity, first as an addict and then as an addict in recovery (Best et al. 2016). Philosophers have also discussed the importance of recognizing that the identity of being an addict can exert a substantial pull, and can be a response to environments in which other sources of identity are hard to acquire or maintain (Tekin et al. 2017). According to these sorts of theories, changing how people who struggle with addiction imagine their own self-efficacy and agency can be transformative (West 2013, 59).

Finally, there are models of addiction that attribute it not to factors within the individual, but factors within the environment. A provocative study of this sort was Alexander et al.’s

so-called “Rat Park” experiment, which supported the hypothesis that addiction is more common in rats subjected to social deprivation and stimulus-poor environments (Alexander et al. 1978). In contrast, rats who lived in a stimulus-rich environment, where they were allowed to maintain their natural family structures, mutually groom, and play together, showed less interest in consuming addictive substances. In light of these experiments, Alexander and Hadaway argued that opiate addiction was better explained as a rational response to distress and deprivation than as a conditioned shift brought on by drug exposure (1982). More recently, Carl Hart has argued that the science behind claims that addiction is a brain disease is shoddy and misleading, and that addiction is better understood as the result of the psychiatric disorders often comorbid with it, and of socioeconomic factors like poverty, systemic racism, and unemployment (Hart 2017). According to Hart, there is nothing unique about the addicted brain that isn’t also true of brains that undergo other sorts of stress and trauma brought about by similar circumstances.

The Problem with Paradigms

Although the theories of addiction surveyed in the previous section are not exhaustive, they give a good indication of the kinds of accounts today’s best science suggests. What is striking is that none seems able to solve the problem of explaining why addiction would be mitigating in a way that other causal histories would not. Instead, theories of addiction tend to provide a scale of function on which addicts are taken to cluster at the low end. None of these scales of function correspond in any straightforward way with our intuitions about moral responsibility. So, without a clear indication of where on the scale one becomes “like an addict,” they provide at best an imprecise guide. If one gives up on that sort of specificity and rules that anyone who acts in a way that is abnormal with respect to one of these functions is suitably like

an addict, one would end up exculpating a whole host of everyday figures like the hot-head, the hedonist, the egoist and the victim of circumstance — that is, all of us, in our less proud moments. In this section we consider why this is the case.

Philosophical theories of freedom and responsibility vary widely, but most locate agency at least partly in psychological processes that allow one to respond to reasons that express one's "deep self" or true values. Young children and squirrels, for instance, are not morally responsible for stealing a sandwich because they are simply incapable of controlling or guiding their actions in light of reasons related to property rights. Similarly, typically adults are less blameworthy for an insensitive remark if it was out of character, is something that they wholly disavow, or otherwise fails to "mesh" with their higher-order convictions. The trouble is that, regardless of which particular philosophical approach one takes toward freedom and responsibility, none yield a categorical difference between addictive and non-addictive choice, in tandem with the science.

Let us begin with the idea that, e.g., alcohol abuse is mitigating because "alcoholism is a brain disease." What plausible theory of responsibility could deliver this verdict? By calling something a brain disease we mean that there are known neurobiological correlates for a recognized category of disorder. The existence of such neural correlates in addiction need not impact the afflicted's desires such that they fail to mesh with their higher-order convictions, in the sense of Frankfurt (2003 [1971]). Frankfurt and followers argue that people are not responsible for their actions if the desires that led to those actions are in conflict with more deep-seated features of their psychology. Nor do neural correlates preclude the alcoholic's "valuing" his addiction in the sense of Watson (1987). Watson suggests that an action is unfree when the agent's pursuits are not in alignment with what they value due to internal dysfunction; we are all familiar with figures like Keith Richards or William Burroughs who thoroughly valued

their addiction, though most people sympathetic to the biomedical view of addiction would say they had a disease. Did their using at least undercut their capacity for “guidance control” in the sense of Fischer and Ravizza? They argue that it is not the capacity to do otherwise per se, but the capacity to do otherwise in response to reasons that matters for moral responsibility (2000). Again, it does not seem so. One can have a brain disease while all of the requisite rational capacities remain intact (as with, say, chronic migraines). Nor need a brain disease disrupt the “sane deep self” in the sense of Wolf (2012); the simple fact of cognitive pathology does little to support the normative conclusion that the subject’s deep self is not functioning *well*. For example, many disorders described in the DSM do not bring about the ipseity disturbance typical of psychosis; think of the general anxiety disorder clinicians often use to diagnose the “worried well.” Evidently, whether having a brain disease mitigates moral responsibility depends on whether the brain disease engenders compulsion, and so the biomedical definition of brain disease is, by itself, insufficient to explain why addicts are less responsible than non-addicts.

