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Addiction, self-control and the self: An empirical, ethical study



Anke Snoek

ADDICTION, SELF-CONTROL AND THE SELF:
AN EMPIRICAL, ETHICAL STUDY

Anke Snoek

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Addiction, self-control and the self:

An empirical, ethical study

*'We all want to be a part of something positive.
But our lack of belief in self is what can cause
negative impactful choices.'*

Anke Snoek

BA, MA (University of Humanistic Studies)

A thesis submitted in fulfilment of the requirements for the degree of
Doctor of Philosophy

DEPARTMENT OF PHILOSOPHY
FACULTY OF ARTS, MACQUARIE UNIVERSITY
SYDNEY, AUSTRALIA

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STATEMENT OF AUTHORSHIP



I certify that this dissertation is entirely my original work and has not been submitted for a higher degree to any other university or educational institution. All sources of information used in this thesis have been indicated and due acknowledgment has been given to the work of others. Ethics approval for this research has been gained by the Ethics committee of St Vincent's hospital (11.123) and Macquarie University (5201200001).

Signed
Anke Snoek

ABSTRACT



Addiction is often equated with loss of self-control. Determining what constitutes loss of self-control, however, is complicated. On one hand, substance dependent people often describe their use as involuntary and life-ruining. On the other, substance use requires planning and intentional actions. I will argue that loss of self-control in addiction is poorly understood because current theories do not make explicit which level of self-control they are describing.

In this thesis I argue that developing a hierarchical account of self-control is critical when analysing loss of self-control in addiction. I distinguish three hierarchical levels of self-control: 1) intentional self-control, or doing what one intended 2) instrumental self-control, or reaching ones goals, and 3) normative self-control, or living the life one values living. Loss of self-control in addiction is not underpinned by failure on just one level, but rather by a set of interacting factors. Still, to judge whether someone has lost self-control or not, knowledge of the normative level is essential – are people able to live the life they value living and be the person they value being? This normative perspective is poorly examined in the current literature.

To gain insight into the circumstances in which normative agency is developed or impaired, I designed a longitudinal, qualitative study involving opioid and alcohol dependent people. I followed 69 participants over a period of 3.5 years, asking them what hampered their self-control and the goals they set for themselves.

I conclude that loss of self-control in addiction is often a loss of self. People must see their actions as making sense within their concept of self and their life stories. My first finding is that addiction impacts heavily on people's bodies – their appearances and how others reacted to them, their energy levels, potential life threatening illnesses, and the risk of overdosing when relapsing. Many participants lost trust that their bod-

ies would carry them into the future. They stopped setting goals for themselves. They lost belief in self-efficacy.

I also find that people's agency is threatened when they lose hope, resulting in a resignation from their normative goals. People struggling with substance dependency are disproportionately vulnerable to adverse circumstances which often cause them to abandon plans. The link between resignation and loss of self-control is frequently misunderstood in the current literature. It is often viewed as a choice-based, justified change of normative outlook, rather than a forced abandonment of the outlook. Resigned, addicted people are perceived as 'willing addicts'.

Finally, regaining belief in self-efficacy is a key aspect of recovery. One respondent said, for instance, that he had many capacities for self-control, but only started using them when he began to believe he could attain the future he valued.

My findings highlight the importance of evaluating loss of control within someone's existential situation and normative framework. The findings have implications for treatment. The model of hierarchical levels of self-control I described can be used by practitioners to assess on which levels the self-control of their clients is impaired. I argue practitioners should evaluate whether current dominant treatments are sufficient for boosting their client's normative agency. They should help clients reconnect with their image of their ideal future self. They can do so by showing trust in clients' agency and self-efficacy by assuring them that it is possible to live the life they value living, and to be the person they value being.

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INTRODUCTION



Addiction and self-control

Addiction is notoriously hard to define (Walker, 2010). Most definitions, however, seem to agree on one defining aspect of addiction. Addiction differs from regular substance use because addicted people lose control over their intake of the substance, and this loss of control has serious negative consequences for them (EMCDDA, 2009; Goodman, 2008; Sinnott-Armstrong & Pickard, 2013; West, 2006). If loss of self-control is the defining characteristic of addiction, how should this loss of self-control be understood?

Loss of control in addiction is puzzling, not in the least for people struggling with addiction themselves. ‘You know’, one of my substance dependent research subjects remarked, ‘I hate the idea that addicts don’t have control over their behaviour. But why am I doing the same thing [taking drugs over and over again] when I know it’s not in my favour?’ (MHE-15).

One of the things that makes loss of control in addiction hard to understand is the co-existence of voluntary and involuntary behaviour in addiction. People struggling with addiction often state that their behaviour is involuntary, and that they suffer immensely from their substance use. They know that their substance use is wrecking their lives, yet they claim that they cannot control it. As one of my research subjects described his addiction: ‘I was going over a cliff and not having any brakes’ (R2). On the other hand, the loss of self-control that addicted people face is quite different from other losses of control – for example tics or epilepsy. In the case of tics or epileptic attacks, it is quite clear that the behaviour is involuntary. In the case of addiction, however, a large part of the associated behaviour seems to be intentional: addicted people frequently go through great lengths to obtain a substance and hide

their substance use from their colleagues and loved ones. It seems also dubious that once craving sets in, people are unable to control their behaviour since addicted people often control their behaviour, at least temporarily, under the influence of certain disincentives like the price of the substance, or the proximity of a police officer. On top of that, at least in the early stages of addiction, people seem to get something out of their substance use: pleasure, or at least a painkiller. This reward from substance use seems to be a motivating factor behind the use. People often have *reasons* to use substances.

Substance users seem to neither be 100% out of control, nor 100% in control. So how should we understand the loss of self-control in addiction? How should we understand this tension between voluntary and involuntary behaviour in addiction?

Many theories of addiction have provided plausible explanations for how self-control in addiction can be impaired. However, most of these theories uphold the dichotomy that substance dependent people either have control or they do not. That these theories position themselves either in the ‘control’ or ‘no-control’ camp means that they mostly compete with instead of complement each other. What further complicates the discussion on addiction and self-control is that contemporary theories stem from very diverse disciplines (neuroscience, behavioural economics, psychology, philosophy, sociology, symbolic interactionism). These disciplines have different and often implicit assumptions concerning what human agency is and apply different criteria for when behaviour counts as self-controlled.

In this thesis I will show that self-control is often associated with virtuously resisting temptation, and in our society, it is often seen as a goal in itself. However, I will argue that the people we tend to see as self-controlled are those who are in control of their *lives*, rather than the specific actions they perform. If we examine what self-control is for, we see that it is exercised to enable us to live the life we value living and be the person we value being. So there is a strong normative aspect to self-control.

In light of this, I will offer a layered or hierarchical model of self-control. I will distinguish between different levels of self-control: intentional, instrumental and normative self-control. At each level self-control is exercised for a different reason, and at each level, different threats arise. I will argue that although a person can have intentional or instrumental

control, they can nonetheless lack the capacity to live the life they value, hence they will still lack normative self-control. I will argue that the ultimate test of whether a person possesses self-control, is whether they are able to live the life they value and be the person they value being.

I will demonstrate that this hierarchical understanding of self-control sheds light on how current explanations of loss of self-control in addiction relate to, rather than stand in opposition to, each other. Using data from a qualitative, longitudinal study, I will demonstrate that current theories are missing this layered understanding of self-control, and hence fail to capture a wide range of factors that threaten it. This is especially true of the factors that threaten the level of normative self-control. These issues become much clearer when loss of self-control is studied within the concrete existential situations that people face.

In my qualitative study, I recruited 69 alcohol and opioid dependent people, they were interviewed annually over a period of 3.5 years (4 interviews in total). The main focus of the interviews was what kind of things got in the way of people's self-control and agency. The longitudinal character of the study gave us insights in people's ambitions and hopes, and the factors that interfered with that. By studying self-control within a biographical context, we see that loss of self-control in addiction happens on several levels at the same time. Levels that interact with each other.

Better understanding of the multiple ways in which self-control can be lost and regained in addiction can help to design better treatment and policies, and in doing so reduce the immense suffering addiction can cause to the individual, his or her loved ones, and society in general. This empirical study also offers important insights for philosophical and psychological theories on self-control. I will argue that it shows how substance use can alter a person's beliefs about himself and about what is possible in his life. These beliefs are essential for an individual to be motivated to exercise the control he or she has.

Outline of the thesis

In chapter 1 I will look at what self-control is and, more importantly, what it is for. I will start by examining our most common sense understanding of self-control. Self-control is often equated with resisting temptation,

but resisting temptation is not a goal in itself – rather, we resist temptation in order to achieve our goals. I will argue that we exercise self-control to be able to live the life we value and be the person we value being. I will then present a hierarchical or layered account of self-control with intentional control at the bottom, instrumental control in the middle, and normative control at the top (Kennett, 2001). Intentional control is about doing what one intended. Instrumental control is about reaching one’s goals, and normative self-control is about being the person one wants to be, and living the life one values living. This hierarchy shows that we can exercise self-control in different ways and for different reasons. It also shows that temptations are not the main threat to self-control.

It is important to distinguish these levels as we can exercise self-control on one level, but fail to exercise it on another one. For example, we can successfully resist temptation, yet fail to reach our goal because we lack planning capacities. If we do not specify which level of self-control we are interested in, we will not agree when people will count as self-controlled: should they possess intentional control, instrumental control, or normative control? I will argue that normative self-control is the most important level of self-control, and that in order to see whether someone is self-controlled, we need to know what their normative goals are and whether they are able to reach these goals.

In chapter 2 I will compare the hierarchical model of self-control that I developed in chapter 1 with current theories of loss of self-control in addiction. I will examine, in particular, neuroscientific models of addiction and rational choice models, and I will make explicit which view of self-control each specific theory holds: they are mainly interested in intentional and instrumental self-control. The level of self-control a model is concerned with determines which capacities for self-control and threats to self-control it focusses on. The neuroscientific model of addiction describes many factors that make intentional and instrumental control harder for people who are substance dependent. Repeated substance use creates a strong sensitivity for substance related cues, these cues provoke a strong craving or wanting, even in the absence of liking the substance (Robinson & Berridge, 1993). Substance use can become highly automatic, habitual behaviour that is hard to redirect by means of cognitive control (Baler & Volkow, 2006). While the neuroscientific model claims that addictive behaviour is no longer reasons-responsive,

rational choice models on the contrary highlight many of the (local) reasons people have to use substances (Heyman, 2009). However, as I will argue, having a reason for using is not enough to count as self-controlled. The reason why people use is not always a reason the person also normatively endorses.

Although the current theories offer us valuable insights on how intentional and instrumental self-control are impaired, they are incomplete with regard to normative self-control. I will argue that addiction is a complex impairment of self-control. If we only study one level of self-control without relating it to the other levels, we do not know if the loss of self-control at one level is compensated for at another level. I will also argue that there might be an asymmetry between the level at which self-control is initially lost, and the level at which it is regained. If we only look at the capacities of self-control without looking at the agent, loss of self-control can only partly be understood. The ultimate test of self-control does not concern a person's capacity to resist temptation, but their ability to live the life they value living. For this, an understanding of the normative level of self-control is essential. If we mostly focus on self-control as resistance to unruly desires, we fail to acknowledge a richer set of issues that threaten normative self-control.

To understand how normative self-control is exercised or impaired, we need knowledge of the autobiographical context in which normative frameworks are developed and exercised. In chapter 3 I will discuss the method of the empirical study. I will also present a detailed case study to show that when we look closely at a real case of someone who is struggling with addiction, we see that it is hard to apply the current models of addiction and self-control consistently across the whole trajectory of addiction. We see that the current models partly explain some aspects of the loss of control people are struggling with, but miss an important and crucial aspect of self-control. I suggest that this blind spot is caused by the theory of motivation these theories hold. The rational choice models argue that people are motivated by what gives them the most pleasure or the least pain in that moment. But our behaviour is not only motivated by pain and pleasure, it is also motivated by our self-concept and beliefs about our self: who I am, what I am capable of, and what seems a likely continuation of my life-story. This concept of the self is missing

in the current theories, and its absence means they cannot satisfactorily explain how self-control is lost in addiction.

In chapter 4 I will look closer at how our self-concept can motivate behaviour in general, and I will review empirical evidence that shows that a changed self-concept can play an important role in recovery from addiction. Our self-concept makes certain options more salient to us, and so determines whether we use the capacities and opportunities we have. I will argue that most theories of addiction and identity focus on the content of identity change: how someone changes his or her self-concept from user to abstainer. However, although noticing that one lives in an identity incongruent way often sparks the ignition to change, a changed self-concept is not enough to sustain change. Rather, a changed self-concept needs to be accompanied by a belief in self-efficacy. Our self-concept is also influenced by external factors that are largely out of our control: stigma, negative reinforcement from others, lack of opportunities, or a hostile environment (perceived or actual).

Therefore, we need to examine in more detail the factors that affect the self-concept of people struggling with addiction. Pursuant to this aim, in Chapter 5 I will look at how the body constitutes agency. Although there is a vast literature on how addiction changes the brain and the consequences this has for self-control, there is almost no literature on how addiction changes the body *and the consequences for self-control*. There is of course a large medical literature on how addiction changes the body, however these changes are deemed irrelevant for self-control. Respondents, however, are very clear that for them, their substance use has strong physical consequences, and that somatic changes influence their agency in several ways. The experiences the respondents narrated with regard to their body and their agency bear striking resemblance to testimonies of chronically ill people and how their changing bodies influence their agency. Lack of energy, feeling miserable, feeling marked by their substance use, seeing many of their friends die from substance related issues changed their perspective on their future, their belief in self-efficacy, and reinforced a local perspective on their lives. In order to exercise our agency, we need to have a basic trust that our body will carry us into the future, as well as energy to perform actions. Somatic changes can have a profound effect on our agency. These losses of health are of-

ten viewed as a consequence of reduced self-control (a symptom), rather than a factor that influences self-control as well (a cause).

In chapter 6 I will show how a certain kind of life, or a set of external circumstances, can shape our beliefs in whether it is worthwhile pursuing the life we value living. Most theories on self-control focus on whether or not people achieve their goals, but fail to look at why people set certain goals for themselves, and whether their goals really reflect their values (Horstkötter & Snoek, 2013; Horstkötter, 2009). It is often thought that addicted persons either act on a covert normative outlook (willing addicts), are overpowered by addictive desires and hence unable to act on their normative outlook (unwilling addicts), or lack a normative outlook altogether (wanton addicts). However, there is a fourth option: addicted persons can give up on their normative outlook because they think that the life they value living, and the person they value being, are unattainable (Kennett 2013). I will describe the struggle of one of my respondents in overcoming his addiction and trying to live the life he values living. I will describe the relentless stream of adversities he has to overcome: persistent poverty, mental illness, physical illness, stigma, lack of social support.

In chapter 7 I will show that although there are many ways in which normative self-control can be impaired in addiction, it can also play an important role in recovery. It is often argued that addicted people do not have a view of the good life (Dalrymple, 2006). They do not know what they want in life, as they are too fragmented by their substance use (Levy, 2006). I will, however, argue that most addicted people do possess an image of what life they value living and what person they value being. This image fails, however, to motivate them because they do not believe it is possible to accomplish living this life and be the person they value being. What the case study in chapter 7 nicely illustrates is that for a subgroup of addicted people, a turning point occurs when a belief in self-efficacy is regained.

In the conclusions (Chapter 8), I will bring together the key insights that emerge from this thesis, and provide leads on how to operationalise these insights into treatment policies. In general, the hierarchical account of self-control can be a helpful tool to help clinicians and politicians understand and analyse addicted people's loss of self-control, and to understand how the levels of self-control interact. The results of the

study also stress the importance to understand how normative self-control can be lost and regained in addiction. The results urge people to take into account the importance of a person's body and self-concept for their capacity for self-control. Importantly, my results also highlight that addicted persons are at risk of losing belief in their self-efficacy, due to persistent poverty and stigma, and this has serious consequences for their agency and recovery. Reconnecting people with their image of their ideal future self and valued life should be accompanied by assuring people that it is possible for them to live the life they value living and be the person they value being.

I conclude with two caveats concerning scope and terminology. First, for the sake of precision, this thesis focuses solely on addiction to *substances*, to the exclusion of behavioural addictions, even though some of the findings will likely apply to behavioural addictions as well. Of the substance addictions, I mostly focus on alcohol and opioid dependency, although many of the respondents in this research were poly drug users (amphetamines, cannabis, tobacco). Second, throughout this thesis I avoid using the word 'addict', since it is considered stigmatising. However, due to its common usage in the philosophical literature on addiction, the term is sometimes used in this thesis when citing the work of others. In general the terms 'addicted person', or 'substance dependent person' are employed. When I refer to 'substance use', it can both be alcohol or another intoxicating substance.

CHAPTER 1. PERSPECTIVES ON SELF-CONTROL AND WHAT IT IS FOR



1. Introduction

Addiction seems to be synonymous with a loss of self-control. Many addicted people claim that they use against their will. What makes addictive behaviour so puzzling, however, is that in many cases substance use requires a considerable amount of planning and intentional behaviour: substance users have to perform certain actions to use a drug, for example: obtain money, purchase their substance of choice, inject themselves. In addition to this, some addicted people go to great lengths to conceal their substance use from their loved ones or colleagues. The behaviour of purchasing and consuming a substance seems voluntary in many cases. On top of that, substance users seem to get something out of their substance use: if not some pleasure or reward, then at least relief from pain. Suddenly the idea that addiction involves a loss of control does not seem to be so convincing anymore.

The literature on addiction has always been dominated by this tension between the suspected voluntariness and involuntariness of addictive behaviour. Are addicted people to blame for their loss of self-control or not? What makes discussions on addiction and self-control so complicated is a lack of consensus on what the defining characteristics of addiction are (M. J. Walker, 2010). Equally confusing, however, is the lack of clarity on what concept of self-control different scholars hold, and what criteria they hold for behavior to count as self-controlled. In this chapter I will demonstrate that distinguishing hierarchical levels of self-control will help to position the current theories on addiction and self-control, and see that instead of conflicting, they could complement each other. Self-control can be exercised in different ways, for different reasons.

A common understanding of self-controlled behaviour is that it needs to be, in contrast to tics or reflexes, conscious and intentional. This construal has been criticised for offering an overly a limited concept of self-control, and that what matters in self-controlled behaviour is not so much whether the behaviour is intentional, but whether it reflects a person's long term goals (Horstkötter, 2015; Kennett, 2001; Meyers, 1989; Young, 1986). Most discussions however, focus on the role of control rather than the role of self in self-control. However, self-control is not only about controlling our behaviour, but also having control over our *selves*. In this chapter I will describe three hierarchical levels of self-control: intentional, instrumental and normative self-control. I will show that each level is associated with certain capacities and threats.

A very common perception of self-control is that it is invoked when resisting unruly impulses (Baumeister, Vohs, & Tice, 2007). In our everyday language, self-control seems to have become synonymous with resisting temptation, mostly by using strength of will. However, when we look at what self-control is for, we see that it is valued because it enables us to realise our long-term plans. Many of the things we value in life require that we guide our behaviour consistently over time. When we start to see self-control as a means of reaching a goal, rather than just the ability to resist temptation, we see that the capacities to exercise self-control go beyond strength of will-power. The exercise of self-control also encompasses planning – for example, the practice of setting goals and related sub goals for ourselves. We can resist temptation using our willpower, but we can also use planning to avoid temptations: for example buying a small package of biscuits so that we are not tempted to eat a whole family pack. If self-control is rather about reaching goals than about resisting temptation, we should know a little bit more about what goals people set for themselves before we can judge whether someone is self-controlled. Thus, if we want to fully understand self-control, we should not only look at control, but also at the self. We should not only focus on whether people are able to achieve a certain goal, but ask why they set this specific goal for themselves, and how committed they feel to their goals more general. Committing to a goal over a longer period of time is important for instrumental reasons, as it helps us acquire the things we value. But there is more to it than this: by setting goals and committing to them over time, we constitute ourselves as persons. Perceiving oneself as a cer-

tain person who behaves a certain way, carries a motivational force and is an important form of self-control.

