Responsibility for addiction: risk, value, and reasonable foreseeability

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Although drug addiction encompasses a vast domain of cases with amply variable characteristics, harm is among the common features that seem to bring some unity to the category[1]. Among people who have been diagnosed with a substance use disorder, some see their lives disrupted by the disorder in relatively local ways, and many, at least for some time, fit the portrait of a "functioning addict." For others, addiction is more like a hurricane that rips through their lives leaving nothing intact behind. The substance or substances to which the person is addicted usually makes a difference. Nicotine addiction can lead to serious health problems and possibly death, but it typically has a modest impact on most other spheres of a person's life. Other drugs are more expensive, more difficult to obtain (especially if they are illegal), and their immediate effects more difficult to reconcile with other pursuits, all of which contribute to the overall extent to which addiction disrupts the person's life. All these differences notwithstanding, it is difficult to imagine addiction without harm. Many would go further and argue that harm is definitional of the condition, suggesting that whatever pattern of drug use a person may engage in, if it does not lead to harmful consequences, then it is not properly called addiction. (This is a sensible criterion if we think of addiction as a clinical construct: if there is no harm, then arguably there is no clinical concern and no need to consult a clinician). Whatever one's position on the theoretical question of definition, harm stands out as a salient feature of the condition for anyone familiar with cases of addiction. Some people find it so difficult to reduce or regulate their drug use that they end up suffering loss of

health, estranged family relationships, loss of livelihood or housing, and, in some cases, death. People in close relationships with those suffering from addiction usually end up being hurt in countless different ways as well.

In sum, addiction is bad, especially when it is severe—I will take that as a given. It is remarkable, however, how little sympathy people with addiction are typically met with, even when they are suffering greatly from their condition. The stigma surrounding addiction has many roots[2]. In some people's minds, addiction may be particularly associated with crime and immoral behavior. For others, the stigma may result from a picture of addiction as fundamentally robbing people of their autonomy and/or ability to control their behavior. Negative attitudes may also spring from the combination of two other common foci of stigmatizing attitudes: drug use per se, even when not in the context of addiction, and mental disorder. Whatever else may be true about the sociological and psychological roots of addiction stigma, at least part of it arguably stems from the insidious thought that the people suffering from addiction are responsible for getting themselves into this situation. People with addiction may experience harm, true, but it is something *they have brought upon themselves*.

The ethical outlook behind this attitude can be criticized on several grounds. One may think, for instance, that people who are suffering and experiencing great distress generally deserve sympathy and, if possible, a helping hand, regardless of how they got into that situation. Or one might think responsibility for health and illness lies fundamentally at the level of society rather than at the level of the individual. Here, I intend to motivate a different concern. The seemingly appealing idea that people are (typically) responsible for becoming addicted to drugs rests on an argument that is quite a bit more complicated than it is sometimes assumed to be. My aim in this chapter is to look closely at this argument. In particular, I will focus on one premise that plays a critical role in this context: the claim that people who use drugs *should have known* that doing so was likely to lead to addiction.

I'll say it up front: I don't have an answer to the question of whether people can, in general, be aptly held responsible for becoming addicted. Furthermore, I don't think that a fully general answer to this question can be sensibly argued for, be that for or against—excluding full-on moral skepticism or an equally general skepticism about indirect responsibility. I suspect, however, that many people are inclined to think that, except perhaps in a few rare cases, people with addiction can be aptly held responsible for having acquired the condition. I aim to draw attention to some challenges that anyone willing to argue for this view must face. These challenges may ultimately not be insurmountable. But once we consider in some detail what would have to be true for someone to be aptly held responsible for becoming addicted, the prospects for making a convincing case to that effect look, I argue, somewhat more uncertain than they might at first appear.

Kinds of responsibility: causal versus moral

One thing that distinguishes addiction from many other medical conditions is that intentional actions typically play a crucial role in the causal history of the condition. Things are arguably less clear when it comes to the maintenance of the condition once someone has it, for a variety of reasons, including, crucially, that addiction in some sense detracts from the voluntariness of choices to use drugs. I will not consider here, however, whether people with addiction can be aptly held responsible for *remaining* in that condition, but whether it can be appropriate to hold them responsible for *acquiring* it in the first place. One of the various ways in which the latter question differs from the former is that it seems much clearer that the actions in question—a series of decisions to use drugs that the person made before becoming addicted, and that put her at risk of becoming addicted—appear to fit the paradigm of actions for which someone can be aptly held responsible. Part of the causal chain leading to addiction appears to involve actions that a person does voluntarily and knowingly. In this respect, addiction looks different from, say, appendicitis or schizophrenia[3].

The fact that voluntary actions play a role in the relevant causal chain implies that the agent bears at least partial *causal* responsibility for becoming addicted. One can assume that, except in rare cases, the outcome would not have occurred without the causal contribution of the agent[4]. But the thought that someone *should have known* what they were doing implies that there is more than just causal responsibility involved, for the simple reason that one can be causally responsible for producing an outcome through no fault of one's own. (If I woke you up by listening to loud music, but I had good reason to think that you were out and none to think that you were asleep upstairs, I may be causally responsible for disturbing your sleep but not morally blameworthy). Insofar as it is deemed appropriate to *reproach* someone for the outcome their actions produced, we seem to be entering a different dimension of responsibility.

The sort of reproach at issue is often meant to reflect the judgment that the agent is *morally responsible* for having become addicted. Very roughly, questions of moral responsibility arise whenever someone is causally responsible for an action or the production of an outcome that belongs to the realm of things that are properly moralized. Becoming addicted to drugs, however, seems primarily to raise the question of whether the person acted imprudently or unwisely. How, then, can morality be involved in this?

Consider, first, a couple of uncompelling ways to answer this question. In the minds of some people, addiction may be a moral issue simply because they think that drug use itself, in whatever form, is morally impermissible. I will assume that people who think this way are wrong, and that there is nothing *intrinsically* wrong about using drugs[5]. Alternatively, one might think that the issue becomes moral insofar as addiction reliably leads to harm to the user herself, and harming oneself may be deemed morally impermissible. I remain neutral on this possibility, but the idea that one has a moral duty not to harm oneself is too controversial to be useful in this context. The prevailing view is that moral norms are fundamentally concerned with interpersonal relationships—in Thomas Scanlon's evocative terms, morality is about *what we owe to each other*.