It might be thought that learning models like the incentive-sensitization model hold more promise insofar as they suggest that, for some of us, substances or activities become “wanted” in a way that is out of proportion with how much we “like” them. In order to think about them in terms of a mesh theory like Frankfurt’s, one might reframe this model in terms of the substances or activities being desired to a degree that fails to align with reflective preferences. The problem is that the constant, unreflective revaluing of stimuli in our environment on the basis of dopaminergic rewards, made possible by the extreme plasticity of neurodevelopment, means that “wanting” fluctuates with respect to *everything* we perceive to be of interest to us -- not just drugs and addictive behaviors. As Lewis writes, “When the brains of addicts (following years of drug taking) are compared to those of drug-naive controls, these scientists can be heard to say

‘Look! Their brains have changed!’ Yet if neuroplasticity is the rule, not the exception, then they’re actually not saying much at all. The brain is supposed to change with new experiences” (2017, 10).

“Wanting” more than we “like” is, as Lewis notes, a common experience outside of addiction. Think of the college student who binges on Netflix instead of studying, the Shakespearean heroine who follows her beloved despite being scorned and abused, or the athlete who is so set on competing that she pushes her body beyond the limits of what she enjoys. The fact that our folk category of addiction is often stretched to accommodate cases like these (think of Robert Palmer’s “Addicted to Love”) means that the question of what sort of conflicts between “wanting” and “liking” counts as *addictive* is really just a question of ethics. On the biological level, the change in activation from the ventral to the dorsal striatum associated with compulsion has been demonstrated to occur in many other circumstances, including falling in love (Lewis 2017). So while a mesh theory of moral responsibility might supply terms for taking the addict’s actions as a paradigmatic case of mitigated blame in our moral reasoning, the result will be that many of our everyday choices will no longer seem to accord with our higher-order desires either, and our responsibility for them will be mitigated too (Pickard 2017, 2015).

It might be thought that rational choice accounts of addiction, in conjunction with some version of the guidance control theory, constitute a more promising approach. Moral agents act on the basis of reasons -- that is, as a result of psychological mechanisms that are reason-responsive and which play a causal role in their choices to act -- even if they could not have acted otherwise. So, attributing to addiction a pathological method of choosing might seem to qualify the addict for exemption from moral responsibility, according to this theory. But as noted above, the leading accounts of addiction that theorize it as a pathology of choice do *not* say

addicts choose in a way different in kind from the rest of us. They are simply at an extreme of functioning with respect to certain kinds of universal decision-making. Hyperbolic discounting, paradigmatic of addicts according to Ainslie, is ubiquitous in children, and undeniably frequent in adulthood too. It can also vary within the same individual over time: just like other sorts of moral reasoning can be swayed by circumstances (Ditto et al. 2009), hyperbolic discounting can be improved when people are assisted in contemplating their future selves in a concerted way before choosing (Hershfield et al. 2011). If one wishes to say that addicts are exculpated from moral responsibility because they aren't responding in the right way to reasons and thus are not exerting the right kind of guidance control, appearances suggest that one would need to say the same of all of us in those cases where, for example, we skip the gym despite our best intentions.

We have still not considered identity-based explanations of addiction, which are congruent with valuing theories of responsibility. These take moral responsibility to turn on an action's compatibility with the agent's "deep self". Wasmuth et al.'s success at replacing one occupation (addiction) with another (theater) — as well as the impressive efficacy of AA's encouragement of a transformative social role — suggest that addiction affects addicts like other occupations, shaping "not only their surroundings but also their personal identities, values, and personal roles" (607). To this extent, then, it would be question-begging to declare that addiction is mitigating, rather than the result of individuals acting in accordance with their deeply-held values. One would need to show that, contrary to substantial evidence, addiction is not an identity, or not the right kind of identity to engender personal values.