To understand how self-control can fail, it is necessary to distinguish between different levels of self-control, and to recognise that at each level is exercised for different reasons: resisting temptation (intentional self-control), reaching one's goal (instrumental self-control), or living in accordance with the life one values and being the person one values being (normative self-control). In this chapter I will outline in more detail the different levels of self-control, how they are exercised, and what threats occurs on each level. This chapter strongly draws on work on agency by Kennett (2001) and Horstkötter (2015; 2009). In the next chapter I will show how these different levels of self-control provide new insight into the current debate on losses of self-control in addiction.

2. Intentional self-control and controlled behaviour

In our everyday language, self-control is often seen as synonymous with resisting unruly impulses with effortful, cognitive control. The main capacity for self-control, in this view, is will-power, and the main threat to self-control – unruly impulses – originate from within the agent. On this view, self-control is equated with conscious control of one's behaviour. Consequently, automatic behaviour, which is by definition not under our cognitive control, is not considered self-controlled behaviour.

However, this popular perception of self-control does not take us very far when it comes to understanding how self-control is being exercised. To see this, let us look first at intentional control. Intentional self-control is the control we exercise over our actions in order to do what we intend (Kennett, 2013). Intentional control seems to be synonymous with controlled actions: I intend to call my mother, so I take my phone and dial her number. When we, in contrast, absent-mindedly finish a whole bowl of chips in front of the television, our behaviour seems not to be guided by an intention hence our behaviour is not self-controlled. However, what might be most important in intentional self-control is not *how* we end up doing what we intended, but rather, *if* we end up doing what we intended (Horstkötter, 2009; Kennett, 2013). Absent-mindedly finishing

a bowl of chips is not a problem if I do not mind that I ate lots of chips. It is only a problem if I had the intention to eat a handful and no more. Behaviours that are not under our direct cognitive control are not necessarily a threat to our self-control, and can also support our intentional control. Many of our intentional behaviours do not require much cognitive control, but happen almost automatically, in a blindly habitual way: making tea, brushing one's teeth, driving and typing. Recent work in social psychology, especially the dual processing theory, has shown us two things. First, that our behaviour does not need to be under cognitive control to count as intentionally self-controlled, and second, that cognitive control can sometimes hinder intentional self-control (Kennett, 2013; Stacy & Wiers, 2010).

According to the dual processing theory, our behaviour is the outcome of two different systems of information handling (Chaiken & Trope, 1999; Kahneman, 2003; Masicampo & Baumeister, 2015; Strack & Deutsch, 2004). System 1 involves fast, spontaneous processing that is easily accessible. It strongly relies on intuition, association, and emotions. System 1 is triggered by sensory cues: things we see, hear, smell or feel. For example, when I arrive at the train station and notice a person with grey hair and a stooped posture standing in the ticket queue, this may activate a concept I have of elderly people. Based on previous experiences, I may associate elderly people with being slow and annoying when you are in a hurry. As a consequence, I might choose another line to queue in. This decision to change queues might happen in a split second, and outside my conscious awareness. Further, when I need to make my decision, it is not really important if the elderly person in question is indeed slow. My assessment is made based on an association that occurs automatically rather than reasoned deliberation.

In time-pressured contexts, such as preparing to board a train, it is often more efficient to rely on system 1. That way we can make a quick decision based on limited information. However, sometimes accuracy is important: we may need to know, to continue the example, whether or not the person with grey hair and poor posture is in fact elderly and indeed slow. In these kinds of cases, system 2 is activated. System 2 involves a more cognitively controlled, but slow and laborious mode of information processing. In system 2 processing, the reliability of the assumptions becomes more important. We weigh the pros and cons of behaviour, and

we try to form knowledge about the value and probability of different outcomes. When we come to a decision, an intention for behaviour is formed. In system 1 on the contrary, behaviour can be activated without a conscious intention (your hand absent-mindedly moves to the drink that is offered to you). System 1 is sometimes referred to as implicit cognition, while system 2 refers to explicit cognition. In many cases system 1 and 2 can come to the same conclusion (in line x is an elderly person, who is slow, so it is better to choose line y), but will do so using different modes of information processing.

System 2 relies on input from system 1. Perceptual cues and levels of positive or negative arousal from system 1 will be taken into account by system 2. For example, when I get offered a job as an accountant in a facility for elderly people, system 1 might quickly react: 'Oh no, annoying, slow, elderly people, I do not want to work there'. Through system 2 I will assess if elderly people are really slow, if slowness is as annoying as I initially think, or if it is only annoying when you are hurrying for the train (the environment where I usually meet elderly people). I will also assess if the benefits of having a job outweigh any negative affect I might feel when working around elderly people. System 2 is responsible for our conscious judgements and attitudes, as well as the truth of our assumptions, expected outcomes and long term perspectives.

Although both systems mostly work in parallel, there is an asymmetry between them: system 1 is always available, while system 2 can be unavailable when it is depleted. System 2 draws on limited cognitive resources; it is laborious and cognitively expensive (Baumeister, Bratslavsky, Muraven, & Tice, 1998; Vohs et al., 2008). These cognitive resources can get depleted because they consume so much energy, similar to how muscles can get tired when we use them a lot. Baumeister calls this ego-depletion. When system 2 is depleted, it works less effectively, and can become unavailable. When System 2 is unavailable, we have to fall back to system 1, even when that is not the optimal system in that particular situation. System 1 is always available because it does not depend on limited resources, and can therefore operate under sub-optimal conditions. Which system we use is not a deliberate choice, but happens largely unconscious and as a response to our internal and external circumstances. We have seen that many of our quick, hasty decisions are initiated by system 1. Impulsive behaviour is also initiated by system 1. Another type of

behaviour that falls under system 1 is habitual behaviour. Because system 2 is so laborious and needs many cognitive resources, system 2 frequently outsources tasks back to system 1. One of the roles of system 1 is to preserve system 2, so it can be accessed when necessary. Some decisions (say, which job to choose) are more important than others (e.g. which queue to choose), and when we are faced with important decisions, we need to be able to access system 2. To preserve system 2, we form habitual behaviour. Habit formation occurs when an outcome of system 2 is confirmed and outsourced to system 1 on multiple occasions over time. For most people, for example, morning rituals proceed near-automatically, without the need to ask *will I get dressed first, or will I have breakfast first?* According to the dual-processing model, both systems of processing information have their own role in guiding our behaviour (Strack & Deutsch, 2004). Our self-control can fail when we use the wrong system in the wrong situation. We can, for example, errantly use system 1 instead of system 2. This would be the case if I were to let my irritation about the slowness of elderly people in public transport be decisive in declining an otherwise perfect job. We can also errantly use system 2 instead of system 1. An example of this kind of misallocation is a hurdle racer, who, after a devastating prior loss, suddenly starts to contemplate every step he takes, rather than trusting the skilled habits he has cultivated through intensive training.

This elaborate dual-processing model of the role of desires and judgments in self-control highlights a specific way in which self-control can fail. The dual processing model outlines how, in an ideal situation, system 1 informs and supports system 2. System 1 informs system 2 by alerting it to cues and their saliences, and it supports system 2 by habituating its deliverances. When system 2 is unavailable due to depletion, or when we are in a stressful situation where we need to decide fast, system 1 guides our actions. However, system 1 can also distort system 2 by providing it with too strong negative or positive arousal, or by habits that have become dysfunctional and we fail to bring them back under the control of system 2.¹ System 2 can also distort system 1 by overthinking rehearsed, functional behaviour. System 2 can also fail due to depletion.

¹ Kahneman has outlined that we can also cultivate our use of system 2. System 2 can influence learning and unlearning of habits in system 1 (Kahneman, 2003).

In this section, I have described intentional control – doing what one intended – as the first level in our hierarchy of self-control. Intentional control can be delegated to system 1, as long as one ends up doing what is intended. For example, we often do not remember whether we scanned our public transport card before boarding the train, we did it habitually, absentmindedly, but we did what we intended. Habitual behaviour can be a way to end up doing what one intends more efficiently. Responding to sensory cues can be an efficient way to respond when system 2 is depleted, or needs to be preserved, as long as the resulting behaviour does not conflict with our system 2 evaluations.

Being able to do what one intended is an important prerequisite for any exercise of control (Kennett, 2001). According to a common understanding of self-control, forming an intention and acting on it is all that is needed for self-control. In the next section, I will argue that intentional control is not sufficient for self-control. As I will describe next, people can act intentionally, yet fail at another level of self-control.

3. Instrumental self-control and reaching one's goals

In the previous section I described how self-control is necessary in order to act in accordance with one's intentions at any given moment. Successful self-control is often identified with successful intentional control. If I act according to my intentions at different moments in time, I act in a self-controlled manner. However, there is an important diachronic aspect to self-control. Self-control is not merely about acting intentionally at different moments, but acting consistently over time in order to reach one's goals. What matters is not only whether we control our every action, but whether we are able to reach the goals we set for ourselves (Horstkötter, 2009, 22).

Instrumental self-control is the ability to co-ordinate an often complex series of actions over time in order to achieve a goal. In order to achieve long term goals, people need to be able to regulate their actions over an extended amount of time (Kennett, 2013). The exercise of intentional self-control does not necessarily result in instrumental self-control. We can have a goal to pass our exam. The classical image of loss of self-control is that we intend to study every day, but that due to temptations

we go to the movies instead. However, we can also intend to study the weekend before the exam, only to find out that this was not enough time to study, and we fail the exam. In that case, we do what we intend, but we fail the exam because we did not plan well enough. One can feel in control of one's behaviour at different moments in time, yet not end up reaching one's goals. As Meyers (1989) points out, 'living for the moment without a care for the future is almost certain to diminish a person's control over his or her life in the long run.' (117-118).

In this sense instrumental control is very important for normative control, since most of the things we value in life are not easily acquired, but require that we persistently invest in them over a longer time span. The successful pursuit of cherished long-term goals, such as a career, or a family, requires that we consistently make choices in a certain direction. However, we can also pursue goals that are not normative in nature – for example, a career that our parents approve of but that we do not really endorse. Instrumental and normative self-control are thus distinct from one another. I will discuss this distinction between instrumental and normative goals in more detail in the next section on normative control. Behavioural economics uses a purely instrumental, non-normative concept of goals, which focusses on maximising preferences (Becker & Murphy, 1988; Heyman, 2009). Behavioural economics operates on the assumption that in order to have most agency over our lives, we should not make decisions from a local perspective ('what do I want most now?'), but from a global perspective ('What *set* of choices will give me most satisfaction overall?'). For example, if I really like sushi, I shouldn't eat it as often as possible, because I will get bored with it easily (Heyman, 2009). Instrumental self-control is not about what one should do in this moment, but what one should do in this moment to maximise the outcome of available choices. For example: how much can I party at the weekends without jeopardising my job? What work-life balance do I need to successfully complete my PhD? Which frequency of sex will maximise the quality of my orgasms? The self-controlled person from the perspective of behavioural economics is someone who thinks carefully about which actions serve her desires *overall*, and in doing so maximises her preferences. She is instrumentally self-controlled.

Instrumental self-control takes long-term perspectives into account. In contrast, while intentional control can align with long-term perspec-

tives, it can also conflict with them. Behavioural economics has highlighted one source of conflict between intentional and instrumental control, a phenomenon known as ‘temporal discounting’. Research has shown that rewards that are available now tend to attract a higher salience than future rewards. Since the future is uncertain, in many cases it is best to choose sooner rewards over later rewards. If I can choose between 100 euro’s now or 100 next year, it is better to choose 100 now. So there is a rational way to discount the future. However, research in behavioural economics show that this discounting of the future can also be irrational. When rewards become available, they tend to be extra salient. This extra salience can lead to an evaluative illusion in which more proximate, smaller rewards suddenly seem more rewarding than the larger later goods. Due to this evaluative illusion, a judgment shift occurs in which we decide that the currently available reward is more valuable than the future, larger reward (Ainslie, 2001). This loss of self-control is distinctive from a temptation, it is a judgment shift. So we act intentionally, on our best judgment, only our judgment does not reflect our best diachronic interest. If two options are in the future (one nearer by than the other), we can make a rational calculation about how much we should discount the future, and what the greater good is. However, when one option becomes directly available and the other is still in the future, we tend to reevaluate our judgment in favour of the option we judged less favourable.

Take, for example, a man who wants to buy a new phone. He makes a prior assessment of the available phones, and judges that he prefers the iPhone over the new Nokia. Although the Nokia is cheaper, and will be released earlier, the iPhone possesses more features that are desirable to him. However, when the new Nokia is released, the man has yet to save enough money for the iPhone. Instead of waiting until he can afford the iPhone, he sees a new Nokia in a shop window, his assessment of the two phones changes, and he decides to purchase it. While the man certainly makes this purchase intentionally, his decision conflicts with his longer-term preferences. He is happy about his choice at that moment, but the choice itself is the product of a judgment shift caused by the salience of the availability. Later he regrets his decision and feels that he should have had more self-control.

Intentional and instrumental control can diverge due to judgment shifts that favour those goods that are immediately available over the long term goods we really want to pursue (Ainslie, 2001). The person who possesses instrumental self-control is especially good at resisting the lure of the now-appeal of certain goods, by remembering and focussing on the relevant facts at the right time (Kennett, 2001, 127).

In this section I have described how agents can fail at self-control despite possessing intentional control. When intentional behaviour conflicts with long-term goals, instrumental self-control is impaired. Instrumental self-control can be impaired due to judgement shifts related to future-discounting. In the next section I will argue that although agents can exercise instrumental control, they can still lack self-control in another important way.

4. Normative control and self-constitution

In the last section I described two situations in which instrumental self-control is relevant. The first is one in which we evaluate what we should do relative to the different options we have, at the time they become available to us. Instrumental control is used here to maximise the satisfaction of our preferences. In this context of preference-maximisation, the goal we try to achieve through instrumental self-control is non-normative. The second situation in which instrumental self-control is relevant is one in which we pursue long-term goals. Here, instrumental control also has instrumental value: it helps us acquire the diachronic goods we want. However, instrumental control is only self-referential: the only thing that matters is that the goal that is set is reached. It is irrelevant as to whether the goal in question is worth pursuing against my normative standard. In this context instrumental self-control can help to secure normative goals, but does not necessarily do so.

When the diachronic goods we pursue are aligned with our values and identity, we also possess normative self-control, and it is then that the full potential of our agency is reached. In section 3. I described a discrepancy between intentional control and instrumental control by illustrating that although intentional control is important for self-control, it is not always sufficient. Sometimes we can act intentionally, yet our actions

go against our long-term interest. In a similar way, we can act instrumentally, yet in a manner that is detached from our normative reasons.

What are normative reasons? Most discussions of self-control focus on what it means to be a rational agent and to be responsive to reasons, as opposed to being controlled by appetites. However, I would like to make a distinction between rational reasons in general and normative reasons. Normative reasons reflect our identity, the person we would like to be and our values. For example, during the Second World War we can have rational reasons not to hide Jews in our house because of the risk it poses to our family. However, we can also have a normative reason to offer shelter to those who need it: because it aligns with our values and who we want to be. Watson (1975) has argued that many things create reasons: opportunities, desires, calculations about the maximising of preference satisfaction, and values. What matters is not so much what the cause of the reason is (values, rationality), but whether we endorse the reasons. For example, if I am hungry, my hunger creates a reason for me to eat. This reason to eat can be perfectly valid. We could even argue that we do not have a reason to eat if we do not have appetite. However, it can also be the case that I do not endorse the reason to eat my appetite creates, for example, because I will meet a friend for dinner in 1,5 hours, or because I have an ascetic ideal to only eat modestly. Not every reason is a normative reason (Horstkötter 2009, 23). When people give us a reason for their actions, we should try to determine whether it is a normative reason or not. To count as normatively self-controlled, it is not enough to do what one wants (intentionally or instrumentally), it is necessary to normatively *want* what one wants. Self-control is not only about control, but also about the self. When our reasons are in line with our values and identity, we act in a normatively self-controlled way.

In the next section I will outline how intentional and instrumental self-control can conflict with normative self-control, and argue that the normative level is the most important level to assess whether or not someone acts in a self-controlled way. Having done this, I will elaborate on the bi-directional relationship between diachronic goods and self-constitution. Living in accordance with one's values creates diachronic reasons, and committing to diachronic projects is importantly constitutive for the self. I will show how identity can be a motivational

force for self-control. But first, I will give some examples of what normative self-control looks like.

4.1. Normative self-control

So what does it mean to exercise normative self-control, or, to exercise self-control through the self? Chang (2014) points out that there are many decisions we have to make in life that we cannot make solely based on a maximization of our preference satisfactions, we have to make a normative choice, we have to make a decision about what kind of life we want to live, and what kind of person we want to be. Chang (2014) describes how she had to choose between a career as a lawyer or a philosopher. Philosophy was her passion, but coming from a modest immigrant family, she thought that pursuing that career was frivolous, and that job security mattered more to her. She described this choice between the two careers as a hard choice. According to Chang, easy choices are choices in which we can quantify the two alternatives and decide which one is quantitatively better. When a competing company offers me the same job for a higher salary, it might be an easy choice: the same job, in a similar company, but with a higher pay. But Chang valued both options: she valued being a lawyer, and she valued being a philosopher.

With hard choices one option is better in light of some reasons, the other better for other reasons, but neither is better overall. However, the choices on offer are not equal either, we cannot just flip a coin, as it does matter what we choose. What makes hard choices hard is that they are qualitatively different, not merely quantitatively different. They are both good choices, they are in the same league of values, yet, they reflect different values (see also Kennett & McConnell, 2013). When we try to make a choice in these cases, we will not find a solution when we balance the pros and the cons of both options. Rather, we have to set normative reasons for ourselves: this is the kind of person I want to be, this is the life I want to stand behind wholeheartedly. Chang described how she initially pursued a career as a lawyer, but noticed that she did not find her career very fulfilling, and she changed her life-plans and became a philosopher. Chang chose her passion over job-security, and this seemed to be the best choice. However, the best choice depends on the person, and the normative reasons they possess. Kekes (2005) gives an example from Edith Wharton's novel *The Age of Innocence*. In this novel an unhappily married

woman, Countess Olenska, falls in love with a young man, the lawyer Archer, who is already engaged. Their love for each other is very deep, true and passionate. They both agree that they would be happier with each other than in their current relationships, such that for these reasons, they believe that divorcing their spouses and running off together would improve their lives in many ways. However, this choice would conflict with another value they each hold dearly. Both Countess Olenska and Archer see themselves as decent people, and take pride in belonging to a community with certain moral standards. Violating these moral standards by getting a divorce and pursuing their love would tear the fabric of their identities and in doing so extinguish that which they find valuable in one another. It would also tear the fabric of the community they value dearly, as well as their family and friends' lives (Kekes, 2005, 78). For these reasons, they decide that the only way that they can love each other is when they give each other up. As Kekes' explains, the ill-fated lovers 'settle for a self-respecting life in which their love has no place. But they have no realistic alternative to that because acting on their love would deprive them of a good life, self-respect, and, therefore, also happiness' (Kekes, 2005, 78).

While their decision procedure could be read as one of preference-maximisation, doing so ignores the fact that their choice only became clear to them once a normative conclusion was reached. They made a conclusion about what kind of person they wanted to be. Because normative agency has a narrative structure, normative agents do not ask themselves: 'what would maximise my preference satisfaction?'. Rather, they ask themselves: 'what would be the best continuation of my life story? Which choice would fit best my self-concept?' (Kennett & Matthews, 2008; McConnell & Snoek, 2012; Velleman, 2006). Living in accordance with one's values means living in accordance with one's ideal of a good life, and the person one desires to be. Living in accordance with one's values creates diachronic reasons, long term commitments. Committing to, and fulfilling diachronic projects, constitutes the person, and shapes one's identity. On the other hand, having a strong identity, a strong sense of self, is a way to exercise self-control. Seeing oneself as a certain person frames our choices and makes us behave in a certain way. Below I will discuss how living according to our values creates diachronic reasons, and how commitment to diachronic projects constitutes the self and hence

enables normative self-control. But first I will discuss that instrumental self-control can also conflict with normative self-control.

4.2. Instrumental control is not sufficient to count as self-controlled

Instrumental control can conflict with normative self-control, because we can commit to goals that are not in line with our values. Take, for example, a young man who has always been a very friendly soul, a pacifist. However, after he is severely bullied and excluded at school, he decides to commit suicide and kill as many of his peers as possible in the act. For months he plans the attack. His behaviour is intentional and instrumental; he is doing as he intended, he is working towards a goal. However, he is not valuing what he wants; the act he is planning is out of character. The fact that he has a reason to act the way he acts does not mean he endorses that desire. The loss of self-control is not with regard to his intentional or instrumental behaviour but with his normative agency. Because he no longer sees a future for himself, he acts deliberately against his values.