There are, however, a number of not uncommon situations in which responsibility for addiction can touch on properly moral issues. To illustrate, consider two of them. First, addiction may be relevant in assessing accountability for particular decisions to use drugs that occur in a morally relevant context. If someone chooses to use drugs in a situation where doing so overlooks relevant moral reasons for doing otherwise—imagine, for instance, a parent who chooses to use drugs when doing so leads to neglect of their children— attention to the fact that the person suffers from addiction may invite the conclusion that she is less blameworthy than she might otherwise have been for the relevant actions[6]. The point can be argued in several different ways, but it appears to concern primarily the way in which addiction undermines the person's ability to choose at the moment of the act[7]—a matter of *direct* responsibility. The thought that addiction excuses in this way, however, might be defeated if it were true that the person culpably put herself in the position of not being able to respond to relevant moral demands in the first place. Thus, even if the parent were not directly accountable for neglecting their children at the time on account of their condition, they may still be *indirectly* responsible for it, and hence morally blameworthy[8].

Consider a second sort of situation in which the issue of responsibility for addiction may arise in a morally charged context. Imagine that a person with a history of heavy drinking needs a liver transplant. Suppose further that the person had been advised by her doctors some time in advance that she urgently needed to stop drinking to avoid needing a new liver, but she kept drinking nonetheless. Given the scarcity of transplantable organs and, more generally, the budgetary constraints of the medical system, one may wonder whether responsibility for ill health can be a morally appropriate consideration in deciding who gets care or who is prioritized under conditions of scarcity[9]. Some may think that there are utilitarian reasons to prioritize people who have a greater chance of living longer and healthier lives after receiving the transplant. But a different concern may be raised about backward-looking considerations of fairness, asking whether people who are in some sense responsible for their ill health have an equal claim to care as people who have ended up in a similar situation through no fault of their own. For these purposes, it is

relevant to know whether the drinker who needs a liver suffers from addiction. Suppose that she was simply unable to stop drinking when the doctors advised her to. In that case, it may seem that she does not bear the relevant kind of responsibility for this behavior: she was not *culpably* neglecting her health at that point. However, if the case could be made that she was responsible for putting herself in a position where she could no longer stop, this might block the appeal of the addiction excuse and thus reopen the question of whether she was *indirectly* responsible for neglecting her health.

Kinds of responsibility: direct versus indirect

Despite some important differences, the two scenarios just considered instantiate the following schema: an agent does something at time t1 that, let us assume, belongs to the realm of things that can be properly moralized (e.g., neglecting their children, refusing to follow medical advice in a way that jeopardizes resources that someone else might need); the agent appears to be less than fully responsible for doing so *at that time*, given the way that addiction undermines her ability to respond to the relevant reasons; the question then arises whether the agent can be *indirectly* responsible for her actions at t1 if she could be aptly held responsible for things she did at an earlier time, t0, that bear the right sort of causal connection with her incapacity at t1. In short, the question is whether her responsibility at t1 can be *traced back* to her responsibility at t0.

The paradigm case for tracing accounts of responsibility is the drunk driver. Suppose a drunk driver causes an accident. It may be true that at the moment of the incident she did not have sufficient ability to control the car to avoid the outcome. It may not have been possible for her to do otherwise *then and there*. We ordinarily feel, however, that incapacity while the person was already behind the wheel is not enough for an excuse, as we would then want to know if the person was responsible for putting herself in that situation in the first place[10].

It is difficult to spell out precisely what must be true for the trace to hold[11]. As an approximation, consider a pair of prima facie appealing *principles of derivative*

responsibility discussed by Carolina Sartorio[12]. The first purports to identify a necessary condition for indirect responsibility:

> N: Responsibility for an outcome requires responsibility for behaving in a way that caused the outcome.

N expresses an avowedly minimal but plausible idea: if the happenings at t0 that resulted in the relevant outcome at t1 are themselves things for which the agent cannot be aptly held responsible, then she cannot be responsible for the outcome that was caused by them. In the present context, the relevant outcome is the person becoming addicted. This raises a somewhat different issue than is typically at play in discussions of tracing, in that it concerns not a happening or an event, but the acquisition of a disposition. The causal chain leading to the acquisition of this disposition is itself quite complex, and arguably not traceable to any one particular action. Moreover, it is controversial how exactly to specify what the disposition consists of and how exactly someone comes to have it. It seems fair to assume, however, that the relevant causal chain must at some point have included decisions to use drugs that played a role in the acquisition of the disposition, and it is to these decisions that responsibility for becoming addicted can be (putatively) traced back to. Note also that this is not a single decision, but a *series* of decisions all of which took place before the person acquired her addictive disposition, so it is only loosely that I refer to such decisions collectively as taking place at t0, which names not a particular point in time, but an extended pre-addiction period in which the relevant decisions were made.

One way for the trace to fail would be if the agent did not (fully) possess the capacities that make someone (fully) responsible for their actions at t0. When it comes to addiction, this is not far-fetched. Many people become addicted at a very early age, before they have fully developed the sensitivity to reasons and capacities for self-governance that are plausible requisites for morally responsible agency. Many people with addiction suffer from comorbid psychiatric conditions that may also have impaired their relevant capacities at t0. There is also evidence that people with addiction are often more impulsive and have

more difficulty assessing risk than experimental controls, raising the difficult question of whether these traits are the result of addiction or an antecedent condition[13]. For present purposes, however, I intend to exclude all such cases from consideration. I will assume that the relevant choices made by the agent at t0 were made while she possessed to a sufficient degree the psychological abilities required to be considered an appropriate target of moral demands[14].

Now consider Sartorio's second principle:

> S: If an agent is responsible for an act, the act caused an outcome, and the agent foresaw that the act would cause (or was likely to cause) that outcome, then the agent is also responsible for the outcome[15].

S articulates a crucial epistemic condition for indirect responsibility. If the outcome in question was foreseen by the agent at t0, and the agent was responsible for producing it, then it seems *prima facie* appropriate to hold her responsible for it. If, on the other hand, it was not possible for her to foresee the outcome through no fault of her own, then the trace seems to fail. (Consider Sartorio's case: if an evil mastermind secretly rigged things in such a way that eating the last apple in your refrigerator would set off a series of events leading to the destruction of a remote village, you would not be responsible for that outcome)[16]. The most intriguing type of case concerns situations where the agent did not foresee the outcome, but it is open to question whether she *should have* foreseen it, i.e., whether she is blameworthy for her lack of foresight. In the case of addiction, we can safely assume that the relevant decisions at t0 were not made with full awareness that they would lead to the life-wrecking consequences that people with severe addiction experience. Of course, no one chooses to become addicted in this sense. In a typical case, the relevant decisions at t0 were plausibly made for whatever reasons the person then had to use drugs, presumably not in full awareness that this was part of the causal chain that would lead to addiction down the line. The vexing question then becomes whether the agent should have known.

Reasonable foreseeability

Theories of moral responsibility typically make a distinction between volitional and epistemic conditions for morally responsible agency. Though not beyond dispute, the distinction is useful for present purposes, in part because the more difficult questions about tracing concern particularly epistemic issues.

Consider this *prima facie* plausible rendering of the epistemic condition due to Manuel Vargas[17]:

> KC: For an agent to be responsible for some outcome (whether an action or consequence) the outcome must be reasonably foreseeable for that agent at some suitable prior time.