This worry is in the spirit of Wolf's criticisms of valuing theories (2012). She argues that they fail to attend to the source of our values. If the true self originates in trauma or other corrosive factors, the individual may be incapable of forming the right values, and thus not

responsible for their true self. The problem is that the causal history of the addict need not be uniquely traumatic, nor uniquely anything. Many people with unfathomably difficult personal histories do not become addicts, and many lacking that sort of precipitating cause do. So, while one might want to say that identities *like* addiction are mitigating, this just returns us to the question of what it means to resemble an addict in the way that matters. It is hard to see how we could, in a principled way, delineate between people who resemble addicts but whose behavior fails to count as mitigated -- like that of the hypercompetitive stock-trader or the besotted lover -- from those people that are excused on the grounds that they just *can't* make the right choice.

Taking Stock

Is there another pair of theories -- of addiction on the one hand and responsibility on the other -- that might justify our intuitions about the mitigating power of addiction? Not that we are aware of. We suggest that, with the paradigm of the addict, the method of paradigms does not elucidate much. Science cannot save the day by opening the black box of addiction and explaining why it would be peculiarly mitigating, compared to the circumstances in which non-addicts regularly find themselves. All the science can do is tell us whether addicts are categorically different from non-addicts, and it seems to have told us that they are not.

If addiction is conceived of as mitigating because, e.g., it is the result of socioeconomic hardship, it is hard to see how we could avoid the conclusion that all manner of antisocial actions should be excused when they too result from difficult personal history. When Hart describes, in his memoir *High Price*, the conditions which make the dealing and consuming of drugs a rational choice, he describes the intentional disempowering and oppression of minority communities. Insofar as addiction is a proximate cause of, say, a criminal action and conditions like these are

the ultimate cause, it is arbitrary to regard addiction as what is mitigating, rather than the conditions themselves. Indeed, a reasonable next step is to ask why we don't view an environment of deprivation and injustice as itself a mitigating circumstance, whether or not addiction plays a mediating role. The accounts of addiction we considered above suggest other widespread features of being human that, if similarly accepted as mitigating, would liberalize our notions about desert.

Of course, it remains possible that there are other paradigms, such as "obsessive-compulsives," "sociopaths," or Tourette Disease patients from which we might abstract instead, which would more narrowly demarcate the kind of causal histories that should be seen diminishing blameworthiness. Maybe the problem is with addiction, not with the method of paradigms. But we submit that any such paradigm drawn from psychopathology is likely to engender analogous problems. For example, obsessive-compulsives can also have desires that mesh, can value their behaviors, can be reason-responsive by any ordinary standard, and may exhibit guidance control (see Summers & Sinnott-Armstrong, this volume). So, it does not help much to say that someone is less responsible for their behavior to the extent that it is like the obsessive-compulsive's. *What is it* about the obsessive-compulsive's behavior that could be mitigating? Absent an answer to this question, such slogans are without clear content.

Within psychiatry, concerns have been expressed about the reification of psychiatric diagnoses, which can increase stigma and provide obstacles to the biomedical exploration of the full range of psychopathology (Hyman 2010, Tabb 2017). Another casualty may be philosophy, where the use of diagnostic kinds as paradigmatic cases risks obscuring the complexity of outstanding problems in moral philosophy. But it may be that the paradigm of the addict can help clarify our intuitions in a different way, by bringing into view a radical dilemma. If non-addicts

display the key features of addiction to some degree or other, and if the line can only be drawn arbitrarily and subjectively between the normal and the pathological, it would seem that we either need to stop excusing addicts, or start excusing others. We suggest that a step toward progress would be to consider what feels fair about mitigating our judgments of blameworthiness when it comes to addicts, and to examine the barriers that stop us from extending the same dispensation to others who display intemperance from time to time – that is, to everybody.

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