Compare this case to someone who strongly endorses the values of white supremacy and the violent practices that are often associated with it. He has endorsed these values for years, and on his own account – he is not brainwashed by his parents or peers. Recently, his worries are increased about the high number of immigrants coming to his country. He is especially worried about Muslims taking over the world. So he plans and executes an attack on a left-wing politician. In this case, one can state that the person does not only act intentionally and instrumentally, but also according to his own values.

While both agents act intentionally and instrumentally only the second agent endorses his action. There is an important distinction between doing what one wants, and wanting what one wants (Frankfurt, 1971). Several authors have argued that in the end, what matters in self-control is not only whether we are able to reach our goals, but that we are able to pursue goals that reflect our value, and who we want to be (Horstkötter, 2009; Kennett, 2001; Watson, 1975; Meyers, 1989; Young, 1986). When the goals we set for ourselves match our values, we are said to exercise normative agency (Horstkötter, 2009; Kennett, 2001).

Although instrumental self-control can diverge from normative self-control, they are often connected tightly in a bi-directional relationship. Liv-

ing according to one's values means committing to certain projects over an extended period of time, and so this requires and informs instrumental agency. Fulfilling projects that are important to us constitutes us as a person, so instrumental agency can support normative agency. I will discuss both of these aspects in more detail below.

4.3. Values create extended diachronic reasons

Values create diachronic reasons. Watson (1975, 215) defines values as 'those principles and ends which [people] – in a cool and non-self-deceptive moment – articulate as definitive of the good, fulfilling, and defensible life'. Reflecting on our values means reflecting on how we want to organise our life, and what kind of projects we want to engage in. Taylor (1989) observes that when we orient ourselves to the good life, we 'determine our place relative to it and hence determine the direction of our lives' (51) Our values propel us into the future (Korsgaard, 1989, 113-4) and generate diachronic reasons (Kennett, 2013). These orientations to the future and diachronic projects are 'inescapable structural requirements of human agency', according to Taylor (51-52).

When I decide that animal welfare is extremely important for me, I will organise my life according to it. I might decide to become a vegetarian, and I might leave my meat-eating partner for an animal activist. I might decide to volunteer at a local animal shelter, and to study politics in the hope that in the future I can make a difference to animal welfare through changes in regulations. This might seem like a radical example, so let us take a less radical one. Take a young woman who comes from a family of science-oriented people, and whose elder sisters both choose science-subjects in high school. When it is her time to choose her subjects, she chooses science-subjects as well, but at the last moment, she changes her mind. Although she always enjoyed most of the subjects in school, she realises that she is truly fascinated by humanities. Although pursuing this interest would mean less status in her family, less job security, and perhaps a lower income, she realises two things: humanities rather than science electives reflect the kind of person she wants to be, and the life that would make her happiest is one in which she pursues her dreams. She believes that being passionate about something will carry her a long way. And it did.

Values and the diachronic reasons they generate shape and coherence in our lives. Reflecting on my values means reflecting on which projects I want to engage in, which relationships I want to get involved in, which talents I want to develop, which interests I want to follow. Reflecting on my values means reflecting on where I want to go to, and how I want to get there. Although instrumental planning plays an important role in normative agency, the scope of planning in normative agency is more encompassing, and has a longer diachronic focus.

The values we hold dearly, values that are essential to our identity, create extended diachronic reasons. Living according to one's values is not so much about reaching a goal, but living a certain life. The diachronic reasons that values create are often called life-plans (Flanagan, 2013a; Meyers, 1989). Life-plans are an answer to the question: 'What do I really want, need, care about, value, etcetera?' (Meyers, 1989, 52). We shouldn't see these plans as too rigid, fully articulated or overly mechanical. Flanagan (2013a) emphasises that a life-plan should not be understood as a blueprint for one's whole life, but rather multifarious projects and plans nested together in various, possibly ever-adjusting, relations of priority and expansiveness. Meyers (1989) stresses that life-plans are flexible, dynamic, partly articulated, sometimes fine-grained but sometimes vague, and are responsive to changing circumstances (55; 70). Life-plans are contextual: they take into account our specific physical properties and possibilities. Life-plans are developed in dialogue with the people who are important to us (Meyers, 1989, 80; Young, 1986, 7).

Life-plans complement and motivate intentional and instrumental control. Life-plans enable people to get more out of life than a mere satisfaction of desires would do or mere instrumental planning would (Meyers, 1989, 49). When I bet on horses, I do it to make as much money as possible. I am not loyal to a certain horse, but pick the horse I think will have the most chance winning. When I support a football team however, I do not choose another team each season or each match. I choose a football team whose emblem and club mentality reflect my values, as well as my geographical or familial identity. I do not change teams willy-nilly, but commit to them over a longer period of time. Life-plans are not about optimizing pleasure, but committing to something we find valuable. Life-plans enable us to acquire those diachronic goods that make our lives meaningful (Kennett & Matthews, 2008).

Authors like Velleman (1991), Williams (1981) and Kennett (2013, Kennett & Matthews, 2006, 2008) outline the intrinsic importance of diachronic goods for a good life. ‘Flourishing lives’, Kennett and Matthews (2006) state, ‘are marked by such things as relationships which stand the test of time. They are marked by challenges and also by the rewards that accrue to a person who has stuck at a task and completed it. (...) though good lives may come in many different forms they all have significant *diachronic value*.’ The good life is about nurturing the things we value, watching them grow while we devote our time, attention, and energy to them to bring them to fruition. These kinds of long-term engagements and relationships make our lives valuable and give us a sense of meaningfulness. These commitments and projects do not need to be high-brow like writing a novel or doing a PhD. They can also mean supporting a football club through good and hard times, staying with loved ones when they experience illness or hardship, or meaningfully participating in the lives of one’s children.

4.4. Diachronic goods and self-constitution

The intrinsic value of diachronic goods lies in their close relationship to our identity. The extent to which we are able to live up to our values over time also unifies us as agents by creating an integrated personality (Kennett & Matthews, 2006, 2008; Meyers, 1989, 59). Committing to and fulfilling projects that we value help to constitute *character* (Williams, 1981). Normative agency is thus not only valuable because it helps us achieve our goals better, it also provides a ground for our moral personhood, and in that sense it is intrinsically valuable (Young, 1986, 109). ‘A life plan is not merely a list of projects, a schedule for undertaking them, and a set of strategies for carrying them out. Implicit in this agglomeration of projects is a conception of a desirable personality’ (Meyers, 1989, 60). Our very identity is tied up with the values that give structure and direction to our lives (Taylor, 1989). A long term project is more than just goal-setting; it also provides us with roles. These roles are crucial for our sense of identity (Kennett & Matthews, 2006). Losing these projects and roles removes meaning from our lives. For example, when I lose my job, I may lose a part of my identity: that of provider for my family, as well as the identity my profession afforded me.

Life-plans are not a blue print the person has of his or her life, rather the relation between self and diachronic plans is reciprocal and dynamic. Our life-plans stem from our sense of self, but as we flesh out our life plans, as our plans succeed or fail, so too do we flesh out our self-concept. We have certain ideas of what we want in life, but we are also dependent on which opportunities arise, and how our core-projects work out. When the aforementioned young woman decided to trade her science-subjects in high school for humanities subjects, she did not have clear a picture yet that fifteen years later, she would become a bio-ethicist and philosopher. She first studied the humanities with a strong interest in philosophy and research until, through luck, she found work in a bio-ethical research field, before an opportunity came by to pursue a PhD in empirical philosophy. The development of her life-plan and the constitution of her self was a dynamic process between the opportunities that arose, her personal values and interests, and the success and failures of the different projects she undertook.

Life-plans help us to test and refine our self-concept. ‘Without life plans (...) the self-concepts against which people would check their decisions would be untested and, for that reason, tenuous.’ (Meyers, 1989, 51). At the same time, as our insight into our self evolves, so do our life-plans.

4.5. The motivational force of the self

Normative agency, in the form of self-constitution, is an important form of self-control. How? As Kennett has argued, ‘One’s diachronic plans, projects, and commitments provide a structure that obviates the need for constant decision-making and choice.’ (Kennett, 2013, 154). People who are unified are more often able to act on their values without incurring persistent regrets or hesitation (Meyers, 1989, 73). Through the formation of a self, we experience less battles of the will (Horstkötter, 2009). ‘Those who determine who they are, control what they do. In this sense, self-control can also consist of self-constitution. (...) Self-control becomes a matter of a person’s basic constitution rather than of her strongest will.’ (Horstkötter, 2009, 112-3). When we see ourselves as a certain kind of person, some paths or actions simply cease to be options. There is also empirical evidence for the motivational force of identity, which I will discuss in chapter 4.

We can actively shape our self-concept in order to exercise self-control and start thinking about ourselves as a different type of person. Velleman (2002) gives the example of a smoker who thinks of himself as a non-smoker. Every time craving occurs, he thinks: ‘I am a non-smoker now, and for a non-smoker, this is not an issue’ (Velleman, 2002). Miller (2003) labels this strategy ‘living as if’. This strategy involves impersonating the person you want to be. He states that it can be a very effective form of self-control. I will discuss these techniques in greater detail in chapter 4.

Now that I have established different levels of self-control, it will now become clear that the ways in which self-control can be exercised, as well as ways in which it can fail, are also multiple. Below I will outline a range of threats to self-control, and the capacities needed to exercise self-control.

5. Some capacities for self-control

The different levels of self-control I have outlined are distinct: they can be exercised in different ways and for different reasons. However, they also rely on each other and involve shared capacities. In this section I will highlight two capacities that underlie all three levels of self-control: attention and habit formation. I will discuss these two capacities because they play a prominent role in losses of self-control in addiction.²

5.1. Attention

Most models of cognitive control start with attention, ‘because noticing something is by definition the first stage in information processing’ (Baumeister & Heatherton, 1996, 4) When we notice the cue that triggers us, we can prevent the associated chain of behaviour from ensuing. Effective self-control often seems to involve intervening as early as possible, and for this, attention is very important. When I notice that I am falling in love with my charming colleague, I can redirect, narrow or expand my attention every time he enters the room (Kennett, 2001, 136). For example, I can redirect the focus of my attention to my work, or to

2 Although other capacities like memory, learning and motivation also play a prominent role in losses of self-control in addiction, to limit the scope of this thesis I extensively focus on attention and habit because these played an important role in the stories of the respondents in the qualitative study. So this theoretical focus is informed by the qualitative data I will discuss later on.

the picture of my husband and children on my desk. I can narrow my attention to one of his features I dislike, such as the bald spot on his head. Or I can expand my attention to the bigger picture, by considering (for example) how acting on my romantic feelings will affect my husband and children, or my work.

We saw before that one of the threats to instrumental agency is an evaluative illusion which makes proximate, smaller rewards seem the greater good. At these moments, moments high in ‘now-appeal’, it is important to keep one’s attention focused on the relevant facts (Kennett, 2001, 127). Baumeister and Heatherton (1996) call this *transcendence*. Transcendence means focusing awareness beyond the immediate stimuli, broadening one’s attention, seeing an action in the context of more distal concerns. This change in attention helps us to delay gratification. This technique is also, to some extent used in intentional control, when we compare the action triggered by the cue with our intended action. However, in instrumental control, the need for the technique of transcendence is higher because the set of actions we are required to oversee are more complex. Attention plays an important role in instrumental control: being focused on the right reasons, at the right time. If the aforementioned gentlemen who purchased the Nokia had reminded himself of his reasons to buy the iPhone, the now-appeal of the Nokia would have disappeared. Attention is also important in normative self-control. Oyserman (2015) for example, describes how successful self-control relies on perceiving our desired future self as important in the current situation. I will discuss this later in Chapter 4 in more detail.

5.2. *Habits*

Habits can support all three forms of self-control, and manifest themselves slightly differently on all three levels of the control hierarchy. For example: as a mechanical action in intentional self-control, as a skill in instrumental self-control, and as a character trait in normative self-control. I will describe all three forms briefly below.

I described earlier how in intentional self-control, functional habits can free up system 2, so that system 2 will not become depleted and is available when needed. I also described how dysfunctional habits threaten intentional control – by guiding our actions absent mindedly – as well as

how hard dysfunctional habits are to break because they are not under the control of system 2.

Habit formation is also very important for instrumental agency, and fulfilling one's life-plans. When I am doing a PhD I have to create habits to make sure I can devote enough time to my thesis, so I will not get burned out, and in doing so preserve a good work-life balance. Good habits regulate our internal and external circumstances in such a way that they provide an optimal environment for reaching our goals. Habits help in realizing long-term plans by preserving our system 2 capacities, but, more importantly, by ingraining our values in our everyday life.

Habits also support self-constitution and hence normative self-control. As Aristotle points out in his *Ethica Nicomachea*, one becomes an honest person not by being honest once in a while, but by being honest on every available occasion. Through this process honesty becomes a habit, a virtue, a character trait, and next time we face a situation where honesty is required, we automatically act honestly: it is not a battle of the will anymore, but an expression of our character. Lewis (2015) states that when we are asked what someone is like we mostly describe their most remarkable habits. Habits thus help to form our identity.

In Chapter 2 it will become clear that it is precisely these two capacities – habits and attention – that are affected in addiction.

6. Threats to self-control and ways to exercise self-control

In distinguishing different hierarchical levels of self-control, it becomes clear that self-control can be exercised for different reasons: to resist temptation, to reach a goal, or to shape one's sense of identity. In distinguishing the different levels of self-control it also becomes clear that there is more than one way to exercise self-control, and more than one way in which self-control can be threatened. If we are predominantly interested in intentional control, we will focus on the capacities important for intentional self-control, and the conditions that threaten it. If we are mainly interested in instrumental self-control or normative self-control, we will focus on different capacities and threats. In this section I will distinguish three ways in which we can exercise self-control: synchronic,

diachronic, or through the self. First, scholars who are mostly interested in intentional self-control often understand self-control as synchronic self-control or exercising self-control using willpower. In contrast, those who are mostly concerned with instrumental self-control often understand self-control as diachronic self-control or planning. Finally, people who are mostly interested in normative self-control look at how self-control can be exercised at the level of the self. However, the ways in which we can exercise self-control are not restricted to a certain level of the hierarchy I have proposed. When our intentional control is threatened by temptations, we can resist them by using force of will-power, or by planning ahead so the temptations will not occur. Similarly, exercising diachronic self-control can function to both help us reach our goals and constitute our identity. Let us look more closely now at the different ways in which self-control can be exercised and threatened.

6.1. Synchronic self-control or strength models of self-control

Traditionally there has been a strong focus on unruly desires as the main threat to self-control. The main strategy proposed for counteracting unruly desires seems to be strength of will, or willpower. This standard view reflects most of our daily experiences with self-control: you have a deadline to meet at work, but you keep checking your email or social media. You stay up late, although you made a resolution to go to bed earlier to feel less tired in the morning and being more productive at work. You plan to go for regular jogs, but you keep postponing it. These are situations in which we typically perceive ourselves as being weak-willed, and our self-control is relatively easily restored with will-power.

This view has led to strength models of self-control (Baumeister, Vohs, et al., 2007; Horstkötter, 2009). On these models, self-control is equated with strength of will-power: people who act self-controlled are strong-willed. Although this is a useful way to understand how we can exercise self-control when faced with temptation – so-called synchronic self-control – there are two reasons why a strength model of self-control is limited. First, a strength model focused on unruly desires provides an incomplete picture of the factors that can pose a threat to our self-control (Kennett, 2013). For example, I can fail my exam because I did not study enough because I preferred watching television. In that case unruly desires threatened my goal. But I can also fail my exam because I sim-

ply started studying too late; in this case, bad planning threatened my self-control. Or I can fail my exam due to unexpected internal or external factors, like having a black-out during the exam (internal), or my parents divorcing (external). In none of these cases do unruly desire play a role in disrupting my self-control.

The second reason why focussing on strength of will provides a limited understanding of self-control is that will-power seems to be a limited resource. Baumeister and colleagues have shown that people perform worse at a self-control task when it is preceded by another self-control task, rather than a neutral task (Baumeister, 2003; Baumeister et al., 1998). Will-power can be depleted by a range of factors: fatigue, strong desires that have to be suppressed, stress, and even a lack of glucose (Gailliot et al., 2007). For example, when I leave my house in the morning, refreshed and ready for the day, the smells of a bakery cause my mouth to water, but are more easily resisted than the pizzeria I come by on my way back from work when I feel tired. Relying solely on will-power when exercising self-control is a doomed strategy because it is a depletable resource (Levy, forthcoming; Lewis, 2015).

It seems likely that people who are good at self-control prevent temptation rather than try to resist it (Kennett, 2013). There is evidence that people who are high in self-control, so called trait self-control, deploy diachronic strategies to avoid temptation, rather than possess high will-power strengths (Levy, forthcoming). A beeper study let subjects report their temptations at regular intervals. Those who score high on self-control experience less temptations in their everyday lives (Hofmann, Baumeister, Förster, & Vohs, 2012). Although this could simply mean that people we see as having high self-control simply do not have many distracting desires, another study found evidence that this group skilfully avoided unwanted desires. When presented with the option of doing a task in a boring, non-distracting environment or in an appealing but distracting environment, people with high trait self-control chose more often the non-distracting environment (Ent, Baumeister, & Tice, 2015). However, this study pointed out that will-power was still an important source of self-control: it was used to apply the pre-emptive strategies. Will-power was thus used strategically and briefly, and so was not depleted as easily.

With diachronic strategies we can either prevent the desire from occurring, or we can shape our future circumstances in such a way that it is harder for us to act on our desires when they occur (Kennett, 2001, 134). For example, when I go grocery shopping when I am hungry, I end up buying way too much food, and unhealthy food at that. My internal state of hunger threatens my self-control. I can deal with this threat by making sure that I eat a banana before I go shopping if I am hungry. In doing so, I prevent myself from getting into a situation where I am tempted to buy too much food. Alternatively, I can take a limited amount of money with me to the shop, so I cannot act on my desire to buy too much food. Or I could make a bet with my partner that I will only buy the necessary things, and in doing so raise the incentive to act with self-control. There are large individual differences in the extent to which people have developed their strategies for diachronic self-control (Horstkötter, 2009; Mischel, Shoda, & Peake, 1988).

6.2. Diachronic self-control or planning models of self-control

We saw above that in the battle against unruly desires, it might be best to avoid the desires altogether rather than battle them with an uncertain outcome. There is another reason why diachronic strategies are important in self-control: unruly desires are not the only, or even main, threat to self-control. Other internal and external states can threaten our intentional control as well, but there is considerably less focus on these failures of self-control in the literature (Calhoun, 2008; Kennett, 2001). Let's return to intentional self-control, or the control that is achieved when actions conform to intentions. We saw that intentional control can be threatened by goal-discordant temptations. I will outline two more ways in which intentional control can be threatened: internal and external states.

Consider the following example. I intend to call my mother-in-law to wish her happy birthday. When I decide to watch a nice movie on television rather than call her, I fail to act on my intention due to competing desires. This is a case of goal-discordant temptations. However, I could also intend to call my mother-in-law, but just when I try to call her, my phone rings and a friend calls me with a disturbing story, and she needs some comforting words. By the time I am finished talking to my friend, it is too late to call my mother-in-law. Or I intend to call my mother-in-law,

but at that moment the fire alarm starts ringing, I get distracted and I forget to make the call. In both cases I fail to do what I intended because of external factors. My intentional behaviour can also be disturbed by internal factors. Just before I pick up my phone to call her, I remember a nagging comment she made last time, and I am afraid she will say something that will upset me, and I end up not calling her. Or when I call her, her new partner picks up the phone, and I always feel shy towards him, so in an impulse I hang up. In these cases I fail to do what I intended to do (congratulating my mother-in-law) because of my internal states: anxiety or shyness. In the same way as internal and external states threaten intentional control, they can also threaten our instrumental and normative self-control.