As the reader can tell, the key question is what exactly does 'reasonably' mean in this context. The motivation for introducing such a qualification is clear enough. If responsibility required that the agent had actually foreseen the consequences of her actions at t0, this would surely be overly restrictive, getting too easily off the hook agents whom we feel are responsible. (When I ate all the food in the fridge, it may not have occurred to me that there would be nothing left for my partner, but obviating extenuating circumstances it seems that this is a sort of thing I should have taken into consideration). On the other hand, unqualified foreseeability seems to cast the net too wide, setting the bar too high for fallible agents like us. Suppose that a certain outcome was foreseeable, in the sense that it was *possible* to foresee it, even though doing so would have been extremely difficult for an average person. Then it seems that someone could not be blameworthy for failing to do so. (Consider the analogy with cases of duress: it is often possible, strictly speaking, for a person held at gunpoint to confront the threat placed upon her, but it seems unfair to demand from an average person that she does so. The hero who confronts the threat may be praiseworthy, but the average person who fails to do so appears not to be blameworthy for it, at least in most cases).

What is reasonable to demand that the person using drugs at t0 be able to foresee? One thing we can safely assume is that people are generally aware that addiction is among the possible outcomes of such a decision, however unlikely they take it to be. In other words, pleas of complete ignorance of the existence of addiction as a phenomenon can be safely ruled out in most cases. It seems reasonable to expect members of contemporary society to be aware that addiction is something that can happen to people who use drugs.

Things get trickier, however, when we consider that the link between the decisions the agent made at t0 and the outcome —becoming addicted— is probabilistic in nature. It seems reasonable to assume that the agent understands at t0 that there is *some* risk of producing the relevant outcome and that she values that outcome negatively, i.e., she does not want to become addicted. But we ordinarily engage in all sorts of activities with full awareness that they carry *some* risk of producing an undesirable outcome, and in many cases it does not seem unreasonable to do so. A perfectly careful driver still runs the risk of unexpectable mechanical failure (excluding culpable negligence) or of being hit by another car through no fault of her own, but we don't normally consider driving around to be reckless behavior. Furthermore, a *hyperbolically* cautious agent who refused to engage in any activity that involved even a marginal degree of risk would arguably not be acting reasonably either. On the other hand, there are in fact cases where agents are culpable for doing excessively risky things that they should have known were too risky. It is reasonable to demand of drivers that they realize that they are endangering themselves and others by zigzagging lanes at 200 mph. The crucial consideration is not whether risk is involved, but whether the agent acted *recklessly*.

Of course, it is difficult to articulate precisely what it means to be reckless[18]. One difficulty is that people with different outlooks will have different views about how much risk is acceptable. Some people are simply, in the language of personality psychology, more naturally inclined to seek novelty, while others are more risk-averse. When it comes to decisions that are properly moralized, however, the relevant standard appears to be not the agent's view of how much risk is tolerable, but what a reasonably prudent person

would be expected to do. (Consider again the analogy with duress: a standard way of articulating the duress excuse is that a person cannot be required to confront a credible threat if doing so would not be expected of a person of *reasonable firmness*[19]). Ultimately, this comes down to a matter of judgment in light of the circumstances of each particular case, as it is not the kind of difficulty that can be resolved by a simple algorithm.

In approaching this question it is crucial to have an estimate, however imperfect, of the amount of risk a person has taken. With this in mind, consider the following figures on addiction. A 2020 study by Kimberly Johnson and colleagues, based on figures from the US National Survey on Drug Use and Health, estimated that 26.5 million people in the US (about 10% of the population aged 12 and older) met diagnostic criteria for substance use disorder[20]. Estimates from the Substance Abuse and Mental Health Services Administration (SAMHSA) for the same year put the figure at 15.4% of the population aged 18 and older[21]. It is crucial to note, however, that the criteria for inclusion used in these studies are very likely to be overly broad (as a point of reference, the same SAMHSA study estimated the prevalence of mental illness at 21% of the adult population for that year in the past 12 months). The surveys on which these estimates are based use the diagnostic criteria in the DSM-5, and many experts have raised serious concerns about the excessive expansiveness of the diagnostic criteria used in current psychiatric clinical practice[22]. Interestingly, the DSM notes that the term 'addiction' differs from the more encompassing category of substance use disorder and is typically used to refer only to the severe range of cases included in the latter[23]. When only severe substance use disorder is taken into account, Johnson and colleagues place their prevalence estimate at 4.6 million people in the U.S. for that year, or about 1.7% of the adult population[24].

To get at least a rough idea of the risks for the occasional drug user, we need reliable figures on the prevalence of drug use. Again, alcohol use is the most common. If we take lifetime prevalence (i.e., having used alcohol at least once in one's lifetime) as the relevant measure, this arguably covers the bulk of the adult population in most modern Western societies. The SAMHSA study estimates the figure at 220 million people in the U.S., out of an approximate population of 270 million people aged 12 and older[25]. If all

drugs are taken into account, the lifetime prevalence of drug use (including alcohol) will be even higher.

These figures should be read with caution. There are several difficult methodological issues involved—how the samples are selected, how the questionnaires are constructed, how the fieldwork is conducted, how the results are analyzed and scaled to population size figures, etc.— that are difficult for non-experts to ponder. There are also some not insignificant differences between the estimates produced by different studies. Nevertheless, it seems warranted to conclude that the number of people who become addicted is indeed remarkably low in proportion to the total population of drug users. In short, from a statistical point of view, addiction is a relatively unlikely development of occasional drug use.

Does that mean the risk of becoming addicted is negligible? Not necessarily. Absolute likelihood is not enough to settle the issue, because what constitutes a tolerable level of risk depends on other variables as well[26]. Importantly, the harmfulness of the outcome certainly needs to be considered in estimating how much risk is tolerable. (Imagine that the risk of a surgical procedure resulting in death was 1.7%. Dying as a result of the surgery would be highly unlikely, but most people would probably be terrified going into the operating room). When it comes to severe addiction, the consequences can certainly be extremely harmful, both to the person herself and to others. My argument is not that people with addiction are not responsible for acquiring the condition simply because the likelihood of that outcome was relatively low when they first decided to use drugs at t0. Furthermore, as noted above, the thing to ponder is not likelihood per se, but how much risk a reasonably prudent decision maker can be expected to take. This involves a normative appraisal, and I do not intend to argue here for any definite answer as to which appraisal is correct.