To minimise the negative effect of external and internal states on my self-control, I can take precautions. This approach to self-control incorporates diachronicity, and emphasises strategies rather than strength of will. If I know that calling my mother-in-law can fail due to anxiety and stress, or because of the stress of everyday life, I can choose to send her a card instead. I have to plan this a few days in advance, but it is less likely to fail. I could also put my phone on silent to make sure I do not get any messages or phone calls on the evening I want to call her to make sure I do not get distracted. To return to an earlier example, if the man who bought the Nokia instead of the iPhone knew he was particularly vulnerable to now-appeal, he could have made sure he couldn't access the money he saved until the new iPhone was released. Diachronic strategies take into account the external and internal factors that threaten our self-control.

6.3. Identity-models of self-control

So far I have distinguished different ways in which we can exercise self-control. Firstly, we can exercise synchronic self-control. We exercise synchronic self-control when we face temptations, which are for the most part countered using strength of will. Secondly, we can exercise diachronic self-control. Diachronic self-control is about planning: we can plan our future so that temptations will either not arise or we cannot act on them. But, as I described in section 3, there is a third way in which we can exercise self-control: through the constitution of our

identities. However, this normative way to exercise self-control can be threatened by numerous factors.

One way in which normative self-control can fail is when people stop caring about their goals for various reasons (Horstkötter (2015; 2009). Just like intentional and instrumental self-control, normative self-control can be threatened by internal and external factors. We cannot always control our environment or our internal states. Hostile social environments undermine normative self-control. External threats like poverty, oppressive social values, and a lack of opportunities can cause people to give up forming certain intentions that are important to them. The same counts for internal threats like fatigue, depression, self-loathing, apathy, or lack of confidence in self-efficacy (Calhoun, 2008). When values seem unachievable, people stop trying to act on them. They either still engage in short term goal-setting that ceases to reflect their values and identity, or they start to focus more on the here and now (Kennett, 2013). For self-control, people need social and psychological resources to control their internal states and their environment.

7. How to judge whether someone fails at self-control?

People can exercise self-control on different levels: intentional, instrumental and normative. When we want to determine whether someone loses self-control or not, we need to specify what kind of self-control we are interested in, what capacities are impaired, and what the main threats to self-control are. Let us look at an example to see how the hierarchical levels of self-control can help us determine whether, and at what level, someone loses self-control.

During the soccer world cup of 2006, Italian player Materazzi provoked French player Zidane, making a childish remark about his mother or sister. This resulted in Zidane head-butting Materazzi, leaving the field with a red card, and France losing the final. No-one can claim that the head-butting was not intentional behaviour: we see Zidane walking towards Materazzi, asking him to repeat himself, and then head-butting him. Yet, we are inclined to say that Zidane did lose control. Until that time Zidane had been one of the stars of the tournament. In that same match, he took the most nonchalant penalty ever taken in a world cup,

thus showing his superior soccer skills. One explanation is that Zidane lost control not over his intentional behaviour but – plausibly assuming his goal was to win the world cup – over his instrumental behaviour. This loss of control was caused by an internal state: short temperedness.

When asked about the incident, however, Zidane said that it is impermissible, from the perspective of his cultural background, to tolerate an offensive slur against a female member of one's family. Although Materazzi claimed he just made a very common insult, Zidane concluded, on the basis of his cultural values, that his retaliation was justifiable and was not just a case of juvenile provocation. When Materazzi pulled Zidane's shirt earlier in the game – another provocation – Zidane jokily remarked that if he wanted his shirt so much, he could have it as a souvenir after the game. In this instance, Zidane remained in instrumental control. However, the second incident was not just a matter of provocation, but an assault on his values and identity. In light of Zidane's goal to win the world cup, he lost instrumental control. Yet insofar as his defense of his family's honor reflected his values, it looks as though he nonetheless maintained normative self-control.

However, when he left the field, Zidane did not do so with his head raised high – rather, he was cringing and he seemed angry with himself. If Zidane thought that he adequately solved the situation, and that relinquishing the world cup showed his devotion to his family, he would have left the field triumphant. But he did not. This suggests that, according to his own standards, that he did lose self-control. So what kind of self-control did he lose? When determining what kind of person he wanted to be, for Zidane it was both important to be a loyal member of his family, and to be a great soccer player. Winning the world cup was not only an instrumental goal for him, but was part of one of his core-projects – it defines who he is. When this normative goal conflicted with his other normative goal of defending his family honor, he failed to solve the conflict adequately, due to his short-temperedness. He could have defended his family after the game, and his revenge on Materazzi would have been sweeter if it did not have a negative influence on the soccer match. In this interpretation, Zidane failed in normative self-control. He failed to constitute himself as an exemplary soccer player, and it seems that this might have been his most important value.

This example shows that self-control has different levels in which it is exercised for different goals: resisting a temptation, reaching a goal, or living according to one's values. When considered in isolation from the agent's values, intentional and instrumental control can appear to be genuine self-control (Kennett, 2001, 128). Evidence that a person acted on the basis of reasons is enough for some onlookers to attribute them self-control and hence responsibility. This is because acting on reasons suggests that the person acts in a controlled way. However, not every reason is a normative reason. Desires can generate reasons, opportunities can generate reasons, but only when acting on those reasons does not conflict with a person's normative reasons can we say that an agent is truly self-controlled in a normative sense (Watson, 1975).

The above example also shows that when we try to determine whether someone has lost self-control or not, we cannot just use an 'assorted grab-bag of principles of choice and action' (Young, 1986, 34). When we assess whether or not someone lost self-control, we cannot study the mechanisms of self-control in isolation from the person and his or her social relationships, environment and self-narrative. We need to know something about the context in which the person makes the decision.

Let us return to the example of Zidane. When we assess whether or not Zidane lost self-control, it is not sufficient to look at the incident itself, we need to know something about his life-story. Zidane grew up in an impoverished neighborhood in France as the son of Algerian immigrants. He learned to play soccer on the street, and soon excelled at it. His professional debut was at the age of 17, and since then his career has skyrocketed: he was named one of the best living soccer players in his time. Soccer was not just a hobby or a job for him; it was a way to escape the slums of Marseille, and to escape the stigmatised identity of a son of Algerian immigrants. Soccer was a way to be a role-model for French-Algerian youth. Both proud of his roots and proud of his soccer skills, we can see how both identities conflicted in the world cup incident.

So if both defending his cultural values and winning the world cup were equally important goals for him, why was he so annoyed when he defended his family at the expense of a red card? To answer this question, we need to look at his life-story again. Zidane had announced that he would retire after the world cup of 2006. Instead of ending his career in glory, it ended in a red card and his team losing. His career and his

exemplary status has been stained by that crucial moment in which he responded aggressively to a provocation. The story of Zidane's soccer career ended in a way he did not like. The importance of that red card can only be understood in the light of the broader story of his career, the tournament, and his life. If the same incident had happened in another match, we might have judged differently about whether or not Zidane lost normative self-control.

To determine whether someone succeeds at normative agency, or to live the life they value, and be the person they value being, we need to look at their biography, at the social and physical reality that formed their values and intentions.

8. Conclusion

In this chapter I argued that to understand how self-control fails, we need to specify what kind of self-control we are interested in. The type we are interested in will shape our focus on what kind of capacities are important, and what are the main threats to self-control. In line with work of Kennett (2001, 2013) and Horstkötter (2015; 2009) I distinguished three levels of self-control: intentional, instrumental and normative. I showed that each type of self-control is exercised for a different reason: to do what one intended, to reach a goal, or to live according to one's values and identity.

Although the different levels of self-control support each other, they do not necessarily add up. Intentional control is not sufficient for instrumental control, since our intentional behaviour can be in conflict with our long-term goals. In the same way, instrumental control is not sufficient for normative control, since agents can pursue goals they do not really value. People can possess intentional and instrumental control, they can act on reasons, yet, they can act on the wrong reasons. To judge whether someone has self-control, the main focus should be if someone is living the life she values, and is the person she values to be. We cannot judge whether someone has lost self-control by solely looking at the capacities they possess. We need to look at their self-narrative and self-concept as well.

To assess whether a person has normative self-control, knowledge of the autobiographical context is essential. As we saw in the examples of Zidane, the love between Countess Olenska and Archer, and Chang choosing whether to be a philosopher or a lawyer, normative decisions are not made in isolation. Self-control is a complex, diachronic, embodied, and social process. Self-control is not only about capacities, but also about opportunities, and, more importantly, about the self.

To make judgments about self-control we need to understand what the agent believes, and what led her to form those beliefs. We need to understand what image the agent has of a good life, of her identity, her life story. These beliefs, images and stories are formed within someone's physical and social reality. When we try to understand self-control, it is not enough to look at isolated capacities of self-control such as will-power, and diachronic strategies. If we want to understand self-control, we have to look at the person, a self-control encompassing the self.

When we focus primarily on models of cognitive self-control, we miss many factors that are important in self-control and its failures. We miss the normative deliberations that are undertaken in an autobiographical context, and we miss most of the internal and external threats that make people lose concern about their goals.

Throughout the thesis I will show how this hierarchical account of self-control can enlighten the current debate on addiction and self-control.³ In the next chapter I will review the current theories on addiction and self-control. In doing so, I will show how the above hierarchical account of self-control reveals important hiatuses in the current literature on addiction and self-control.

3 A note on the scope of this study: this thesis seeks to examine the critical losses to self-control brought about in addiction. The framework that is used for investigation this issue is a hierarchy of self-control with normative self-control at the top. The notion of normative self-control used here surely has connections to autonomy – it is necessary if the agent is to enjoy autonomy. But in this thesis I will focus on the narrower notion of normative self-control rather than the broader notion of autonomy, since a central claim of the thesis is that loss of self-control in addiction is not primarily about failures of willpower that occur at the point of action and this is better addressed by looking at ascending levels of self-control. There are many other conceptions of autonomy extant in the autonomy literature which are also relevant to the problem of addiction, but a full consideration of them is outside the scope of this thesis. An excellent article on addiction and autonomy is: Levy, Neil. 2006. Autonomy and addiction. *Canadian Journal of Philosophy* 36: 427–447. Or: 1. Mackenzie, Catriona. 2014. Three Dimensions of Autonomy. In *Autonomy, Oppression, and Gender*, 6:15–41.

CHAPTER 2. SELF-CONTROL AND ADDICTION: A REVIEW OF THE CURRENT LITERATURE



1. Introduction

In the previous chapter, I distinguished three levels of self-control: intentional, instrumental and normative. Intentional self-control is about doing what one intended. Instrumental self-control is about reaching one's goals: concerns the acquisition of larger, temporally distant rewards over smaller, more proximate ones. Normative self-control is about living in accordance with one's values and being the person one wants to be. Additionally, I argued that in case where we want to determine whether or not an agent exercises self-control, the third level of the hierarchy, normative self-control, should be the ultimate arbiter.

Although the three levels can support each other, they do not necessarily entail each other. Having intentional control does not guarantee that we use our intentional control to support our normative self-control. Although the levels partly rely on the same capacities, they are separate forms of self-control. A failure on one level does not necessarily impair all the other levels, but can be compensated for on another level. If self-control is impaired on one level, it can be restored by a level that is above or below that level. Self-control can be restored in both a bottom up and top down manner, no matter which level it is initially impaired. To study these levels in isolation will not provide enough information to judge whether an agent has lost self-control or not. We can only judge whether an action is self-controlled when we take into account all three levels of self-control.

Although all three levels must be taken into account to determine how self-control fails, the account I proposed is nonetheless a hierarchical

account: at the top of the hierarchy is normative self-control. The ultimate measure of whether an agent has self-control is not whether they succeed in acting intentionally or in an instrumentally rational way, but whether they possess normative self-control: if they are able to live the life they value. As Horstkötter puts it: ‘the difference between the person who successfully exercises self-control and the person who fails to do so is a normative one. It refers to whether or not a person is able to justify her behaviour and to consider it adequate given her own goals and values’ (Horstkötter, 2009, 143).

An agent can act in a controlled manner, yet not in a way that reflects their values or the person they value being. On the other hand, one can act in an automatic or habitual way that is nonetheless in line with their values. What makes actions self-controlled is not whether they are under conscious control, but whether they proceed from a person’s values and identity. To judge whether a person has lost self-control, we need some information about their normative framework: how they see themselves, what their values are, and what narratives they tell about their lives and identity. Although the emphasis in most theories of self-control lies on questions on control, I argue that the normative level gives us the most information about whether control has failed or not.

In this chapter I will show that the current theories of addiction provide us with important insights on different capacities relevant to self-control that can be impaired in addiction. The theories provide very valuable information on many of the challenges substance users face when exercising self-control. However, the current theories are incomplete because they mostly focus on isolated capacities of self-control without relating them back to the agent and his or her autobiographical context. The current theories primarily concentrate on one level of self-control (most often intentional or instrumental self-control) without taking into consideration the others I have discussed.⁴ As I will argue in more detail in chapter 3, addiction is generally characterised by a very complex failure of self-control, whereby different kinds of failures interact. To understand this interaction, and the extent of the impairment of

4 Exceptions to this are Kennett (2013) and Flanagan (2013a). They explicitly call addiction a normative failure because the addicted agent ‘fails to live up to the hopes, expectations, standards, and ideals she has for a good life for herself because of her addiction’ (Flanagan 2013a, 1).

agency in specific cases of addiction; knowledge of the normative level of self-control is crucial.

In this chapter I will give a review of the current theories on addiction and self-control, and I will specify which level of self-control, capacities and threats they are interested in. I conclude by outlining significant oversights in the current models.

2. Current theories on addiction and self-control

I started Chapter 1 by outlining a lay view on self-control, in which unruly desires are the best known threat to self-control. Indeed, self-control is often *equated* with the capacity to resist desires using willpower and cognitive control. Unsurprisingly, most of the theories on loss of self-control in addiction focus on the role of desire, will-power, and cognitive control. I will first discuss the lay and liberal model of addiction, which describes addiction as pleasure orientated behaviour, combined with a lack of will-power. Secondly I will describe the neuroscientific and disease model of addiction, which uses a dual processing model of behaviour, arguing that in addiction system 1 guides behaviour at the expenses of system 2. Lastly I will discuss choice models of addiction, that present addictive behaviour as a conflict between synchronic and diachronic self-control. I will argue that none of these theories take the normative level of self-control into account.

2.1. *The lay and liberal model: addiction as ordinary weakness of will*

The lay view of addiction (Dalrymple, 2006; Peele, 1987) states that addiction is just like any other case of weakness of will, like eating too much chocolate, or sleeping in when one has made a resolution to exercise. People who are weak-willed have the ability to exercise self-control, however, they choose not to. This decision not to exercise self-control in cases of weakness of will is blameworthy, they have no good reasons to do so, they choose pleasure over their better judgment. In their liberal model of addiction, Foddy and Savulescu (2010) adopt a stance close to the lay model, but without the moral condemnation of substance users. According to them, there is a strong possibility that addicted persons are straightforwardly motivated by pleasure and nothing else. Similar

views are articulated by Keane (2002) and Szasz (1975). This lay model and liberal model seems to explain why regular people sometimes drink too much at a party, or how self-control can be lost during recreational substance use. However, there are several reasons to be sceptical about the claim that this is the main failure, or the only failure, of self-control in addiction (Kennett, Matthews, & Snoek, 2013; Snoek, Kennett, & Matthews, 2013).

2.2. The neuroscientific and brain disease model of addiction: addictive behaviour is out of control

The neuroscience of motivation

Addiction neuroscience has shown that repeated substance use can impair important capacities of self-control, due to the large amount of dopamine that gets released while using drugs. The neurotransmitter dopamine plays an important role in motivating our behaviour (Kalivas & Volkow, 2005). Dopamine is released in the reward pathway of the brain, when an experience is 'better than expected'; its release helps us distinguish which activities are beneficial for our survival and hence worth pursuing (EMCDDA, 2009; Holton & Berridge, 2013; Lewis, 2015). For example, when we eat highly palatable food – foods high in sugar, fat or salt – dopamine is released in the brain. In a time when food was scarce, pursuing these highly caloric foods could make an important contribution to our survival, and make our search for food more efficient.

The release of dopamine activates different mechanisms: an attentional bias, an approach bias, and habit formation. I will discuss these three mechanisms in more detail.

Dopamine is involved in creating an attentional bias. Under the influence of dopamine, we quickly learn which environmental cues predict the rewarding activities (Berridge, Robinson, & Aldridge, 2009, Franken, Booij, & van den Brink, 2005; Wiers & Stacy, 2006). We are then able to spot the cues very easily and find it hard to divert our attention away from them. The cues present a motivational force in itself (Kalivas & Volkow, 2005; Franken et al., 2005). Seeing the cues, for example, evokes strong physical arousal and craving: if I always eat chocolate while watching television, watching television in general will trigger craving for chocolate.

These cues not only grab our attention, but also create an approach bias: we are drawn to the cues, which disposes us to react on them, as well as to anticipate the reward they predict. It was long thought that dopamine motivated our behaviour through feelings of pleasure. When we like things, we are motivated to pursue them (Wise, 1985). However, Robinson and Berridge (1993) have argued that an approach bias can occur in the absence of pleasure, as a response to cues. Wanting and liking are not necessarily causally connected but are mediated by different neural pathways (Holton & Berridge, 2013; Lewis, 2015; Nesse & Berridge, 1997). Normally the approach bias is checked by the pre-frontal cortex, which provides a ‘go or no-go’ signal. The role of the reward system is to make us aware of the possibilities in our environment, but the role of the pre-frontal cortex is to provide cognitive control by balancing the different possibilities, and putting them in the context of higher goals. However, since cognitive control is an effortful resource, habits are formed. After an action has been repeatedly approved by the cognitive control centre, a habit forms and the approach bias is no longer checked by the control centre (Lewis, 2015). When we eat a plate of spaghetti, we automatically bring the fork to our mouth. Not every bite we take is motivated by pleasure.

Neuroscience of addiction

When a person uses substances, dopamine is released in the brain. This release of dopamine results in the process described above. The brain does what it is supposed to do. However, what makes substance use so problematic is that the amount of dopamine released is way higher than the amount released in naturally rewarding activities – activities like eating nice food, cultivating social relationships, or feeling the sun on your skin. Substance use rewards quickly out-compete other rewards.

These high levels of dopamine also result in an acceleration of the process described above (Lewis, 2015): stronger craving, stronger cue-sensitization, stronger habit formation, stronger attention and approach bias. Due to the high levels of dopamine released, the motivational core of the brain becomes hyperactive. Dopamine induces craving, wanting or desire rather than pleasure. This craving can occur even in the absence of pleasure or liking (Holton & Berridge, 2013; Lewis, 2015; Nesse & Berridge, 1997). Since we only have limited attentional resources, the strong em-

phasis on substance-related cues happens at the expense of other cues, cues that could distract us and help turn our focus to our other interests (our friends, our jobs). Our attention is instead constantly drawn to substance-related cues, and cues for other rewarding behaviours fail to grab our attention. This is important, because as we saw in chapter 1, keeping one's attention focussed on the right reasons is an important part of the capacity for self-control.

Another effect of these high levels of dopamine and the motivational core of the brain becoming overactive is the distortion of communication between the motivational core and the pre-frontal cortex. This distortion results in the communication between both brain parts becoming partly disconnected, or both parts of the brain not working together as efficiently as they are supposed to (Lewis, 2015). The first way in which the cognitive control centre becomes weakened is due to natural rewards which are not able to compete with substance use cues. The cognitive control centre has to balance the different incoming impulses, but because the substance cues are so much more salient than those of the natural rewards, the cognitive control centre gives in to the importance of these cues. Some have compared substances to a Trojan horse that hijacks the reward system, and falsely flags substance use as desirable (Bechara, 2005; Hyman, Malenka, & Nestler, 2006; Lubman, Yücel, & Pantelis, 2004; Nesse & Berridge, 1997). The second way in which the cognitive control centre is impaired is due to accelerated learning and habit formation. Substance use becomes an entrenched habit relatively quickly, further diminishing the influence of the cognitive control centre. After habit formation occurs, less and less involvement of the pre-frontal cortex is required in the selection of action (Kalivas, Volkow, & Seamans, 2005; Lewis, 2015).⁵ The result of this disconnection between the motivational core and the prefrontal cortex is that 'desire drives behaviour in small redundant circles, independent of insight, perspective, and higher-order goals.' (Lewis 2015, 205). This disconnection between the motivational core of the brain and the prefrontal cortex also distorts memory. The outcome of this is that the negative consequences of sub-

5 Because this is an interdisciplinary study, I use the word habit in several slightly different ways. In neuroscience 'habit' refers to the learning of a behaviour or manoeuvre that involves a number of neurobiological adaptive changes (e.g. a shift from ventral to dorsal striatum) (Everitt & Robbins, 2016).

stance use become relatively easily forgotten, while the positive effects of substance use are over-exaggerated (Hyman et al., 2006).

Some (Bechara, 2005; Volkow et al., 2010; Wiers & Stacy, 2006) have presented these neurobiological findings in a dual processing framework. The reward pathway functions similarly to the fast, intuitive, system 1, and the pre-frontal cortex functions similarly to the cognitive control exercised by system 2. In addiction system 1, which heavily relies on visual cues, becomes over-active, while system 2, or the cognitive control centre, becomes weakened.

These neurobiological insights into addiction and motivation directly contest the lay view of how self-control fails in addiction. The lay view proclaims that addiction is just like any other case of weakness of will: people have the capacity for self-control, but do not use it because they are tempted by desires. Addiction neuroscience first contests the assumption that pleasure motivates substance use, arguing instead that, due to tolerance, the pleasurable effects of substance use fade away quickly. Rather, addiction is motivated by wanting rather than by liking (Berridge et al., 2009).

Addiction neuroscience also contests the claim that addicted people have the capacity for self-control but just do not use it. The neuroscientific data shows how several important capacities for self-control are impaired after repeated substance use: attention bias, cue sensitisation, distorted memory, craving, a lower response to natural rewards, and weakened cognitive control all impair the capacity for self-control of substance users.⁶ Repeated substance use also causes changes to the hypothalamic-pituitary-adrenal axis (HPA axis) which impairs its functioning in mediating stress and traumatic events (Koob & Kreek, 2007). Addiction neuroscience argues that although we mostly see behaviour as the outcome of a deliberation, sometimes our behaviour is unreflectively and automatically driven from system 1, system 2 comes online too late to make a difference. I showed in chapter 1 that fast, habitual processes can support self-control, but they can also impair it. I also argued in chapter 1 that loss of self-control can be the result of using the wrong system of information processing in a certain situation. Addiction is an

6 It is important to note that these impairments of self-control are only with respect to the drug, not people's cognitive capacities in general.

example of strong habitual or impulsive behaviour that is very hard to get back under cognitive control.

Research on ego-depletion adds to this picture: it suggests that addicted people do not have weaker will-power, but they do experience more frequent and stronger demands on their will-power – in effect, it becomes depleted by their extremely strong desires. In short, in addictive behaviour either system 2 is left out of the loop, or is worn down by ego-depletion (Levy, 2011).⁷

The above findings suggest why synchronic self-control is particularly difficult for addicted people. When cues and cravings present themselves, they are hard to resist at that moment in time. Addiction neuroscience also sheds light on why diachronic self-control might be harder for people who have repeatedly used substances. Planning occurs in the pre-frontal cortex, and since the reward pathway and the prefrontal cortex became disconnected, substance-dependent people find themselves in a double bind: on the one hand they face the now-appeal of the substance-related cues, and on the other hand they are in a condition where they fail to contrast this against a long term perspective (Lewis, 2015).

The brain disease model of addiction

The aforementioned neuroscientific data shows that repeated substance use impairs our capacities for self-control. However, it remains unclear how strong this impairment is. According to the brain disease model of addiction, the impairment is extremely strong, and addiction is characterised by compulsive behaviour: addictive behaviour is no longer reasons-responsive and no longer under the control of the agent (Charland, 2002; George F Koob & Le Moal, 2006; Leshner, 1997). Charland (2002), for example, argues that neurobiological changes in the brain ‘nullify any semblance of voluntary choice’ in addictive behaviour. Since the changes in the brain that are caused by substance use are long-lasting, addiction is also defined as a chronic disease.

7 At this moment the ego-depletion theory (Baumeister et al., 1998; Baumeister & Heatherton, 1996) is being re-evaluated. Although a meta-analysis in 2010 (Hagger, Wood, Stiff, & Chatzisarantis, 2010) confirmed the ego-depletion theory, a recent meta-analysis (Carter, Kofler, Forster, & McCullough, 2015) also took into account unpublished studies, and looks more critical as to whether studies really measured ego-depletion. This study found that although for some tasks depletion of self-control happened, the depletion effect is not as general as is presumed. A recent large scale attempt to replicate the ego-depletion theory also failed (Hagger et al., 2016). However, Baumeister insists that the replication failed because the wrong test was used, not because his theory failed (Engber, 2016).

2.3. Choice models: addictive behaviour is reason responsive

Many have contested the conclusions of the brain disease model. First, reviewing the neuroscientific data does not necessarily lead to the conclusion that substance use is compulsive. Neuroscience shows why it is harder to control a craving for heroin than a craving for sugar, but not that the behaviour is compulsive (Pickard, 2015). While the brain disease model conceives of addictive desires as irresistible, choice models argue that substance-dependent people still can and do act on reasons. The choice model advances two lines of evidence supporting this claim.

The first line of evidence to show that addicted people do act on reasons comes from epidemiological data. Epidemiological data shows that in their late twenties most addicted people cease to use substances, and they often do so without receiving treatment (Heyman, 2009, 2013). They recover *spontaneously*. This phenomenon of spontaneous recovery suggests that the brain disease model is not telling the whole story: addiction might not be a chronic disease, characterised by persistent long-term changes in the brain. What would then explain why most addicted people spontaneously recover in their late twenties? An influential theory is that people mature out of their addiction (Dawson, Grant, Stinson, & Chou, 2006; Heyman, 2009; Prins, 1994; Winick, 1962). When people are young, they tend to have a local perspective on their lives: they act on whatever seems most pleasurable in the short run without thinking of the long-term consequences. However, when people grow older, they seem to adopt a more global perspective on their lives and they start to think more about their life plans. The reason why people stop using substances in their late twenties is because this is a stage in their lives when they have more reasons to stop using: their careers are advancing, they have started a family, or they want to buy a house.

The second line of evidence that substance-dependent people still respond to reasons come from observation of substance dependent people. In everyday life addicted behaviour seems not as unresponsive to reason as the brain disease model claims. Addicted people often respond to local incentives like the price of substances or the presence of a police officer. On top of that, much of the behaviour of addicted individuals, such as obtaining money for drugs, and concealing their drug-taking from loved ones, requires extensive planning. To conclude, substance-dependent people are responsive to local reasons, they can delay their sub-

stance use, and when the stakes are high enough, they can refrain from it altogether (Morse, 2011).

These findings of spontaneous recovery, the responsiveness of addicted behaviour to local incentives, and the planning involved in substance use, have led to another line of enquiry on how addiction influences self-control. A simple conclusion could be, as some proponents of the liberal model have concluded that since addicted people act on local reasons, their behaviour is reason responsive. However, this seems counter-intuitive since addicted people do not seem to act in their best interest. Choice-models have offered another interpretation of why addicted people seem to be reason-responsive, yet not act in their best interest. When we distinguish between local and global choices, it becomes clearer how substance-dependent people can act on reasons, yet end up with an overall diminished well-being.

Addiction is the result of making local choices instead of global choices

Behavioural economists claim that the choices of addicted people can be explained by the same mechanisms as our everyday choices (Becker & Murphy, 1988; Heyman, 1996; Heyman, 2009). The choices of addicted people are not hijacked from below, or impervious to cognitive control. Their choices are informed by reason, only these reasons are local rather than global. Addicted people fail to adopt a global perspective when making their choices, where taking this perspective would help them achieve the highest overall well-being. Instead, they maximise their preference satisfaction in the present. In other words, addicted people are myopic (Becker & Murphy, 1988; Heyman, 1996; Heyman, 2009).

Let us look at an example. Say that most of us rate our wellbeing on an average day with a six. However, when one day we try a highly pleasurable addictive substance, our well-being for that day climbs to ten. The next day we will feel worse than if we hadn't used the day before, due to the hangover or withdrawal, and our day will feel more like a five rather than the usual six. However, when we use again, we can improve the well-being of that day, only it will not be a ten anymore, due to tolerance, but a nine. This nine will still be overall better than the baseline of six, so it makes sense to use again for that day. The graph below shows how the pattern further develops. From a local perspective, using makes more sense than not using: doing so will provide more well-being on a daily

basis, because the baseline of the user is gradually getting lower. However, from global perspective, we soon end with an overall lower well-being (Becker & Murphy, 1988).

| | Day1 | Day2 | Day3 | Day4 | Day5 | Day6 | Day7 | Day8 | Day9 | Day10 | Total |
|--|--------|-------|-------|-------|-------|-------|-------|--------|--------|--------|--------------------------|
| Abstainer | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 60 |
| Substance user (use/not-use after using on day 1) | (10/6) | (9/5) | (8/4) | (7/3) | (6/2) | (5/1) | (4/0) | (3/-1) | (2/-2) | (1/-3) | 55 (if used for 10 days) |

FIGURE 1: overview of the difference in overall welfare between an abstainer and a substance user (derived from Yaffe, 2001)

Adopting a local perspective can be the right response to an uncertain future
 If people are preference-maximizers, as behavioural economists maintain, surely they can perform the above calculation, and see that this pattern of decision-making will ultimately diminish their wellbeing? If this is the case, why do they keep using substances? The answer is that people tend to discount the future (Ainslie, 1991; Axelrod & Hamilton, 1981; Shubik, 1970). Discounting the future is a good thing, since the future is uncertain. When we are presented with the choice between a small reward now or declining that reward now for a larger reward in the future, we should try to determine whether the future reward is big enough to compensate for the risk that we will miss out on it due to some contingency. How much we should discount our future depends on our circumstances. A person who is terminally ill will probably discount the future more than a person who is in the prime of their life (Carel, 2008). Some groups of people also tend to discount the future more strongly than others. For example people from a low socio-economic background seem to discount the future more sharply than people from high socio-economic backgrounds (Chisholm, 1993), and this is exactly the background of most addicted people (Compton, Thomas, Stinson, & Grant, 2007; Galea & Vlahov, 2002). Dalrymple (2006) states that due to coming from a disadvantaged background most addicted people have little hope for the future, and '[d]elusory euphoria - the paradise at three

pence a bottle (...)– is the best that they think that they can hope for in life’. Hart (2014) also identifies a lack of future perspective as one of the reasons why people start and continue using drugs. Becker and Murphy (1988) argue that addicted people discount the future in the right way, and that considering their circumstances adopting the local perspective instead of the global is not irrational. In their view, addicted behaviour may be fully rational.

Adopting a local perspective is part of adolescence

Contrary to Becker and Murphy, Heyman (2009) claims that addictive people do not correctly discount the future. Addicted people, or people who notice that their substance use gets out of control, should adopt a global perspective on their lives, but fail to do so. Their behaviour is irrational from a global perspective, although from a local perspective it makes sense.⁸ However, Heyman points out that most addicted people do start to adopt a global perspective during their late twenties, and quit their substance use without clinical intervention. These epidemiological findings are supported by neuroscientific evidence. Adolescents seem to discount the future to a greater extent than adults and young children (7-12) (Crone, 2009; Van Leijenhorst, Moor, et al., 2010; Van Leijenhorst, Zanolie, et al., 2010). Around age 7, children start to adopt a global perspective. However, in adolescence this changes again, due to the fact that the striatum (responsible for regulating impulses) matures quicker than the pre-frontal cortex (responsible for evaluating impulses against a global perspective) (Crone, Vendel, & van der Molen, 2003; Crone, 2009; Smith, Xiao, & Bechara, 2012; Van Leijenhorst, Moor, et al., 2010; Van Leijenhorst, Zanolie, et al., 2010). This asymmetrical development of both brain parts results in more impulsive behaviour in adolescence, and less cognitive control over behaviour. However, once an agent’s pre-frontal cortex catches up, at around age 24, they start to adopt a global perspective again. Epidemiological data shows that most people start experimenting with substance use during early adolescence, and seem to mature out in their late twenties.

8 Ainslie (2000) also claims that addicted people do not discount the future in a rational way. He explains addiction via the mechanism that I described in chapter 1 that makes sooner smaller rewards look bigger than larger later rewards. Addicted people do adopt a global perspective, but experience judgment shifts once the substance becomes available in time.

Addiction is reasonable self-medication of co-morbid psychological disorders and social hardships

There is a group of people however, who do not mature out. According to Heyman (2009) and Pickard (2012) this is because they have co-morbid mental health issues. For this sub-group, substance use temporarily relieves symptoms of stress, anxiety and depression (Khantzian, 1985). People who have to cope with mental illness often use substances deliberately to relieve the symptoms of their mental illness (Pickard, 2012; Schlimme, 2010). In these cases, substance use is a chosen means to an end: coping with mental illness. Substance use in these cases is behaviour that is self-controlled, even self-determined according to Schlimme (2010). Schlimme argues, along with Foddy and Savulescu (2010)⁹, that it is only our own normative framework that makes it hard to accept that some people use substances for good reasons:

Can we deny someone this idea of life even if it is not a very healthy way to live? Can we deny them this life simply because most people do not approve of a life in which one pursues happiness by a means that often impairs one's ability to pursue long term goals? (Schlimme 2010, 57).

For people who have to cope with severe mental illness or the effects of childhood trauma, substance use can be the best life available, insofar as it allows them to float above their struggle. Pickard (2012) adopts a similar stance: as long as people's mental illnesses are not treated and they have not learned new ways to cope with their symptoms, they will always have a stronger reason to use than to be abstinent.

Co-morbid psychological disorders are not the only reason why people self-medicate, people can also self-medicate due to the impact of trauma and social hardship. (Alexander, Coombs, & Hadaway, 1978; Szalavitz, 2016)

Choice models outline the reasons people have to adopt a local perspective on their lives rather than a global perspective: poverty, youth, or mental illness. Neuroscientific models, on the other hand, have highlighted that substance users might not be acting on reasons, or system 2

⁹ Foddy and Savulescu (2010) argue that substance dependent people are just motivated by pleasure. Because our society condemns pleasure-seeking behaviour, we regard their behaviour as pathological and out of control while they are in fact just acting on their value of pleasure.

deliberation, but on system 1 impulses. In the above section I described what concept of self-control the different models of addiction hold. Let us now have a closer look at whether the thresholds they prescribe for behaviour to count as self-controlled are sufficient.

3. Hiatuses in the current models

3.1. Are reasons for use sufficient to call the behaviour self-controlled?

Hiatus in understanding reasons

Addiction neuroscience has demonstrated that repeated substance use can influence our capacity for self-control by impairing our attention, memory, and cognitive control. However, how strong these impairments are remains unclear. The brain disease model takes these impairments to be strong enough to make addictive behaviour compulsive, and portrays addicted people as helpless bystanders who are violated by their own desires (Charland, 2002; Leshner, 1997).

Choice theories contest the brain disease model's claim that addictive behaviour is compulsive behaviour. However, it remains unclear exactly what it would mean for addictive behaviour to be *compelled*. Some choice theorists have interpreted the compulsion claim to mean that addictive behaviour resembles automatic behaviour like tics or epileptic attacks. Using this construal of compulsion, choice theorists argue that addictive behaviour is intentional and therefore cannot count as compelled (Heyman, 2009; Morse, 2011). To underscore that addictive behaviour is intentional and not automatic behaviour, they outline the reasons substance users have to use substances.¹⁰ However, as I will argue below, equating controlled behaviour with intentional behaviour is unduly simplistic. Let us look more closely at in what sense addictive behaviour might be considered compulsive.

It is unlikely that most addictive behaviour resembles unintentional behaviour like tics. Certainly it is true that *some* addicted people describe their consumption of their drug of choice as almost happening mindlessly: in some cases, they report suddenly finding themselves in a liquor store, although they made a resolution not to go to the liquor store, or

¹⁰ And even if addiction is a mindless habit, or automatic behaviour, it is a habit, says Peele, that one endorses and has cultivated (Peele, 1987).

finding themselves with a beer or cigarette in their hands without recollection of making a decision to drink or smoke. And indeed neuroscience supports this view by describing how addictive behaviour becomes increasingly habitual and can happen automatically without cognitive deliberation (Stacy & Wiers, 2010). Although this accounts for some addictive behaviours, it is unlikely that all are akin to ‘sleepwalking’. Most people describe their substance use as an internal struggle rather than a mindless affair. This would support the choice models.

Historically, the brain disease model emerged as a response to the moralistic lay view on addiction that explained all behaviour of addicted people in terms of their supposed bad values. To free substance-dependent people from moral condemnation, the brain disease model tried to point out that our behaviour is not always the outcome of a deliberation, but is sometimes the outcome of bottom up mechanisms – for example cue sensitisation, ego-depletion, or habit formation. However, in bringing this point home, the focus of the brain disease model shifted too strongly away from the normative reasons substance users might have to use. The brain disease model claims that since addictive behaviour is guided from below and not above, it does not make sense to take the reasons or values of substance-dependent people into account.¹¹ The brain disease model tries to develop a descriptive rather than a prescriptive model of addiction. However, encouraging a strong, isolated focus on the capacities of self-control without linking them to the person seems to miss important insights about what human agency is and what self-control is for. Leaving out the values of substance dependent people, as neuroscience does, risks ceasing to treat people as persons and reduces them to neurological mechanisms (Buchman & Russell, 2009; Buchman, 2008). As I argued in chapter 1, we can only know whether someone has experienced a loss in self-control if we take into consideration their values, goals and identity. The mere fact that a person’s behaviour is habitual or happens automatically does not tell us much about whether their self-control has diminished. Rather, we need to know what the person intended to do, what their goals are in life, and whether they succeeded in living the life they valued and being the person they value being.

11 The risk is that addicted people are presented as wantons rather than unwilling addicts. While unwilling addicts have values, but are unable to act on them, wantons do not have values, but just act on whatever impulse is present at that moment. While unwilling addicts are impaired in their agency, wantons are not considered to be agents.

The choice theorists are right to point out that addiction is not automatic behaviour, but this does not necessarily mean that the behaviour is self-controlled (Kennett, Vincent, & Snoek, 2014; Kennett, 2013). Having the correct understanding of compulsion and its role in addiction will help to explain why even intentional action is insufficient for behaviour to count as self-controlled. We should unravel first the definition that the choice theorists and the disease theorists hold of compulsion.

According to both the disease and the choice model, compulsion and intentional behaviour cannot co-exist. Either behaviour is compulsive or it is intentional. If the behaviour is compulsive, then it no longer has the status of an action (Kennett et al., 2014, 1070). According to the brain disease model, addictive desires are irresistible and addictive behaviour resembles automatic behaviour. According to the choice model, addictive behaviour responds to at least local incentives, hence the behaviour is intentional, and because the behaviour is intentional, it cannot be compulsive. But as Kennett has argued, to show that a behaviour is reasons-responsive is not to show, necessarily, that it is self-controlled in a normative sense. As the hierarchical account of self-control shows, agents can exercise self-control intentionally or instrumentally, yet do so in a way that conflicts with their normative framework. Whether the behaviour is self-controlled normatively depends on what type of reasons someone is acting on. As Kennett states:

When we say of an addict that their life is running out of their control we don't mean that they are incapable of responding to such contingencies and initiating successful intentional action. We mean that their lives (and their particular actions) are no longer governed by their values, and so lack the shape and coherence that this brings. (Kennett, 2013, 154).

The reasons the choice theorists outline for substance use are not necessarily normative reasons. For example, I can pursue a career not because I endorse it, but because my parent's do. In that case I can reach my goals, but I am not normatively self-controlled: I am not living the life I want to live and being the person I value being. Unless my most important value is to obey my parents.

To better understand compulsion in addiction, Kennett proposes a third view on what compulsion is. Compulsive motivation is motivation 'that

is largely impervious both to the agent's *values* and to available techniques of self-control.' This condition, as we will show below, is often satisfied in addiction (Kennett et al., 2014, 1071).

In addiction, the persistent and insistent nature of drug related thoughts and cravings dominate the agent's attention and eventually exhaust their self-control resources. At some point the agent loses their grip (metaphorically speaking) *on their prior resolution or intention to abstain*. (See Holton 2009 and Levy 2006 on judgment shift in the face of temptation.) They then use drugs intentionally. (Kennett et al., 2014, 1071)

Kennett argues that rather than being compelling, cravings are coercive and resemble duress (Kennett et al., 2014; Wallace, 1999; Watson, 1999). This view is supported by Pickard (2015). Although Pickard makes a strong claim that addictive behaviour is guided by reasons to use, she does not see addiction as self-determination as Schlimme claims. Rather, she claims that the stress caused by mental illness can sometimes be so strong that it resembles duress (Pickard, 2015). However, her emphasis is on reasons for substance use. This emphasis is potentially misleading because it does not critically examine what kind of reasons people act on.