However, the figures just discussed are worth noting and are surely relevant to assessing responsibility for addiction. I suspect that most people who are inclined to think that people with addiction are responsible for acquiring their condition tend to assume

that the likelihood of becoming addicted following decisions to use drugs is much higher than it is. The prevalence figures suggest that the grounds for thinking that addiction is a reasonably foreseeable consequence of earlier decisions to use drugs are, on closer inspection, probably less compelling than conventional wisdom would have it. Given these figures, it becomes somewhat more plausible to think of the proportion of drug users who become addicted as people who were unlucky to suffer harmful consequences that accrue only a relatively small proportion of people who do similar things.

In addition, personal trajectories to addiction are highly variable. Some people report becoming 'instantly' addicted after trying drugs for the first time, while others find themselves on a sliding path of increasing dependence that builds gradually over many years before leading to addiction[27]. The fact that addiction-related outcomes are so variable underscores the difficulty of predicting them from the user's perspective.

Consider, lastly, that the statistics just discussed are mute on several factors that are likely to explain at least some of the variability in outcomes. The statistics suggest a probabilistic picture of the link between drug use and addiction, but it is probably true that not all drug users are *equally* likely to become addicted. Genetic factors, for instance, are widely believed to explain a significant portion of susceptibility to addiction[28]. Socioeconomic deprivation and other environmental factors also appear to increase susceptibility[29]. Importantly, these are things that seem not to be up to the agent in the sense relevant to moral responsibility, since they concern things that are beyond a person's control[30]. Moreover, it is not reasonable at present to expect the average person to know whether, for instance, her genetic makeup makes her particularly vulnerable to addiction.

From the perspective of the person who decides to use drugs at t0, and who is non-culpably ignorant of factors that might increase her vulnerability to addiction, the decision to use is made with the knowledge that it carries some risk. It is far from obvious, however, that the amount of risk she accepts in making this choice should seem intolerable to a reasonably prudent agent.

Navigating the risk/value ratio

So far I have focused on the likelihood and harmfulness of becoming addicted as major considerations for thinking about whether decisions to use drugs at t0 can be considered imprudent in a way that makes the agent blameworthy for the relevant downstream consequences of such decisions at t1. Now consider a different variable in the equation, namely the expected value of the agent's decisions at t0 or, to put it differently, the positive reasons for using that the agent had at the time. Expected value does not, of course, affect the likelihood of negative downstream consequences. But it certainly enters the picture when we ask whether a given level of risk was tolerable by the standards of a reasonably prudent decision-maker.

Consider again driving a car. Everybody knows that even for the most careful driver, there is some risk involved. What makes the decision to drive a car normally look reasonable is not just the low probability of an accident or mechanical failure, but the value—in terms of expediency, cost, maybe comfort—that one obtains from making such a decision. Conversely, accepting even a marginal level of risk would look completely irrational if you got *nothing* in return. This picture emerges clearly in the way we think about decisions to undergo surgery for non-life-threatening conditions. Even the simplest procedures involve some risk, but the risk often looks acceptable when we consider the value we expect to gain.

The question, then, is what value a person can (rightly) expect to gain from using drugs. There are, of course, many ways to answer this question: people who use drugs choose to do so for many different reasons. The particulars of each case are important, and the circumstances in which the person finds herself are relevant. Further, the answer is likely to be different for different drugs. But it is clear that people normally use drugs (non-addictively) because they find value in doing so. A proper assessment of responsibility for addiction must take into account the positive reasons the person had for

engaging in drug use in determining whether the risk the person took in making such a decision was, all things considered, reasonable.

From a commonsensical point of view, people who use drugs are often portrayed as primarily in the business of seeking pleasure. This picture is seriously incomplete—I will turn to this point in a moment. But even if the value of using drugs was all about pleasure and pleasure alone, it is far from obvious that this is not an ethically legitimate pursuit. I suspect that some people who are inclined to blame those who are addicted assume that pleasure-seeking was their sole motivation for using drugs, and see pleasure itself as a disreputable pursuit. As Foddy and Savulescu have pointed out, modern society still adheres to some extent to an age-old taboo against wanton pleasure-seeking behavior[31]. I take it, however, that there is nothing intrinsically wrong, from an ethical point of view, with the pursuit of pleasurable experiences. To the extent that people who choose to use drugs are seeking pleasure, it seems *prima facie* appropriate to count the pleasure they expect to obtain from using drugs as something to be considered in the risk/value equation.

However, it is too simplistic to think that most people who choose to use drugs do so solely seeking pleasure. There are many other ways in which drug use can be valuable to people in different circumstances. People choose to use drugs as a way of altering their mental states, but in an important range of cases they do so *instrumentally*, as a way of obtaining or facilitating other non-drug-related goods. The instrumental framework for thinking about non-addictive drug use proposed by Christian Müller and Gunter Schumann lists these goods as improving social interaction, facilitating sexual behavior, improving cognitive performance and counteracting fatigue, facilitating recovery from and coping with psychological stress, and improving physical appearance and attractiveness[32]. This list is not exhaustive. Hanna Pickard has convincingly argued that people may find value in using drugs as a way of securing a sense of self and social identity[33]. Other people may choose to use drugs as a means of religious or spiritual fulfillment or to promote artistic inspiration.

Coping with stress is likely a major reason why many people choose to use drugs. Some people may see the mind-altering effects of drugs as a way of temporarily escaping the problems they find themselves in, while others may find in them a way of dulling the pain as they continue to face the challenges of their situation. Of course, stressors can be very different in nature and affect people from all walks of life. But some people may find themselves in situations where coping with stress becomes something of a chronic necessity, sometimes due to difficulties that have no short-term solution. For people in such circumstances, the stress relief they find in drug use can be particularly valuable. One such situation is given by contexts of socioeconomic deprivation. Smoking, for instance, is often portrayed as a stress reliever and is indeed more common among people of lower socioeconomic status[34]. Not coincidentally, addiction disproportionately affects people of lower socioeconomic status, particularly those facing housing and employment instability[35].

Or consider Pickard's account of the role of social identity in explaining addiction and, more generally, drug use. Some people may come to identify with the social type of the drug user, finding in it a source of meaning and a sense of personal identity. Adopting such an identity and acting to conform to the group-specific norms associated with it can provide a variety of social goods, ranging from social reward and group membership to the opportunity to express values that are seen as contrary to those of mainstream society, to the creation of structure and purpose in life, and to finding in this identity a source of self-esteem and a sense of self. All of this may be particularly valuable to people who feel marginalized from mainstream social values or who, for whatever reason, have lost a grip on the sense of who they are as persons.

Of course, there are also costs involved in decisions about use that a reasonably prudent decision-maker will consider. Importantly, the risk of addiction is not the only risk. There may be other health-related hazards both short and long term. There are risks resulting from the fact that the precise origin and chemical composition of illicit substances are often unknown, and for some drugs the risk of overdose may be a lively concern.

In sum, I don't presume to have an answer to the question of how the balance between risk and value should be resolved. The point I am making is more modest, and in fact, should be fairly obvious to any non-prejudiced observer, and it is simply that there is value to be gained from using drugs—which is the obvious reason why some people use them. If we accept the premise that how much risk it is reasonable to accept depends in part on the expected value involved, this becomes a key part of the equation in assessing responsibility for addiction. Once we consider the value that drugs can provide, especially to people in circumstances that make such goods particularly attractive, it becomes less clear that the risk involved in the decision to use drugs at t0 is one that a reasonably prudent decision maker should necessarily shy away from.

The threat of overgeneralization

A final challenge to the view that people with addiction can in most cases be aptly held responsible for their addiction is to avoid overgeneralization. The threat looms that making a case for responsibility for addiction requires a commitment to a standard of what it is reasonable to demand of a prudent decision-maker that, when applied to cases of a different kind, yields intuitively unacceptable results.

The domain of cases that more closely resemble addiction insofar as the possibility of tracing is concerned is that of other medical conditions whose causal history also typically involves voluntary choices by the patient. Hypertension and type II diabetes are plausible examples[36]. The main features of typical cases are, at least superficially, similar to those of addiction in the relevant respects. Acquiring these conditions is harmful to the person who has it, but there are ways in which it can lead to outcomes that fall into the realm of things that can be properly moralized, such as placing an undue burden on others to care for the person or consuming limited medical resources. In both cases, the relevant actions (or omissions) that took place in the causal chain leading to the acquisition of the condition appear to be things for which the agent was properly responsible at the time,

i.e., they appear to be traceable to choices that the person made, in typical cases, with sufficient knowledge and understanding of what she was doing. The relevant actions (or omissions) then gradually and cumulatively led to an outcome that the person did not intend to produce, but complete ignorance of the possibility of acquiring the condition cannot be credibly pleaded: it is reasonable to expect that people in modern societies are aware that overindulging in salty or fat-saturated foods and an excessively sedentary lifestyle can lead to health-related difficulties. Moreover, many people seem to be able to do these things to some extent without suffering serious consequences. There may be factors beyond a person's control (such as genetic influences) that make some people more likely to develop the condition than others. In addition, there may be circumstances in which a person finds herself (often through no fault of her own) that make it more difficult to avoid (or do) the relevant actions (or omissions)—things related to the affordability of certain foods, for example, or the availability of leisure time and inviting conditions to do exercise.

Again, I am not committed to any definite general answer about how to think about these cases: the particulars of each case are bound to make a difference in the extent to which it seems reasonable to demand that the person acted otherwise. But it seems that anyone who holds the view that people are typically responsible for becoming addicted will be hard-pressed to avoid the implication that people can also be blameworthy in the relevant sense for having hypertension or type II diabetes. Recall that the issue under consideration is backward-looking responsibility, i.e., whether the agent *deserves* to be met with a range of negatively valenced responsibility responses, such as indignation and resentment, when properly moralized consequences of her actions are at stake—as opposed to, say, whether there are forward-looking reasons to hold the person responsible for her behavior, such as providing an incentive for her to change her ways. If you are inclined to think that holding people responsible in the desert sense is too harsh when it comes to acquiring hypertension or diabetes, then this should give you pause when considering responsibility for addiction.

Now consider another way in which the threat of overgeneralization looms large. As noted above, it seems reasonable to expect all adults in modern societies to know that addiction exists and that it is something that can happen to people who use drugs. But it is less clear that it is reasonable to expect all people to have information of a *sufficiently good quality* about the extent to which addiction can undermine the ability to control drug use of those who have it[37]. People's understanding of how addiction works can be deficient in many different ways. But one possibility is particularly noteworthy. It is not hard to imagine that many people when considering the possibility of becoming addicted, may think something along the lines of 'Addiction is something that can happen to some people who use drugs, I know, but it surely won't happen *to me*. If using ever becomes problematic, I'll just quit'.

How reasonable is it to blame someone for thinking this way? Note, first, that when use becomes problematic, most people *are* indeed able to quit. The majority of people who experience drug-related problems at some point in their lives are able to achieve "stable remission" without resorting to any kind of medical treatment. This seems to be especially true of many people who experience drug-related problems in their youth and then seem to quit spontaneously around the time they turn 35—they "mature out", as it is sometimes put[38]. But, of course, many people reach a point where their use becomes problematic and then attempt to quit, only to find it exceedingly difficult to do so successfully. Some people seek treatment and are eventually able to stop for some time, only to relapse sometime later, and many go through this cycle again and again over several years. Some people in this situation are never able to quit successfully in the end[39].

The point I am making is not about the chances that the person will be able to quit when the time comes, but rather about how difficult it is to imagine that there might come a moment when one is not really in control of one's behavior. The very notion that it may happen that one seriously wants to quit and yet may *not be able* to do it is a profoundly puzzling notion that experts struggle to wrap their heads around. Folk-psychological lore is ill-equipped to properly appreciate how addiction can impair crucial agential capacities. Moreover, commonsensical proxies for addictive motivation can foster a false sense of

understanding. The predicament of the person with addiction trying to abstain is not, despite everyday metaphors, like the common difficulty of abstaining from eating too many chips or too much ice cream. There is something extraordinary about the difficulty that people with addiction face. This extraordinary difficulty in abstaining is, to put it bluntly, the main reason for thinking of addiction as a mental disorder.

Importantly, the difficulty in properly assessing the extent to which addiction can impair one's ability to control drug use arguably reflects a more general limitation that humans have in making accurate predictions about the extent to which *visceral factors* can influence our behavior. The point was convincingly argued, several years ago, by George Loewenstein[40]. Visceral factors include drive states (e.g., hunger, thirst, sexual desire), certain moods and emotions, and also physical pain. What they all have in common is that, when experienced at sufficient levels of intensity, they seem to override rational deliberation and cause people to behave contrary to their own long-term interest, often with full awareness that they are doing so. At sufficiently high levels of intensity, they have a peremptory nature that profoundly influences the person's evaluation of the relative desirability of different goods and actions.

Loewenstein's point was that we usually tend to underestimate how profoundly our preferences will be altered under the influence of such factors and to overestimate our ability to act by our more stable and considered preferences in such situations. Consider, for instance, pregnant women who make a considered decision not to use anesthesia during childbirth but who subsequently ask in no uncertain terms to be relieved of their pain once they experience it firsthand. Interestingly, as Loewenstein notes, this can happen to women who have given birth before and have experienced such pain in the past. For another illustration of this point, consider *The Story of a Shipwrecked Sailor*, the non-fiction by Gabriel García Márquez, which vividly portrays the desperate situation of a person stranded on a boat in the middle of the sea. After several days, feeling in his gut what extreme deprivation is like, the protagonist begins to contemplate doing things he would never have imagined himself being able to do before. He catches a bird with his bare hands, kills it by removing its head, and attempts to eat it raw—which he is ultimately

unable to do due to sheer disgust, another extremely powerful visceral factor. He then tries to eat his shirt, belt, and shoes. For those of us not experiencing such extremely potent urges, it is exceedingly difficult to truly imagine the state of mind a person must be in to do such things.