Let us now look closer at the proposed reasons to use, and examine whether they are normative reasons or not. Many non-addicted people use substances for specific reasons: to relax, to party, to drown away sorrow (Müller & Schumann, 2011). Their behaviour is intentional and self-controlled. Many addicted people use substances for the same reason: they expect the substance will relieve their stress, or will be pleasurable. But although their reasons are the same as those of non-addicted people, there is reason to doubt that their behaviour is self-controlled. Take, for example, using substances to relieve depression, anxiety or stress. Using substances to self-medicate is often only effective in the short term, or when taken sparingly. In the long run, or when used structurally for a long time, the development of tolerance to a given substance means that its efficacy in reducing symptoms of mental illness diminishes. In the long run, substance use even aggravates psychological distress because the substances interfere with the chemical balance in the brain, or the substance related lifestyle subject people to traumatic experiences

(Steward & Conrod, 2008). Many substance dependent people are aware of this diminished effect over time (Snoek, Kennett, & Fry, 2012). The same goes for using substances for their pleasurable effects. Although initial substance use is often characterised by feelings of hedonia, long term substance use is instead characterised by anhedonia (Hatzigiakoumis, Martinotti, Giannantonio, & Janiri, 2011; Kennett et al., 2013).

If substance use contributed to the end at which it was aimed, then the behaviour of using could count as self-controlled. However, the substance use of substance-dependent people appears to be counter-productive to their self-proclaimed goals, as I will discuss later in more detail. Although substance users have some reasons to use, using is not what they have *most* reason to do. Rather, substance users act on a narrow set of reasons, or reasons at the intentional level. Addicted people know that their substance use is not contributing to a goal anymore, yet they continue to use. This makes us suspect that although they may have commenced their substance use for a reason, they no longer do so; they continue to use substances, for example, out of habit. Many choice models fail to distinguish between different phases of use, and neglect the ways in which reasons can cease to be reasons. Addiction knows different stages (experimental or recreational use, dependency, and recovery), and across these stages reasons for use can and do change.

When looking at reasons to use, often a singular view on motives and reasons is presented: for example, the perspective that addicted people use substances to alleviate psychological distress. Choice views seem to suggest that people hold only one dominant value or reason: people use because it gives them pleasure, so they must value pleasure most (Foddy & Savulescu, 2010). However, value theorists have outlined that people often hold a range of values or reasons, and these can conflict (Frankfurt 1971). It is on the normative level of self-control that these conflicts are resolved (Horstkötter, 2009). When people fail to solve this conflict on the normative level, they lose self-control, although their behaviour is still motivated by some sort of reasons. The fact that behaviour is motivated by reasons does not entail that it is motivated by normative reasons. While behavioural economists make a strong claim that addicted people possess a stronger degree of intentional control than the neuroscientific model suggests, they stay silent about normative control. The fact that addictive behaviour responds to local contingency, and can be explained

by the local reasons of the agent, does not automatically mean that the behaviour is self-controlled in a normative sense, or that the behaviour is not the result of compulsion or duress (Kennett, 2001). The claim that choice is involved in addiction can all too easily be misread as the claim that addictive behaviour is only a matter of choice (Kennett, 2013; W. R. Miller, 2003).

Choice theorists claim that substance-dependent people are not aware that they are jeopardising their long term goals, they just fail to adopt a global perspective. Although this could be true for some adolescents who have not been addicted for long, many addicted people seem to be aware that they are missing out on diachronic goods. Despite this awareness, they still fail to be motivated by a global perspective. Kennett and McConnell (2013) give two explanations for this. The first explanation is that maybe the brain disease model is right. Addictive behaviour is involuntary, not in the sense that it is automatic behaviour, but in the sense that addictive cravings are intrusive and impervious both to regular techniques of self-control (synchronic and diachronic) (Kennett, 2013). Addictive desires may be at least temporarily irresistible and compulsive (Kennett, 2001).

The second explanation Kennett and McConnell (2013) give for why addicted people fail to be motivated by larger later rewards is that there are factors other than reward, such as identity, that motivate behaviour. A person's self-concept plays an important role in the motivation of their behaviour (Kennett & McConnell, 2013). As I argued in chapter 1, identity is an important aspect of normative agency. We do not only act on values, but also on our identity. We see ourselves as a certain kind of person, and one who will do certain things. 'I am someone who is always on time', 'I am someone who keeps their promises'. We exercise normative control if we act in accordance with our valued identity. Part of our identity is also our belief in our own self-efficacy. In trying to reach our normative goals, we ask ourselves two questions: first, *how probable is it that I will get X when I do Y?*, and second, *how probable is it that I will successfully do Y?* Choice theorists see these estimations of probabilities as a rational calculation. However, as I will show, belief in self-efficacy is often very subjective and determined by our self-concept. Choice theorists neither acknowledge the way in which a person's belief in self-efficacy feeds into

their estimations, nor the way in which identity can be a distinct motivating factor.

As I will discuss in more detail in chapter 6, addicted persons often seem to have given up on themselves; their initial failure to control their substance use results in feelings of low-self-esteem. Substance-dependent people often perceive themselves as persons who cannot act consistently on their values. This negative self-image influences the choices they make. Chronically addicted people often perceive themselves as ‘someone who always stuffs up’ or someone who is not worthy of the good life they value. One could argue that addicted people act on this resigned identity, hence are self-controlled in a normative sense after all. As I will argue later on, however, a better explanation is that the negative effects of their substance use have brought about this resigned identity, thereby resulting in a normative failure of self-control. It is not that substance users value what they are doing, they simply lack confidence in their own efficacy. They think it is not likely that they will successfully perform the steps needed to reach their desired goals (whether that is cessation of substance use or improving their circumstances). Hence, they think they have less reason to act on their normative values. I will discuss this in more detail in Chapter 6.

3.2. Hiatus in how to understand human agency and self-control

The view on human agency presupposed by both the choice model and the neuroscientific model lacks insight into what it means to be a person. Being a human agent involves more than merely exercising cognitive control. Further, being self-controlled amounts to more than acting on reasons given by our contingent desires: it is about acting on the right reasons, reasons that are compatible with our normative framework. Humans are not just preference-maximisers who seek pleasure over pain, they are also motivated by values and identity.

The neuroscientific model provides us with a bottom-up story of how self-control becomes impaired in addiction. Specifically, the model demonstrates how impairments at the bottom level of the self-control hierarchy make it harder to exercise self-control. If we are not able to control our behaviour at the lowest level – that is, the level of impulses and desires – then it does not make sense to look at the higher levels of self-control. According to the neuroscientific model, the behaviour

of people with addiction is guided by their impulses and cue sensitisation. It does not make sense, in light of this, to look at their reasons, values and identity, since these are thought to play no role in guiding the behaviours in question. Self-control, on this view, is thus equated with the ability to resist temptation, and substance users fail this test due to changes in their brain chemistry.

However, as I argued above, the different levels of self-control are distinct, though mutually influencing. Peele (1987) argues that since a shift in values seems to herald recovery, values must have motivated the substance use all along. But the fact that people suddenly seem to exercise top-down control does not necessarily mean that they possessed this top down control for the entirety of their addiction. Instead of experiencing a value shift, as Peele argues, perhaps addicted persons have an invariant value set that suddenly regains motivational force at the outset of their recovery. In chapter 7 I will closely examine the circumstances in which top-down self-control can become activated. In doing so, I will argue that where the normative agency of an addicted person is implicated in their behaviour, it is not so much that their values change, but their belief in their ability to act on their values.

From the above analysis, three questions rise that have been neglected by the current literature. First, how do the impairments, highlighted by neuroscience, in intentional and instrumental control influence normative control? Second, under what circumstances can normative control still be exercised in a top down fashion in cases where there are impairments on lower levels? And third, what other factors impair normative self-control? I will show in the next chapters that if we study agency within a person's biographical context, within their normative framework, we get a better understanding on how to answers these questions, and a better understanding of the complex ways in which agency is impaired in addiction.

I will also argue that the distinguished levels of self-control will give us a better understanding not only how agency is impaired in addiction, but also how it can be repaired. Although neuroscience provides a plausible image of how self-control can be impaired, it stays silent on the question of how self-control can be repaired. As Miller remarks, there are no good animal models of recovery, primarily because they fail to capture something important about human agency (Logan, 1993; W. R. Miller, 2003).

What makes us human is not so much the cognitive control we wield over our impulses, but rather our normative level of self-control. In Frankfurt's words, we are not only beings with a mind and body, we are also persons (Frankfurt, 1971, 5).¹² I will describe in more detail in Chapter 4 how our identity and sense of self can motivate our behaviour and play a role in recovery.

3.3. *Hiatus in (internal and external) threats to self-control*

Another gap in the current literature relates to the factors that threaten self-control. In the previous chapter I distinguished different threats to self-control: unruly desires, habits, automatic behaviour, attentional bias, ego-depletion, evaluation illusions, and internal and external factors. Most of the focus of the current theories is on how unruly desires threaten self-control. Addiction neuroscience, for example, has shed light on how habits, automatic behaviour, and attentional bias threaten self-control. Similarly, studies from psychology have shown how ego-depletion threatens self-control in addiction. Choice theorists have elaborated on the role of the evaluation illusion in the impairment of self-control in addiction.

However, other internal and external factors that threaten self-control remain under-explored in theories of addiction and self-control. In what follows I discuss internal factors, before turning to external factors.

Internal factors

As I outlined above, many have argued that substance use is self-medication in response to unbearable psychiatric symptoms (Heyman, 2009; Pickard, 2012). Substance use is the best option people have at that moment in their lives because it alleviates their suffering. For some people their psychological suffering is so high, that suicide is a serious option, so they have very little hope for the future. In this context, it doesn't matter that substance use diminishes the long term perspectives (Pickard & Ahmed, 2015). According to these theories, substance use is self-controlled behaviour, and people use substances for the right reason.

Instead of construing mental illness as a legitimate reason to use substances, I will argue that some mental illnesses, such as depression and

¹² 'What concerns Strawson and Ayer is the problem of understanding the relation between mind and body, rather than the quite different problem of understanding what it is to be a creature that not only has a mind and a body but is also a person.' (Frankfurt 1971, 5)

anxiety, are an internal threat to self-control. They thereby constitute an impairment of self-control rather than a ‘reason’ to use. Calhoun (2008) has argued that depression impairs our normative agency because it deprives ‘the individual of either interest in her own reasons or interest in deliberating on the basis of them’ (Calhoun, 2008, 194). Depression simply drains our normative reasons of motivational force and estranges us from them. It is often noted that when external circumstances change and offer more opportunities, people find it easier to cease using substances (Hart, Haney, Foltin, & Fischman, 2000; Heyman, 2009; Pickard, 2012). However, Calhoun cautions that when we are estranged from our normative outlook by depression or other mental illness, we lack the motivational force to pursue what we value – even when life affords us opportunities to do so (Calhoun, 2008, 198).

Mental illness might force people to adopt a local perspective on their lives, hence making them more susceptible to substance use. Substance use can be the best option for an individual from a local perspective, yet it can nonetheless go against their normative reasons. From a global perspective self-medication is often not that effective because in the long run it tends to aggravate psychiatric symptoms rather than relieve them. In order to determine whether a mental illness provides a reason to use, or instead poses an internal threat to normative self-control, we need to determine what effect the condition has on the person. In addition to this, we must ask how effective the self-medication is for the person in both the short term and long term, and whether there are more effective and accessible alternatives.

External factors

As I have already claimed, self-control is not only about possessing the right capacities, but also being subject to the right circumstances. External factors can also threaten self-control. There are several studies which highlight the importance of life opportunities in determining whether or not people turn to substance use. In the famous rat park experiment, for example, rats that were held solitarily in empty cages self-administered more heroin than rats that were held in entertaining cages with rats of the opposite sex (Alexander, Coombs, & Hadaway, 1978). Another example are the studies done by Robins (1974; 1993) on Vietnam veterans who had used heroin extensively in Vietnam, yet ceased all substance use when back in the US. And then there are the recent studies by Hart and

colleagues on crack heroin users in poor neighbourhoods in the United States and the stigma and discrimination they experience from law enforcement. Hart and colleagues argue that decision making capacities of these crack heroin users are intact: when they can choose between small money incentives or crack, they often chose the money. What they lack are not decision making capacities, but options in life (Hart & Krauss, 2008; Hart, Haney, Foltin, & Fischman, 2000; Hart, 2014).

However, the results of these studies are not linked back to discussions on self-control in addiction, or the influence low socio-economic status has on identity and hence normative self-control. These theories often propose that substance use is not a problem of self-control, but of bad circumstances, hence the influence of bad circumstances on self-control remains under-explored. External factors, however, can greatly influence internal factors like belief in self-efficacy and self-esteem. Studies in poverty have shown how resource scarcity can change our decisions making capacities: people tend to shift to local instead of global choices. This change can be persistent and continue after the scarcity is elevated (Shah, Mullainathan, & Shafir, 2012; Blacksher 2002). Not only is this a case of diminished *normative* self-control, also *cognitive* control can be depleted by difficult circumstances like poverty and associated challenges, such as hunger, bad housing conditions and the health problems that accompany them (Shah, Mullainathan, & Shafir, 2012; Spears, 2011). Low socio-economic status and stigma can influence a person's identity and sense of self-efficacy, which renders them apathetic towards their goals.

Choice theorists also bring some of the circumstances of addicted people back into focus and argue that – given their circumstances and lack of perspective – the behaviours associated with addiction make sense. However, although it is understandable that people abandon their normative goals when they face persistently hard circumstances, yet this is still a loss of normative self-control. The harsh circumstances addicted people find themselves should be viewed as a threat to their normative self-control rather than as providing a positive reason to use. I will discuss this in more detail in chapter 6.

3.4. How do the models relate to each other? Hiatus in the interaction of models

In this chapter I have described different models of addiction. These models are often contrasted with each other. What is missing is a framework to see how the models can complement our understanding of loss of self-control in addiction. The hierarchical account of self-control offers such a framework, by showing that each model describes a different aspect of self-control.

I will propose three explanations on how the models relate to each other. Which explanation is most applicable will depend on the specific case. The first explanation is that the different theories might describe different profiles of impairment. Addiction is not a singular disorder, and can manifest itself in different ways. This explanation might be true for cases in which there is a simple loss of self-control – which means that there is only one cause for the loss of self-control. Take for example a woman who drinks too much at Friday night drinks at work. This might be a case of someone who should have exercised more will-power. Another woman at that party drinks too much to self-medicate her social anxiety. And a third person managed to control his drinking, because he recently discovered that his drinking makes him less focussed at work and this influences his career prospects. This person successfully matured out. For each of these cases a different theory seems to have the most explanatory power. Research by Bechara and colleagues (Bechara, Dolan, & Hindes, 2002; Bechara, 2005) supports the development of different typologies of substance users. In an IOWA gambling experiment, they distinguished three groups of addicted people: high functioning people, who like using substances but not at any price; people who are highly sensitive to rewards, who use substances despite knowing that choosing the reward could have negative consequences; and people who have a myopic view of the future, who use substances and are unaware of the possible negative consequences of doing so.¹³ With these distinctions in mind, it is

13 In the IOWA gambling task participants can choose between four decks of cards. By drawing cards, participants can win or lose money. Two decks will give low wins, but also low losses, and in the long run an overall positive amount of money. Two decks will give high wins but also high losses and in the long run an overall negative amount of money. During the test skin conductance responses were measured to register emotional arousal and stress. Normal participants began by randomly choosing cards, and soon developed a preference for the low-risk decks. They also developed an anticipatory skin conductance response every time they selected card from the high-risk deck. Persons with damage in the prefrontal cortex did not exhibit this skin conductance response and kept picking cards from the high-risk deck, even if doing so caused overall higher losses. Becha-

plausible that the different models of addiction describe different *types* of addictions. However, most cases of addiction seem to entail a more complex failure of self-control, instead of a simple one. For these cases, there are two other possible explanations of how the models relate to each other.

A second explanation is that the different models do not so much reflect different types of addiction, but rather different stages in addiction. Addiction is a progressive disorder which knows different stages. The lay view might best reflect the stage of initial recreational use, the brain disease model that of hitting rock bottom, and the choice theory is applicable to the recovery of a large group of users who do mature out. Someone who matures out of their addiction, however, might have been compelled at an earlier stage. So a different explanation of loss of self-control is applicable to a different stage in which the addiction progresses. I will give a detailed example of this in the case study I describe in Chapter 3.

However, in most cases of addiction this still provides a too simple image of how the three different models relate. Addiction is in most cases a complex failure of self-control, in which impairments on the different levels of self-control interact. The second explanation needs to be complemented with a third one: different types of impairment at a micro level interact with each other. For example, addicted people might find it particularly hard to resist temptation, and in addition, may be unable to deploy diachronic strategies to compensate for their lack of willpower. As a result of the stigma they experience, their normative self-control may become impaired as well, leaving them incapable of exercising top down control. Failure to control their substance use at a certain stage of their addiction might influence their self-image or identity, making it harder for them in the future to attempt to control their use. As we saw in the previous chapter, missing out on diachronic goods is not only instrumentally important, but also intrinsically important. One oversight

ra and colleagues also tested the performance of substance dependent people on the IOWA gambling task, and in doing so distinguished three subgroups. First, functional addicts reacted like the normal participants: they exhibited skin conductance and started choosing the low risk decks. Second, myopic addicts reacted like the participants with prefrontal cortex damage: they did not show skin conductance anticipatory responses and kept choosing from the high-risk decks. Members of this group seemed insensitive to the future. Third, addicts that are highly sensitive to rewards resembled the participants with prefrontal cortex damage only in part: they kept choosing the high-risk decks, but they showed high skin conductance anticipatory responses (excitement) every time they chose a card from the high-risk decks.

in the current theories is a consideration of how the failures of self-control at the intentional or instrumental level carry over to the normative level of self-control. The loss of control in the early stages of addiction might be quite different to the challenges regarding self-control that one is confronted with in the later stages of addiction.

Additionally, it is important to note that due to the fact that there are different levels of self-control that interact, there might be an asymmetry between the level at which self-control is initially lost, and the level at which it is regained. The level at which self-control is repaired might be quite different from the level where the original impairment occurred. For example, people can be impaired in their diachronic agency, yet the way to repair this may be synchronic (one day at a time). In the same way, restoration of the lower levels of self-control does not necessarily lead to a restoration of normative self-control (Berlin, 1969). Although substance users can get clean, and regain control over their addictive actions, it might be hard for them to regain full normative control. As a respondent in Weinberg and Koegel's qualitative study stated:

[F]irst and foremost is I'm extremely lonely (...) I'm totally unemployable. I'm over the hill, got no references, no appreciable skills, patchy work history at best, former alcoholic and addict, homeless (...) it's very depressing. I mean [participating in treatment] is not the answer to all my problems. Recovery is not going to make my problems go away. (Weinberg and Koegel, 1995, 217).

The different levels of self-control do not necessarily add up: although someone can have intentional and/or instrumental self-control, we still need to assess whether they also have normative self-control.

4. Conclusion

In order to determine whether, and how, self-control is impaired in addiction, we must first specify criteria for assessing whether or not a given behaviour is self-controlled. In chapter 1 I distinguished different levels of self-control. In this chapter I reviewed different accounts of self-control and addiction, and made explicit what concept of self-control they

each presuppose. Although these theories offer plausible explanations for some cases of addiction, I have argued that they are insufficient. The theories mostly focus on one aspect of self-control, without relating it to the others. The theories also focus on an isolated capacity, but do not take into account the person and his or her normative framework.

I have argued that self-control in addiction is a complex failure. To understand failures of self-control in addiction, we need to take into consideration the different levels of self-control, and determine which failures occurs on which levels, which failures reinforce each other, and which are compensated for on other levels.