Now consider again the person who is aware of the risk of becoming addicted down the stream, but who underestimates the difficulty she will have in abstaining and overestimates the ability she will have to act on her considered judgment that she should quit. One may wonder how reasonable it is to blame the person for not being able to accurately predict the true extent to which her ability to stop will be impaired under such circumstances. Insofar as the person fails to predict this accurately, her failure reflects, at least partially, a general human limitation in making such predictions: we do poorly at predicting how visceral factors that we are not presently experiencing will affect our behavior when the time comes that we do experience them with great intensity.

However we go exactly in determining what outcomes people can reasonably be expected to foresee from the actions they are currently undertaking, it seems inescapable that we should take into account the epistemic limitations of ordinary human foresight. If you decide, in the end, to stick with the assessment that people with addiction should have known what the downstream consequences of their decisions to use drugs could be, then this arguably commits you to a similar conclusion regarding a vast domain of actual and potential situations in which people ordinarily fail to predict accurately how their future behavior will be affected by a range of visceral factors that they are not currently experiencing.

Conclusion

Addiction seems to profoundly affect critical agential capacities that are among the conditions for morally responsible agency. For this reason, it may seem that people with addiction cannot be aptly held responsible for consequences of their decisions to use that are properly moralized. It might be argued, however, that they are nonetheless

blameworthy for such consequences if their responsibility can be traced to other decisions to act made at an earlier time when they fully possessed the capacities required for moral responsibility, and which caused their later inability to respond to sufficient reasons to do otherwise.

While I have not argued for a definite answer to the question of whether it can be appropriate to hold people with addiction responsible for their condition, I have attempted to illuminate what is involved in arguing for a positive answer to this question. Assuming that early decisions to use drugs were made in possession of normal-range psychological capacities, I considered the key question of whether drug users who become addicted should have known that they were contributing to their later addiction. Although many will probably find this claim intuitively appealing, I have tried to show that the grounds for it are somewhat less compelling than might initially appear.

To that end, I have focused on three different points of contention involved in arguing for this claim: how likely the outcome to be predicted was, how tolerable risk should be weighed against the expected value of decisions to use, and how reliable the relevant predictive abilities of the average person are. There are ways in which someone willing to push the argument could deal with these difficulties. I believe I have shown, however, that it cannot be simply assumed that people with addiction can be aptly held responsible for their condition. An argument to that effect will have to face a number of significant challenges. As a result, the prospects for making a convincing case for responsibility for addiction look somewhat more uncertain than they might at first appear[41].

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[1] I will follow the prevailing trend in the technical literature by focusing on cases of drug addiction, although what I say is intended to be relevant to other types of addiction as well. As for the term 'drugs,' I will use it liberally to refer to any substance that can be the object of addictive behavior, including psychoactive drugs as commonly understood, but

also alcohol, nicotine, and other substances not typically referred to as 'drugs' outside the technical literature. People with addiction are often the target of stigmatizing attitudes that are both inhumane and detrimental to their chances of recovery. I intend my use of 'addiction' to carry no negative connotations about the people who suffer from it.

[2] See S. Sattler, A. Escande, E. Racine, & A.S. Göritz, A. S. "Public Stigma Toward People with Drug Addiction: A Factorial Survey," *Journal of Studies on Alcohol and Drugs*, 78(3), 415–425, 2017. For a more general discussion of the stigma of addiction, see the articles collected in J. Avery & J. Avery (eds.) *The Stigma of Addiction. An Essential Guide*, Springer Nature, 2019.

[3] As will emerge in the discussion below, it is not the case that addiction is the *only* medical condition in which voluntary behaviors play an important causal role. Hypertension and type II diabetes are among the common examples of conditions that share this feature with addiction. For a classic discussion, see A. T. McLellan, D.C. Lewis, C.P. O'Brien, & H.D. Kleber, H. D. "Drug Dependence, a Chronic Medical Illness," *JAMA*, 284(13), 1689–1695, 2000.

[4] This is not a conceptual necessity, of course. It is not inconceivable that the pattern of drug use that initially led to addiction was imposed on someone against their will or was done under conditions of deceit or manipulation. Importantly, some cases of addiction to prescribed drugs that were initially taken under medical advice may provide a stark real-life illustration of this possibility. My focus here, however, will be on the arguably more common case in which decisions to use drugs at the beginning of the causal chain leading to addiction are clearly attributable to the person who would later become addicted.

[5] For an elaborate defense of this claim, see R. Lovering, *A Moral Defense of Recreational Drug Use*, Palgrave Macmillan, 2015.

[6] A proper statement of this claim would arguably require a number of qualifications that are not of central importance in the present context. It seems plausible, for instance, that in some cases addiction may provide a mitigation of responsibility rather than a full excuse, and it is likely the case that the addiction excuse becomes less compelling when the situation under consideration involves particularly serious moral transgressions.

Various forms of the claim that addiction excuses moral responsibility have been advanced by a number of philosophers. A representative sample includes E. Henden "Addiction and autonomy: Why emotional dysregulation in addiction impairs autonomy and why it matters", *Frontiers in Psychology*, 14, 2023; J. Kennett, N.A. Vincent, & A. Snoek "Drug Addiction and Criminal Responsibility", in J. Clausen & N. Levy (eds.), *Handbook of Neuroethics,* Springer Netherlands, 2015; N. Levy "Addiction, Responsibility, and Ego Depletion", in J. Poland & G. Graham (eds.), *Addiction and Responsibility*, The MIT Press, 2011; D. McConnell "Moral Responsibility in the Context of Addiction", in D. Nelkin & D. Pereboom (eds.), *The Oxford Handbook of Moral Responsibility*, Oxford University Press, 2022; H. Pickard "Responsibility without Blame for Addiction", *Neuroethics*, 10(1), 169–180, 2017; T. Schroeder & N. Arpaly "Addiction and Blameworthiness", in N. Levy (ed.), *Addiction and Self-Control*, Oxford University Press, 2013; W. Sinnott-Armstrong "Are Addicts Responsible?", in N. Levy (ed.), *Addiction and Self-Control*, Oxford University Press, 2013; R. J. Wallace "Addiction as a Defect of the Will", *Law and Philosophy*, 18(6), 621–654, 1999; G. Watson "Excusing addiction", *Law & Philosophy*, 18, 589–619, 1999; and G. Yaffe "Lowering the Bar for Addicts", in J. Poland & G. Graham (eds.), *Addiction and Responsibility*, MIT Press, 2011. David Brink and Stephen Morse have argued that addiction may in some cases provide a partial excuse, but they suggest that a successful excuse argument will often be blocked by considerations of indirect responsibility. See D. Brink, *Fair Opportunity and Responsibility*, Oxford University Press, 2021, chapter 13, and S. Morse "Hooked on Hype: Addiction and Responsibility", *Law and Philosophy*, 19, 3–49, 2000.

[7] This involves two assumptions that may be contested. On the one hand, some of those who argue that addiction excuses would object to the claim that the relevant excuse is grounded in considerations about agential control (e.g., Schroeder and Arpaly, "Addiction and blameworthiness," *op.cit.*). On the other hand, although the view of addiction as somehow impairing the ability to control drug use is certainly the mainstream view in the addiction literature, there are powerful dissenting voices that prefer to frame the challenge faced by people with addiction in terms that do not centrally concern agential

control. See, for instance, G. Ainslie, "A Research-Based Theory of Addictive Motivation", *Law & Philosophy*, 19, 77–115, 2000; N. Heather, "Is Alcohol Addiction Usefully Called a Disease?", *Philosophy, Psychiatry, & Psychology*, 20(4), 321–324, 2013; G.M. Heyman, *Addiction: A Disorder of Choice*, Harvard University Press, 2009; H. Pickard, "The Puzzle of Addiction", in H. Pickard & S. Ahmed (eds.), *The Routledge Handbook of Philosophy and Science of Addiction*, Routledge, 2018.

[8] In the intended reading of the case, this raise questions of *accountability*, roughly, the kind of moral responsibility for particular actions that makes one liable to be the target of a range of negatively valenced responses such as indignation and resentment. This is usually taken to differ from other sorts of assessments of the moral character of agents that go by the name of *attributability*. There are, of course, different views on what blame in the accountability sense entails. My present focus is on whether people with addiction, like the parent in the case discussed in the main text, deserve to be blamed for their actions for their own sake, and not on whether blaming them would be justified on consequentialist grounds. The *locus classicus* for the distinction between accountability and attributability is G. Watson, "Two Faces of Responsibility," *Philosophical Topics*, 24(2), 1996. The concept of accountability articulated in terms of 'basic' (i.e., non-derived) desert is expounded, among others, by D. Pereboom, *Free Will, Agency, and Meaning in Life*, Oxford University Press, 2014.

[9] I am not claiming that it is morally appropriate to invoke responsibility for ill-health in healthcare decisions. For discussions on whether it is morally appropriate or not to do so, see A. Albertsen & L. Tsiakiri, "Equality of Opportunity for Health: Personal Responsibility and Distributive Justice", in M. Sardoč (ed.) *Handbook of Equality of Opportunity*, Springer, 2023; R.C.H. Brown, "Moral Responsibility for (un)Healthy Behaviour", *Journal of Medical Ethics*, 39, 695–698, 2013; A.M. Buyx, "Personal responsibility for health as a rationing criterion: why we don't like it and why maybe we should", *Journal of Medical Ethics*, 34, 871-874, 2008; N. Levy, "Taking Responsibility for Responsibility", *Public Health Ethics*, 12 (2), 103–113, 2019, among others. The case of the alcoholic who needs a liver transplant

resembles the scenario discussed by Walter Glannon in "Responsibility, Alcoholism, and Liver Transplantation," *Journal of Medicine and Philosophy*, Vol. 23, No. 1, pp. 31–49, 1998.

[10] The drunk driver case hinges on the distinction between the incapacitating effects of intoxication (presumably including the highly imprudent decision to drive while under the influence of alcohol) and the decisions that the agent made prior to that moment, while not intoxicated, that led to the relevant outcome down the road. An interesting complication of the case, which is rarely discussed, arises if we consider the possibility that the drunk driver suffered from severe alcoholism, and we assume that this in some relevant sense impairs her ability to refrain from drinking. Then the question of whether she was responsible for causing the accident depends in part on whether she can be aptly held responsible for becoming an alcoholic in the first place.

[11] There is a large body of theory about the conditions under which present responsibility can be traced back to prior actions that I cannot hope to do full justice to here. For a representative sample, see J.M. Fischer & N.A. Tognazzini "The Truth about Tracing", *Noûs*, 43(3), 531–556, 2009; D.K. Nelkin & S.C. Rickless, "Moral Responsibility for Unwitting Omissions: A New Tracing View", in D. K. Nelkin & S. C. Rickless (eds.), *The Ethics and Law of Omissions*, Oxford University Press, 2017; S. Shabo, "More Trouble with Tracing", *Erkenntnis*, 80(5), 987–1011, 2015; M. Vargas, "The Trouble with Tracing", *Midwest Studies in Philosophy*, 29(1), 269–291, 2005.

[12] "Responsibility and causation," in D. Nelkin and D. Pereboom, eds., *The Oxford Handbook of Moral Responsibility*, Oxford University Press, 2022, p. 349.

[13] See A. Bechara, "Decision making, impulse control and loss of willpower to resist drugs: A neurocognitive perspective," *Nature Neuroscience*, 8(11), 1458–1463, 2005; and A. Verdejo-Garcia, "Decision-making dysfunctions in addiction", in H. Pickard & S. Ahmed (eds.) *The Routledge Handbook of Philosophy and Science of Addiction*, Routledge, 2018.

[14] In "Taking responsibility for responsibility" (op. cit.), Neil Levy makes a powerful case for the claim that it is often wrong to hold people responsible for the negative health consequences of their choices, because it is often true that people who make choices that are detrimental to their health possess to a less than full extent the capacities required for

moral responsibility. While I agree with much that Levy says, I intend to focus here on cases where the decisions at t0 were made in full possession of the capacities relevant to moral responsibility.

[15] C. Sartorio, op. cit., p. 349.

[16] C. Sartorio, op. cit., p. 350.

[17] M. Vargas, "The trouble with tracing," op. cit.

[18] For a classic discussion, see James Brady "Recklessness," *Law and Philosophy*, 15 (2), 183–200, 1996.

[19] See G. Watson, "Excusing addiction," op. cit.

[20] K. Johnson, K. Rigg, and C. Hopkins Eyles, "Receiving addiction treatment in the US: Do patient demographics, drug of choice, or substance use disorder severity matter?," *International Journal of Drug Policy*, 75, 102583, 2020, p. 2.

[21] See https://www.samhsa.gov/data/sites/default/files/reports/slides-2020-nsduh/2020NSDUHNationalSlides072522.pdf (retrieved March 6, 2024).

[22] For a representative discussion, see J. Wakefield, "Diagnostic Issues and Controversies in DSM-5: Return of the False Positives Problem", *Annual Review of Clinical Psychology*, 12(1), 105–132, 2016.

[23] *Diagnostic and Statistical Manual of Mental Disorders: DSM-5-TR*, American Psychiatric Association, 2022, p. 544.