The current models mostly focus on capacities of control rather than the self. They are procedural approaches: they look at whether or not goals are reached, rather than looking at why people set certain goals for themselves and whether they feel committed to these goals or not. When capacities for self-control are considered in isolation from the person's motivations, they do not tell us very much about self-control, or even allow us to say when it has failed. When capacities for self-control are examined in isolation from the agent, loss of self-control can only be partly understood. Values and identity are thus important concepts in examining how self-control is impaired in addiction.

Another oversight in the current literature on addiction and self-control is that most theories focus on the impairment of cognitive control and the threats posed by unruly desires. However, there is a richer set of issues that threaten self-control in addiction. There are a wide variety of internal and external factors that impair self-control, and not enough attention is paid to these factors – particularly by the neurobiological accounts.

We cannot simply claim that a person's behaviour is self-controlled when it is motivated by a reason. Rather, we need to decide if those reasons are normative for the agent who possesses them. We also need to determine whether they feel committed to their goals, whether they believe in their self-efficacy. We need to determine whether there are factors that influence people's commitment to their normative goals. Those factors will throw new light on how addicted people lose self-control. The reasons why people lose interest in their own goals are important and currently under examined.

The normative side of self-control is under-examined in two ways. First, little attention has been paid to how impairment at lower levels of control influence, or is compensated by, the normative level. Second, we lack an account of how the normative level of self-control can become impaired by other factors. To understand failures of normative self-control, we cannot just look at isolated actions, we need to have some more contextual information about the agents history, expectations, values and social situation. To gain more insights in the lived experience of substance users, and the contexts in which they have to exercise their agency, I designed, supported by the research team I was part of, a longitudinal, qualitative study. In this study I asked substance dependent people a range of questions about their self-control. The aim of this study was to gain more insight in the normative agency of substance users. In the next chapter, I will briefly discuss the methodology of the study, and I will present a case study to illustrate that we can only fully understand failure of self-control in addiction when we take the normative level of self-control into account. When we look at a real case of addiction, and how it develops over time, it becomes clear that the current theories can only account for part of the trajectory.

CHAPTER 3. EXPERTS ON THEIR OWN LIVES: METHODS AND PRELIMINARY RESULTS



1. Introduction

In chapter 1 I established normative self-control as the highest level of self-control. Agency is ultimately about being able to live the life we value and become the person we value being. Agency is fundamentally normative and diachronic. Yet, little is known about how normative agency is impaired in addiction. Although the current literature on addiction and self-control highlights many of the capacities subserving self-control, and how they can be impaired, the focus is mostly on resisting unruly desires, or global against local reasons, and not on how self-control is exercised at the level of the self. The question of how the impairment of capacities at lower levels of self-control impairs normative self-control, or is compensated for by normative self-control, remains unanswered in the current literature.

When we examine self-control in light of normative agency, a whole range of issues become prominent that are neglected in the current literature. These include factors pertaining to our self-concept and belief in self-efficacy. In Chapter 1 I argued that internal factors like depression and external factors like poverty can influence our attitudes towards our goals. Not only are our capacities important, but also our belief in our capacities. To understand how these beliefs are formed, we need to understand the autobiographical contexts in which they are grounded. Persons view their actions within their personal narrative, diachronic plans, and identity. They need to see their actions as making sense within their concept of self and their life stories. When they cannot logically

project themselves into a particular future, that future will not have motivational force for them (Kennett, 2013).

To gain more insight into these autobiographical circumstances in which normative agency is developed or impaired, I designed – supported by the research team I worked with – a longitudinal, qualitative study amongst opioid and alcohol dependent people. The details of this study can be found in appendix 1 of this thesis. Below I will describe the method very briefly, as well as the characteristics of the respondents.

This chapter will conclude with an extensive case study of one of the respondents to illustrate the limitations of the current theories on addiction and agency, and to emphasise the value of studying the loss of self-control in addiction at the level of the self. In the case study I will narrate part of the life story of Nicole¹⁴, a young woman dependent on heroin and amphetamines. I will describe how the current theories explain part of her trajectory: her co-morbid mental illness, as well as her temporarily maturing out. I will demonstrate, however, that the current theories are too thin to fully capture how her agency is impaired. I will show how Nicole’s sense of self and belief in self-efficacy are changed during the course of her addiction, and how this transformation influences her capacity to commit to her diachronic projects. I will describe how her sense of self relies on her body and her social relationships, and how both of these change as a result of her substance use.

2. Brief method: experts on their own life

In the introduction I outlined how loss of self-control is seen as a defining characteristic of addiction, however, this loss of self-control is often very poorly understood. The main aim of the study is to test and refine the current theories on addiction and agency. Do the claims of impaired agency from neuroscientific and rational choice accounts match the lived experiences of drug dependent persons? How does the social and autobiographical context of substance dependent people shed light on the neuroscientific and rational choice accounts of impaired agency?

Since the literature study revealed a hiatus on normative agency, the main focus was on this type of agency and related diachronic issues.

¹⁴ This is a pseudonym; all respondents have been given pseudonyms to protect their privacy.

How does substance use change people's idea of self and what they are capable of? Are they able to extend their agency over time and engage in diachronic projects? If not, what does that mean for their sense of self and normative agency? To study this, a qualitative, longitudinal approach is most suitable.

2.1. Outline of the study design

The study was both retrospective and prospective (for an extended discussion of the methodology, see appendix). It was also longitudinal: we followed participants over 3.5 years, and interviewed them yearly (resulting in a total of 4 interviews). In the first, we used a timeline interview to collect participants' life stories. We used the timeline also to reconstruct different periods in each respondent's life: a period before using, a period of experimental use; a phase when substance use became a problem for the respondent; as well as different periods of recovery (both abstinence and controlled use) and (if applicable) relapse. We were interested in whether the values, goals, and self-concept of each respondent would change over these stages, as well as what caused this change. We asked the respondents about their values and self-perception at each phase. What were their hopes and dreams for the future before they started using? What kind of person were they then, and what kind of person did they hope to be in the future? How do they view their identity now? Did their values and identity change during substance use? What happened during recovery? Did their former values and identity come back, did things change, and why? Are they happy with their lives at the moment? We also used quantitative questionnaires: the Schwartz Value Questionnaire and screeners to measure the substance dependency (AUDIT, SDS, and VAS craving). (For the full questionnaires and a more detailed description of the methodology, see the appendix). These quantitative data were used to triangulate the qualitative data.

The method of interviewing was modelled on the work of Carl Rogers, in the sense that it was fundamentally non-judgmental, respondent-centred and – within the limitations of a semi-structured interview – it is nondirective. This way of interviewing enables the respondent to express the themes that are important to them, while keeping biases of the researcher to a minimum (Rogers, 1945). Importantly, the interpretation of the data happened in collaboration with the respondents. During

the follow-up interviews we invited the respondents to interpret their own stories and validate our interpretations. This way of interviewing and analysing ensured that respondents were treated as experts on their own lives.

To get an idea of the range of factors hindering the fulfilment of their life plans, we asked respondents where they saw themselves in one year's time. If they had any goals for the future, we then asked if they had any smaller steps planned to get there. One year, two years and three years later we conducted a follow up interview, asking the respondents how they had been last year, what kind of things happened to them, how their substance use has been, if they had any relapses or managed to control their use, and what progress they had made with reaching their goals. We also asked them what got in the way of reaching their goals, and if they were happy with where their lives were at the moment of the interview.

The advantages of conducting a longitudinal study were twofold. Firstly, a longitudinal approach provided a clearer picture of how agency over time is influenced, and whether people were able to reach their goals. Secondly, the prospective design enhanced the validity of the study, since we could compare people's views over time. Their stories were not merely post facto rationalisations; by following people over time, we could observe how their stories developed. This meant that our longitudinal interviews were more than just a snapshot of someone's life.

2.2. Characteristics of the respondent sample

At baseline a total of 69 respondents were interviewed, recruited at a detox facility and opioid replacement treatment facility. At the second and third interview, 28 persons were traced, at the fourth round, 20 remained. 18 people attended all 4 interviews. 33 people did at least two interviews. Given that many respondents did not have stable accommodation or financial security to hold on to their phones or addresses for long, we expected a high drop-out. In total 145 interviews were conducted.

Respondents were between 23 and 64 years of age, most (83%) were between 30-60. Around 70% of respondent were male (49) and 30% were female (20). This ratio reflects the gender ratio in the substance using population in general (Greenfield et al., 2007; Swift, Copeland, & Hall, 1996).

| | <30 | <30-40 | 40-50 | 50-60 | 60-70 | Total | Total % |
|---------|-----|--------|-------|-------|-------|-------|---------|
| Male | 3 | 18 | 13 | 10 | 5 | 49 | 71% |
| Female | 3 | 9 | 5 | 2 | 1 | 20 | 29% |
| Total | 6 | 27 | 18 | 12 | 6 | 69 | 100% |
| Total % | 9% | 39% | 26% | 17% | 9% | 100% | |

TABLE 1. Age range of respondents

The main focus of the study was on alcohol and opioid dependency, since these substances have the highest prevalence for the in-treatment population (in Australia and other Western countries). However, a small sample of amphetamine users were recruited, such that a comparison with a stimulating substance was possible (Alcohol=32, Opioids=35, Amphetamines=7, some overlap because of multi-substance use).

Below we can see the main substance people were dependent on. Although many people were poly-users, this table only reflect the substance they struggle with. Some people were dependent on two substances, that is why the total does not add up to 69.

| Substance | Male | Female | Total |
|---------------------|------|--------|-------|
| Alcohol | 25 | 7 | 32 |
| Opioids | 22 | 13 | 35 |
| <i>Maintenance</i> | 17 | 9 | 26 |
| <i>Heroin</i> | 5 | 3 | 8 |
| <i>Pain killers</i> | 1 | 2 | 3 |
| Amphetamine | 6 | 1 | 7 |
| <i>Speed</i> | 2 | 0 | 2 |
| <i>Ice</i> | 4 | 1 | 5 |

TABLE 2. The main substance respondents are dependent on

Most of the respondents have an Australian nationality (50), four respondents were indigenous. Other nationalities were: Greece, New Zealand, Iraq, Vietnam.

There seemed to be little bias in the follow-up sample. The gender ratio was the same as the initial sample. The age range was largely the same, although we seemed to have lost the eldest group >60, probably because they were less familiar with mobile phones. All the substances were also represented in the follow-up sample (for more details, see the appendix on methodology). The main reason why we were unable to follow partic-

ipants up was because they were untraceable. Although we do not have details of those we lost track of, I suspect that a high proportion were severely marginalised and homeless.

To protect their privacy, the respondents all got a number (R1-R69), the follow up interviews were labelled a-d. So R53B refers to the second interview with respondent 53. In the case studies, the respondents were given a pseudonym to protect their privacy.¹⁵

2.3. Strengths and limitations of the study

The main limitation of the study is that participants were recruited and interviewed in a public detoxification treatment facility and an opioid substitute treatment facility. This means that the respondents were dominantly from a poor socio-economic background, and treatment seeking. People who seek treatment for their addiction are considered to have higher comorbidity and more severe dependency, compared to people who do not seek treatment (Heyman, 2009). People from low socioeconomic backgrounds tend to have more persistent additional problems.

Some have been sceptical about the use of self-report in addiction studies (Dalrymple, 2006; Davies & Baker, 1987; Foddy & Savulescu, 2010; Pickard, 2015). Davies and Baker (1987) argue that self-report will not give us any objective information on the nature of addiction. However, the aim of this study is to see how addiction influences self-concept, the narrative a person develops around their substance using, and how this narrative and self-concept influence behaviour. For this, qualitative research is the best method. I started this thesis stating that addictive behaviour is puzzling, also for the addicted persons themselves. Because they found their own behaviour so puzzling, many have thought about their behaviour extensively, and much can be learned from their own reflections. So I would like to argue that the method of self-report is a strength of my study, rather than a weakness. (For other limitations of the study, see appendix).

¹⁵ There is also some data used from a connected study in Melbourne (see appendix). The respondents from the Melbourne study were assigned a label based on the location where they were interviewed - for example, MWE-14, FCA-3 etc. The pilot respondents were labelled P1-P6.

I will now present and discuss a case study to demonstrate how the existing analyses on addiction and self-control can gain in rigour and depth by taking the lived experiences of substance users into account.

3. A case study on the influence of addiction on agency

Below I will narrate the story of one of the respondents, Nicole. I chose this narrative because it was one of the richest I collected, while also being very representative of the other stories. I will first describe Nicole's life story and how her addiction developed. I will then analyse her story using the existing theories, before describing what these theories account for. Lastly, I will highlight what the current theories fail to explain. What will soon become evident in the retelling of Nicole's story is that aspects of it partly support each of the hypotheses in the addiction literature. At some point or another, her story seems to coincide with either the moral model of addiction or the choice theories of Ainslie and Heyman. For example, at a certain moment, the focus of Nicole's life became – as described by choice theories – explicitly global where before it had been predominantly local. Yet the story also shows that the current accounts of addiction and agency, as discussed in chapter 2, are too thin and incomplete. The stories the respondents tell are not the mechanical, one dimensional stories that the literature presents. What the empirical study provides us with is a lived experience of the influence of addiction on agency, and a richer explanation of why and to what extent agency in addiction is impaired. The story reveals how aspects of the current theories are linked together, but it also suggests that there are many elements missing in the current theories – for example, the bodily, temporal and social aspects of agency that are influenced by repeated substance use. I will begin with a brief sketch of Nicole's life story, before providing an analysis of the story from the perspectives of the current theories. The analysis will illustrate the ways in which Nicole's narrative both supports and contradicts each of the theories. Finally, I will point out which aspects of Nicole's story the current theories don't account for – aspects which will be addressed and further developed in this thesis.

3.1. Brief life story

Nicole (R57) is a woman in her early thirties, who I interview four times. When I first interview her, she is on maintenance treatment: she has been administered Suboxone, a low dose variant of methadone. Nicole has been in the treatment program for 3 years now, and tells me she has not used heroin for half a year. She is a friendly and attractive young woman.

Nicole tells me that she comes from a very good family, that she had a happy childhood and a good upbringing. She first tried alcohol at the age of 13, and started experimenting with cannabis at the age of 15. She did not particularly like the effect cannabis had on her, so she stopped using it, but engaged in binge drinking on weekends. With only these details in mind, Nicole's story does not transgress the bounds of normal adolescent experimentation. However, Nicole also describes feeling lonely, depressed, and not fitting in with her peers. Her experimentation did not happen in social contexts, under the influence of peers, but alone in her room. At the age of 18, she was diagnosed with Attention Deficit Disorder (ADD) and prescribed dexamphetamine, an amphetamine-based medicine similar to Ritalin. Around that time she found that her alcohol use made her very depressed; she stopped using alcohol, but started abusing her ADD medication. From there it was only a small step to using ice, another amphetamine. For a long time, her substance use did not interfere with her regular life. She completed her training as registered nurse. Her work as a nurse, however, gave her access to opioids, and she started using morphine and pethidine. At the age of 21, Nicole was caught, and lost her job. The loss of her job meant a great deal to her; in Nicole's words, her 'whole life just completely broke down'. Her substance use, however, did not stop upon being fired. Because she no longer had access to opioids, she resumed her ice use.

Nicole's first turning point emerged when she discovered she was pregnant at 22. She stopped all her substance abuse, including smoking. The father of the child did not want to be involved, but her parents were very supportive. She had her son when she was 23 and stayed clean for a whole year, she started working again, and everything seemed to be alright. She described the birth of her son as a huge turning point:

Yeah, I'm proud, I'm really proud of giving birth to my son, yeah that was massive. Yeah that was huge. Well it was a huge turning point for me, at the time because I stopped using, I had a job, I was working at the child-care centre. Yeah, I was really happy.

But sadly, it was only a temporary turning point. She developed an eating disorder, which led her to abuse diet pills and opioids again; she did a month of rehab, but started using again as soon as she was out. She lost her job again when she was 27. She is very ashamed of losing her job again.

I regret ever using again while I was working, that's something I promised myself never ever to do so the shame of that... You're just ... you're supposed to be a health professional and you really are, I was very sick and you can't look after people who are sick when you're sick. I'm very ashamed of that.

Nicole is confused about why she relapsed then, while she was doing so well.

I don't know why, my son was doing really well, I was really ... and then suddenly I just got really, I got an eating disorder and I think I was on medication for my depression and it just like blew up. There's no excuse, I'm just saying it just sent me off track and I ... yeah, so I started abusing opiates again. Then I lost my job. (...) Then I got kicked out of home.

After she lost her job for the second time, Nicole's parents asked her to leave the house because she was out of control. Her son stayed in their care, and she did not see him for a whole year. Not seeing her son for such a long time is the thing she most regrets about her substance use. What followed was a phase of heavy dependency where the substance use took over her life and her values. She started working as a sex worker to support her ice habit, something she never imagined she would be doing. Her life at that time was very out of control; her substance use took over and changed her personality, her values, and her ambitions.

I know I've made some really bad decisions in my life and that's why (chuckling), and I've actually sat there thinking, should I do this or should I do this, and I've actually chosen the wrong decision. (...) I'm thinking like a drug addict. (...) I know it's the wrong decision but I can't stop myself. It's ... that was back then.

As Nicole describes it, she was 'thinking like a drug addict', she was not seeing her son, hurting the people that are most important in her life, working as a sex worker, and ruining her health. But after living like that for a year, a second turning point emerged in the form of a health-related wake up call. The life she was leading started to make her sick, physically and mentally. It started with her substance use not working for her anymore, but making her increasingly sick instead: 'it's just the worst feeling, it's like you're dying'. On top of that she was diagnosed with Hepatitis C, which really upset her. She did not enjoy working as a sex worker as she is a very shy person, and she was missing her son very much. For a brief period she exchanged her amphetamine use for opioid use again, but then realised things really had to change. She got into the maintenance treatment, and that worked very well for her.

I tried to get off the ice by using opiates (laughs), and it obviously didn't work so I got here onto this program, about only a year after using opiates every day and I was very sick. I just couldn't do it anymore, it was stupid. Got Hep C, was just really ill, I didn't feel well, I wasn't seeing my son at all, which was awful, it was just horrible. So I stopped using the ice and started using the opiates and then I thought no, this is not working so I got here and they got me onto the methadone and then since then I've used a little bit but a little bit of opiate, maybe once a week, but now I don't use anything except for a little bit of cannabis which I'm trying to stop now.

When I first interview Nicole, she is slowly trying to get her life together again; she describes it as getting her life *back*. One of the doctors in the clinic motivated her to start studying again (radiation therapy); he made her believe in herself again. She describes how she is really fascinated by anatomy and is really happy with her decision to study again. 'I really enjoy it, you know, really enjoy it. So I didn't really realise how much I

enjoyed it until I went back to uni.’ The relationship with her parents is better again, and she sees her son regularly. She hopes that in the future she will be working again, have her own place, and maybe can have her son over more often. She wants to get off the Suboxone completely. She hopes her social relationships will improve. She would like to get married as well.

... do you know what I mean, just normal things that people do. They find a partner, they get married, they go and get, maybe settle down and have a nice job. Just want to do normal things but I just want to do things that are healthy, you know.

When I interview her the second time a year later, she is still doing well. She manages to keep her life going the way she wants, although she states that it is hard work on a daily basis. She really enjoys university, but has had a rough year. The study is demanding, and requires quite a change from her old lifestyle. Due to all the new pressure in her life and the lack of well-developed coping skills she has experienced paranoia, (social) anxiety, panic attacks and depression. She had felt overwhelmed and experienced a bit of a breakdown. Luckily she found help in time: she is now seeing a psychiatrist and a psychologist, and she is on antidepressants. She is allowed to do the practicum for her study later, to recover a bit. Her family is very supportive, she is seeing her son often, and she describes how the successes of her current life are a huge motivation to keep on the right track. She has only used opioids once or twice, and managed to quit her cannabis use which makes her feel less depressed and paranoid. She describes many strategies she has now to stay in control of her life and her substance use.