[24] K. Johnson et al., op cit., p. 2. This includes all forms of substance use disorder, including alcoholism, which is by far the most common form of SUD.

[25] The number comes down to 174 million if only those who drank alcohol during the past year are considered. See https://www.samhsa.gov/data/sites/default/files/reports/rpt42728/NSDUHDetailedTabs2022/NSDUHDetailedTabs2022/NSDUHDetTabsSect2pe2022.htm (retrieved March 6, 2024).

[26] J.M. Fischer and M. Ravizza already made a similar point: "In some contexts, it seems appropriate to hold an agent responsible for a later action (or omission or consequence) that is extremely unlikely to occur, whereas in other contexts the extreme unlikelihood of (say) the action seems to rule out responsibility. This makes it reasonable to think that a

full and explicit tracing approach would not specify a degree of likelihood that is always employed straightforwardly to ascertain responsibility; rather, the degree of likelihood employed by the tracing approach would need to be context-relative" (*Responsibility and control*, Cambridge University Press, 1998, p.50).

[27] R. R. Hammer, M.J. Dingel, J.E. Ostergren, K.E. Nowakowski, and B.A. Koenig, "The Experience of Addiction as Told by the Addicted: Incorporating Biological Understandings into Self-Story," *Culture, Medicine, and Psychiatry*, 36(4), 712–734, 2012.

[28] Verhulst, B., Neale, M. C., & Kendler, K. S., "The heritability of alcohol use disorders: a meta-analysis of twin and adoption studies," *Psychological Medicine*, 45(5), 1061–1072, 2015.

[29] This is suggested by the simple fact that addiction positively correlates with socioeconomic deprivation, see W.M. Compton, Y.F. Thomas, F.S. Stinson, & B.F. Grant, "Prevalence, Correlates, Disability, and Comorbidity of DSM-IV Drug Abuse and Dependence in the United States," Archives of General Psychiatry, 64(5), 566, 2007. For a general discussion of the idea that lack of alternative opportunities is integral to the explanation of addiction, see C. Hart, *High price*, Harper Perennial, 2013.

[30] In this there seems to be a pure *luck* component. There is, of course, a vast literature on the proper place of luck in the context of morality. For example, luck egalitarianism as a view of distributive justice is built on the idea that luck is the inverse of responsibility and should be neutralized in ideally just distributive settings (see A. Albertsen & C. Knight, "A framework for luck egalitarianism in health and healthcare", *Journal of Medical Ethics*, 41(2), 165–169, 2015). In this context, addiction may pose a particularly difficult kind of conceptual conundrum, as both luck and morally responsible agency appear to play important roles in determining relevant outcomes.

[31] B. Foddy & J. Savulescu, "A Liberal Account of Addiction," *Philosophy, Psychiatry, & Psychology*, 17(1), 1–22, 2010.

[32] C.P. Müller and G. Schumann, "Drugs as instruments: A new framework for non-addictive psychoactive drug use," *Behavioral and Brain Sciences*, 34(6), 293–310, 2011. Müller and Schumann also discuss the instrumental use of drugs as a form of self-

medication for mental health problems. This is certainly an important type of case, as evidenced by the high comorbidity between addiction and other mental health conditions. Significantly, in the qualitative interview study by Kennett, Matthews and Snoek, some respondents reported that they first started using drugs not for pleasure, but as a way to "feel normal" (J. Kennett, S. Matthews, & A. Snoek, "Pleasure and Addiction", *Frontiers in Psychiatry*, 4(SEP), 1–11, 2013, p. 9). Although this raises an important issue that a full treatment of responsibility for addiction should take into account,

I will leave it out of consideration here, as my focus is solely on decisions to use drugs made by people with normal-range psychological capacities. For a self-medication account of drug use, see E.J. Khantzian, "Understanding Addictive Vulnerability: An Evolving Psychodynamic Perspective," *Neuropsychoanalysis*, 5(1), 5–21, 2003.

[33] "Addiction and the Self," *Noûs*, 55 (4), 737-761, 2021. Pickard makes this point in a different dialectical context, in that she means it primarily as part of a theory of addiction rather than of non-addictive drug use. Nevertheless, she deserves credit for highlighting the importance of thinking about the value people find in using drugs when seeking an explanation for both addictive and non-addictive drug use.

[34] For the link between smoking and stress, see F.J. McClernon and D.G. Gilbert, "Smoking and Stress," in G. Fink (ed.) *Stress Consequences: Mental, Neuropsychological and Socioeconomic,* Academic Press, 2010, pp. 214–218. A.N. Taylor and colleagues make a partly similar point with regard to alcohol use in A.N. Taylor, P. Prolo, M.L. Pilati, "Alcohol, Alcoholism, and Stress: A Psychobiological Perspective", in G. Fink (ed.), *Stress Consequences,* op. cit., pp. 209–213. For the correlation between smoking and lower SES see E. Greenhalgh, M. Bayly, and M. Winstanley, "Trends in the Prevalence of Smoking by Socio-economic Status", in M. Scollo and M. Winstanley (eds.), *Tobacco in Australia: Facts and Issues,* Cancer Council Victoria, 2015, available from: http://www.tobaccoinaustralia.org.au/chapter-1-prevalence, retrieved March 8th, 2024.

[35] See W.M. Compton et al., "Prevalence, Correlates, Disability, and Comorbidity of DSM-IV Drug Abuse and Dependence in the United States," op. cit., and B. Saloner & B.L. Cook,

"Blacks and Hispanics Are Less Likely Than Whites to Complete Addiction Treatment, Largely Due To Socioeconomic Factors", *Health Affairs*, 32(1), 135–145, 2013.

[36] The point is made in A.T. McLellan et al., "Drug Dependence, a Chronic Medical Illness," op cit.

[37] Note further that there are also factors that can affect the quality of information a person can reasonably be expected to have, and many of these factors are only imperfectly under the agent's control. This seems to be especially true of people's level of education, which roughly correlates with socioeconomic status.

[38] For a summary of the evidence on 'spontaneous' recovery, see G.M. Heyman, "Quitting Drugs: Quantitative and Qualitative Features," *Annual Review of Clinical Psychology*, 9(1), 29–59, 2013.

[39] M.L. Dennis, C.K. Scott, R. Funk, R., and M.A. Foss, "The duration and correlates of addiction and treatment careers," *Journal of Substance Abuse Treatment*, 28(2), S51–S62, 2005.

[40] See "Out of Control: Visceral Influences on Behavior," Organizational Behavior and Human Decision Processes, 65(3), 272–292, 1996, and "A Visceral Account of Addiction", in J. S. O. Elster (ed.) *Getting Hooked: Rationality and Addiction,* Cambridge University Press, 1999.

[41] The final draft for this chapter was written while I was a Research Resident at the Brocher Foundation in Geneva (www.brocher.ch).