During the third interview, however, Nicole’s life is completely off the rails again. She almost completed her studies, but she failed her last practicum. From there on, everything went wrong, she relapsed again, ended up in hospital a few times with overdoses and nerve damage. She dropped out of university, is homeless again, and her family broke off the contact with her. Her parents told her son that she is dependent on substances, and he does not want to see her anymore, although they still speak on the phone. She has legal issues about forging scripts for medication, which really upset her. When I interview her she is in detox, and

has just dropped out of rehab after a month. She has given herself a year to sort out things, find a place to live again, and return to university, but she does not sound very motivated anymore. She states that it will be hard to get her life back together again without support from her family, without having any 'clean' friends, without a place to live, and without finances. When I speak to her a year later, during the fourth interview, her life has stabilised a bit. She has been clean for six weeks now, she has found housing, is on anti-depressants, had some psychological treatment, and she sees her son on weekends. However, her life is still a bit bleak. Most of the days she sleeps until two, and she does not do much during the day. Her criminal record makes it hard for her to work, and in general she is quite negative about herself and her life.

3.2. How far do the current theories take us?

How should we assess Nicole's agency, or loss thereof? How far do current theories of agency and addiction take us? I will argue that we can most easily dismiss both the moral and liberal model in this case. The rational choice model, focussing on a shift between local and global values, takes us a long way but cannot explain her recent, serious relapse. Here the neuroscientific model seems to have the last word. However, as I will show in the final sections of this chapter, there are other explanations for Nicole's relapse that none of these theories account for.

The moral model and liberal model: Is Nicole secretly valuing her substance abusing life more than her clean life?

Both the moral model and liberal model hold that substance users act according to their values. Peele (1987), a proponent of the moral model, argues that substance users hold pre-existing anti-social values. According to the liberal model, substance users merely value a life of pleasure. Both theories can be easily dismissed in Nicole's case.

Before her substance use, Nicole remembers herself as a very naturally caring person who would go out of her way to help someone. Her family was and is very important to her, and as a young adult her biggest fear was the prospect of being separated from them. The knowledge that she neglected her son for a while and was not able to spend time with him, hurts her very much. After her recent relapse she is very upset that her parents do not want contact with her anymore.

The things that are important to her are quite consistent over the years that I interviewed her, even though she is in active use the third year. Her family, and especially her son, are very important to her. We asked all the respondents to fill in a quantitative value questionnaire, and the way Nicole fills it in, is quite consistent over the three years: values like benevolence and security are very important to her. Nicole does not seem to hold pre-existing anti-social values. However, during a stage of heavy dependency, her substance use came before anything else – before her son, and before her relationship with her parents.

I've been brought up very well and once I started using drugs it's com ... my whole, mm ... you know, ideals, my whole values, just go completely out the window. You lose self-respect, you lose respect for others. That's why it's damaging. (...) it brings out my sort of angry, I don't give a crap sort of side of me. I don't think about what other people are feeling. Sort of lose my ... I feel like I don't really care about anyone else when I'm using, it's all about me, which is very selfish I think. Yeah, I don't like it. (...) I became a very selfish person, when I used, yeah. You sort of put yourself first all the time. The family comes second, you know it's very sad, mm.

During this stage of heavy dependency, she was not able to live up to the values that in the past, and in periods of abstinence, have been consistently important for her. Most people describe this stage not in terms of having different values, but as having no values at all. Although selfishness could be a value, people mostly do not identify themselves with the behaviour they show during their use. Nicole does not, for example, claim that her real values suddenly emerged during periods of heavy use when she lost some of her inhibitions. Instead, as described earlier, she reports that she was acting and thinking like a user.

According to the liberal model Nicole is using substances either because she highly values the pleasure they give her, or because they help her not to feel pain. Although Nicole names pleasure as one of the reasons to use, she does not describe her life as being very pleasurable. She did not enjoy working as a sex worker, and she suffered intensively from the health problems caused by her substance use and not seeing her son. On the one hand, this supports the liberal theory: Nicole decided to quit when she found out about her health problems, when the pleasure she

got out of her substance use did not outweigh the consequences anymore. However, it does not seem that Nicole stopped when she reached the threshold of what she was willing to pay for her 'pleasure', it more seems like she tipped over the boundaries she had set for themselves of what she thought are acceptable consequences of her use. Nicole already did unwanted, long term, maybe irreparable, damage to her health, social relationships, and identity before she was able to achieve abstinence for a few years. Even then she relapsed again, despite working very hard on her health in those years. The long term harm of her substance use on her identity, health and social life seems to be more dominant in her life story than the experienced pleasure. In general, she does not speak about her life as if she is having a good time, or as though she is paying the price now for fun times she has had before. Rather, she states that her substance use ruined a lot of opportunities for her. The substance use only provided her short term solutions for her problems, but soon made her problems worse. Yet, as her last relapse showed, it is very hard for her to stop. Although during the second interview she clearly describes that the life that gives her most pleasure is one that involves her son, her family and a career, she still craves substances despite no longer receiving any pleasure or satisfaction from them. When judged isolated from her normative framework, proponents from the liberal model could argue that Nicole's behaviour is intentional, hence self-controlled. She craves the substance use because they give her pleasure. However, Nicole stresses that her use undermines her normative self-control: she is not the person she wanted to be, she does not find her life very satisfactory. Another hypothesis we can extract from the liberal model is that Nicole's substance use is an attempt to avoid pain. Nicole's initial description of her substance use as sitting alone in her room and drinking and using marijuana to feel less insecure about herself fits the pain-avoiding theory better than the pleasure-seeking theory.

The reason why I started using drugs was because I wanted to change the way I felt. I felt so depressed and horrible about myself.

Nicole describes how she uses substances to self-medicate for psychological distress. She is still searching for the right diagnose of her mental health problems: ADD, social anxiety, panic attacks, borderline person-

ality disorder, depression. Substance use makes her feel more confident, energetic, relaxed, and happy. Yet, she also states that her self-medication only works temporarily. In the long run the substance use worsens her mental health, making her paranoid, more depressed, giving her a false confidence and hindering her social relationships. In the long run her substance use does not seem to contribute very much to the soothing of her mental pains. Although she used cannabis for quite a while, nowhere in her story is it clear that the cannabis use is beneficial to her –rather, she states that it increases her paranoia which hinders her social contacts. In general she claims that her substance use worsened her mental health. What is also striking about her story is that her substance use became out of control *after* she already had access to mental health services and medication for her ADD. Her substance use escalated despite her having found other ways to cope with the symptoms of her mental health issues.¹⁶ The hypothesis that Nicole keeps using substances to medicate for pain does not seem to take us very far either. Her self-medication is an example of intentional or instrumental self-control. She uses substances intentionally to elevate her mental distress, and to a certain extent, this is effective. But, as Nicole recognises, the self-medication is detrimental to her normative self-control. She wants to be a caring person, a good mother, and substance use makes her selfish and isolated. In the long run, her self-medication is also detrimental to her instrumental self-control. Her goal is to elevate her mental distress. Although substance use relieves her symptoms in the short term, in the long term they get worse. Substance use also hinder her other goals: her career, working on a good relationship with her parents and son.

We saw before that the moral model claims that anti-social values precede substance use. A variation of the moral model, however, is that substance dependency *creates* anti-social values. On this version of the model, substance use erodes our values until we do not care about anything anymore except our substance use. According to this account Nicole was not guided by anti-social values from the start, but during her period of heavy dependency she acted on anti-social values induced by her substance use. There are, however, other explanations for the role of values

¹⁶ One can argue that the medical treatments Nicole received for her mental health problems might not have been as effective as she hoped, hence she fell back on her substance use. However, she earlier stated that using substances was not very effective either in treating her mental health issues.

during substance use. Some respondents describe their period of heavy dependency as a period in which they had no values, rather than one in which their values were merely different to their non-using selves. One respondent in detox said that if I had asked him to fill in the Schwartz value questionnaire before he entered detox, he would have scored low on all the values. He did not claim that he would have scored high on values associated with addiction, such as hedonism, stimulation and power, or low on conformity, which does not. On this interpretation, people stop caring about their goals; they do not think anything matters anymore. Another possibility is that they continue to hold the same values, but in their addicted state do not see a way to live up to them. Nicole's case appears to be slightly different: she seems to engage in self-undermining behaviour as if, in a sense she believes she does not deserve to live the life she values.

Rather than having the wrong values, or chasing a life of pleasure and avoiding pain, Nicole's problem seems to be that she is not able to live up to her own values. In this sense, her case fits the neuroscientific model better than the choice model. Her substance use does not seem to be value-guided; rather, her use appears to undermine both her values and her capacity to achieve them. This inability to live according to her values not only happens at the time of using, but persists long after that. During the first and second interview Nicole says that with a more stable life, her values are resurfacing, but it is a slow process that depends on a lot of factors:

It's coming back slowly. I think it takes time, I think it depends on who you hang around with. It depends on a lot of things, but it's slowly coming back. I think you realise what's important, more important in life. 'Cause when you're on a lot of drugs, you'd sort of, you know you don't feel much emotion. It sort of numbs your emotions. (...) I think about other people a bit more. I'm still a bit selfish but I'm trying to be a bit more thoughtful.

This description of Nicole's loss of values seems to partly fit the neuroscientific model, which says that it takes time before one can find previous values rewarding again. Yet, Nicole also names factors that influence her values that are not accounted for by the neuroscientific model. In the above quote Nicole states that what makes the loss of her values so dam-

aging is that it makes her lose self-respect as well. She also says that her values are contextual, depending on the people she is affiliated with at a given moment.

We can conclude that the moral and liberal models are too thin to explain Nicole's loss of self-control. Her pre-existing values cannot explain why she became addicted to substances, or why she keeps using them. Her pre-existing values were very pro-social rather than anti-social, and she does not seem to value pleasure above all other things. Further, her current substance use does not provide her much pleasure, and she does not describe her life as being very pleasurable. Nicole does not think that the price she has to pay for her substance is outweighed by the benefits (for example, self-medication) that her substance use has afforded her. Although the liberal model claims that addicted people are too stigmatised to honestly communicate their values, Nicole seems sincere and consistent in describing her values and the role pleasure plays in her use. Rather than acting on the wrong values, or chasing a pleasurable life, Nicole seems to lack normative self-control; her problem is that she is not able to consistently act on her values. This lack of normative self-control could be caused by neurobiological changes due to substance use, as described by the neuroscientific model. However, Nicole also names other factors that threaten her normative self-control that are not accounted for in the neuroscientific model: the loss of self-respect she experiences and the influence of her social context on her values, actions and avenues for choice.

The rational choice model: Is Nicole maturing out slowly?

In the previous section I concluded that Nicole's pre-existing values did not lead to her substance use; it was not that her values were wrong, she was just incapable of living up to them. However, when we recall Nicole's second turning point, we see that her values acquire motivational force again. During her second turning point Nicole shifted from a local to a global perspective on her life. At this stage Nicole realised that she was fed up with her life as a working girl, she was shocked by the damage she was doing to her health, and she missed her son very much. As she describes it, she abruptly shifted from a day-to-day perspective on her life to a long-term perspective. Nicole's shift to a more global perspective

on her life is consistent with the maturing-out-hypothesis associated with rational choice theory.

According to rational choice theory, substance users make day-to-day or moment-to-moment decisions: they have a local rather than a global perspective on their lives. From a local perspective, it always makes more sense to use than not to use, since using prevents withdrawal symptoms, mutes the feelings of guilt, remorse and regret a substance user may feel, and often provides more pleasure than not using. A local perspective seems to be a characteristic of people in late adolescence or their early twenties: they make the most of their days and do not worry about the future too much. However, this local perspective tends to transition to a more global perspective during a person's late twenties or early thirties. Heyman (2009) remarks that it is around this time that most people spontaneously quit their substance use. He calls this the maturing out effect: 'the pressures that typically accompany "maturity" bring drug use to a halt in many addicts' (84). Heyman states:

Most addicts choose to stop using drugs by about age thirty, and the reasons that they do so are by and large the same as the reasons that motivate most of our actions, such as finances, job, family responsibilities and self-esteem. (Heyman, 2009, p.112).

Heyman describes two related pathways that can lead an agent away from a local choice perspective. First, their circumstances can change. In their late twenties people tend to acquire more responsibilities in their jobs or relationships. The stakes become higher: people want to buy a house, start a family, or get a promotion. In order to achieve these goals, individual agents have to look at their lives more globally. Nicole's first turning point evolved around the birth of her child. This was a clear change in circumstances, and one that caused her to take a more global perspective on her life. The second pathway Heyman describes is a more direct shift to a global perspective. Users often describe this transition with the metaphor of hitting rock bottom. Nicole's second turning point resembled more this sudden shift, and she describes it as a wake-up call, asking herself: 'what am I doing to myself?'. She describes how she was suddenly and clearly reminded of the global values (her health, her son) that had been overshadowed by substance use.

Nicole's abstinence after her second turning point lasted for almost three years. She clearly expresses, especially during the second interview, a shift to a global perspective as being significant for her recovery.

I just don't want to fall back into using again. (...) I know that if I do, (...) I'm not going to be able to go to uni and all that one and a half years I've already done, well nearly one and a half years, will just be a waste. All that hard work would just be a waste and I'm 32 now, I'm not getting any younger. (...) You have just got to think of it in the long run. You have to think of the consequences and I try and think of the consequences and what's ... Also now that I'm 32 (chuckling), I also start panicking. I'm thinking I'm running out of time, so I think if I start using again it's going to take another five years away and that's what happens, five years goes by. I didn't see my son for a whole year, year and a bit, which was absolutely devastating and I can never get that year back but that's all because of ice. That's what ice does, it just, you lose track of time and I was using ice every day which is scary, yeah. (...) And to tell you the truth I sometimes do feel like using ice but it's always there. I think it will always be there for me. It's just a matter of being able to ignore it and know, not ignore it, know that it's there and say well, if I do use, I'm going to be sick, I'm going to lose in touch ... lose track with my family and my son, so I just think about the consequences and things like that. (...) I think I'm able to identify the consequences of making the wrong decision and I wasn't really able to do that before and I don't know if that's from maturity or from experience of making silly mistakes.

When I interview Nicole for the second time, her story seems to be a text-book example of a person who has matured out. According to the rational choice theory, substance users tend to quit using when the costs become too high, or other alternatives start to become more appealing. This shift mostly occurs when people's late twenties. This maturing out theory seems highly applicable to Nicole. But how, then, can we explain the severe relapse she reports during the third interview, that makes her lose everything she had achieved?

Heyman (2009) gives three explanations for relapse. I will articulate all three and consider whether any of them can adequately account for Nicole's relapse. Heyman's first explanation is that it takes a long period

of abstinence before the global perspective becomes rewarding. People who use substances mostly experience anhedonia for a while after they become abstinent. So it is difficult to maintain the global perspective. 'The first weeks of abstinence will not produce a day that has more value than the worst drug day.' (Heyman, 2009, 130) However, at the time of her relapse, Nicole has been clean for almost three years, and the global perspective on her life is already paying off: she is enjoying her study and is spending more time with her son and family.

Heyman's second claim is that comorbidity with psychiatric and other medical disorders can cause relapse. People who do not mature out successfully use their substances to medicate psychological problems. We already discussed Nicole's comorbid psychological disorders, but concluded that with regard to self-medicating, she had adopted a global perspective as well. She stated that using substances helped her handle some of her disorders, but only in the short run; in the long run, substance use made them worse. When she experienced a deterioration in her mental health due to the stress of her studies, she sought help from a psychiatrist and received anti-depressants. She found other ways to cope with her psychiatric comorbidity.

Heyman's third claim is that people relapse because their global perspective is gloomy: they do not have much to look forward to, and they do not have many possibilities to improve their lives in the long run. 'Those with greater access to meaningful alternatives are more likely to quit using.' (Heyman, 2009, 85). Relapse is caused by lack of long-term options and good support: people who relapse have little to no viable alternatives to their substance use. This explanation also does not seem to fit Nicole's case: she had much support from her parents, she found the contact with her son very rewarding, and she was enjoying her studies. Although she did fail her practicum, this was not the end of her long-term prospects; she just had to redo the year.¹⁷

None of the explanations Heyman offers for relapse seem to be able to explain Nicole's relapse. She met all the conditions for maturing out: she had other options, social support, and took a global perspective on her life. So why did Nicole relapse? Another explanation is offered by the

¹⁷ However, we could argue that although Nicole had support and long-term options, she did not believe in it. Nicole felt that her long-term prospects were obviated by her failure. It was not so much her lack of long term options as her perceived lack of long-term prospects. This explanation will bring us back to the more normative explanations on self-control.

brain disease model, which claims that Nicole has a chronic, relapsing brain disease. Let's explore this hypothesis a bit further.

The brain disease model: Does Nicole have a chronic relapsing brain disease? According to the brain disease model, quitting substance use is extremely hard due to long term changes in the brain caused by repeated use. No matter what people value, and how determined they are to change their lives, they are always at risk of relapse. Even after a period of abstinence, former substance users will find it easier to remember the good times on drugs rather than the bad times. Further, they will still be highly sensitive to cues related to substance use: their attention will be drawn to these cues, and this will evoke strong cravings. Indeed, during the second interview Nicole reports that the craving is always there: 'my craving, my mm ... it's horrible, it's a thing like, it's a horrible thing. (...) You know you just want a drug, you'll do anything for it.' Although she is on maintenance treatment for her opioid addiction, which targets the opioid receptors in her brain and reduces her craving, no such thing is available for her ice use, on which she relapsed.

Nicole herself believes that addiction is a disease and that since she became addicted, it is very hard for her to stop using. She expressed the feeling that she had to hit rock bottom before she could pull out. Although Nicole managed to stay clean for almost three years, her cravings slowly consumed all her willpower. Many other respondents described their addiction as a disease, as something they experienced involuntarily and could not shake off. Many respondents were truly annoyed by the persistence of their symptoms regardless of their hard work. As Nicole describes it:

I'm worried about being stuck in this same spot and be 80 years old sort of thing so time flies by and you really haven't got anywhere, you know?

It seems plausible that Nicole's is caused by a chronic, relapsing brain disorder, rather than the wrong values or a failure of maturing out due to lack of options or comorbidity. However, in the next section I will show that there are aspects of Nicole's story that none of the theories account for. I will show that another explanation for Nicole's relapse is more plausible.

3.3. What the current theories do not account for

We see that the different theories on addiction and agency could explain a facet of Nicole's story. The rational choice theory provides a good explanation for the temporarily maturing-out part of Nicole's story. The brain disease model provides a plausible explanation for her recent relapse. However, when we look more closely at her stories, we can see elements of Nicole's narrative that are not accounted for by either theory. During her second interview, Nicole told me about the struggles she encountered during her recovery. The most prominent one is the influence of her substance use and substance related life-style on her identity and social standing. Related to this is her experience of her body as a source of stigma. Her ideas concerning how others view her based on her bodily appearance heavily influence her feelings of identity. Having a stigmatised identity has negatively influenced her already fragile sense of self-efficacy.

At the time of the second interview Nicole had been abstinent for around 2 years, and enjoyed a stable life for 4 years. From the outside, her life seemed to go well. She also had a good support network in the form of her family and counsellors, and she was strengthening her global perspective. However, Nicole described some nagging issues she encountered during her recovery that would eventually lead up to her relapse. These issues were all closely related to not having control over her identity, her feeling of self.

Substance use can make the old self feel unavailable

As we saw in Chapter 1, identity plays an important role in motivating behaviour. To be able to have control over our lives we need to have integrated personalities (Meyers, 1989, 59-60). The relationship between identity and self-control goes both ways. On the one hand, the consistency of our behaviour integrates our personalities, such that self-control constitutes the agent. On the other hand, our integrated personality renders our behaviour consistent. Unification of agency is an important precondition for accomplishing long-term goals, and by the way Nicole describes it, she struggles with reconciling her pre-substance use identity, her substance use identity, and her post substance use identity:

... when I was younger before I used drugs, I was such a lovely caring person and thoughtful person and a loving person and I used to be very thoughtful and do things for other people without even being asked, just those little things like ... I feel like that's who I am becoming again you know. So much more positive and so yeah I do, I do feel like I'm you know ... I'm ... the drugs made me a different person. (...) I mean I've been a prostitute and it's horrible and I never would have dreamt of doing anything like that. (...) So yeah, going from that to going to university is a big difference. (...) I have been through a lot and I'm not just going to suddenly be old Nicole again, you know the way I used to be.

She describes her substance use identity as a strong rupture from her previous identity. She described how she started 'thinking like a drug addict'.

the way you behave when you're around drugs is very different to obviously how you behave at university. (...) when you've been around lots of people who use, you become ... you get a lot of their traits, you know what I mean, you start speaking like you know you don't care, and things like that.

one of the staff members said to me one day you're really lovely and the next day you seem to be a different person, you know? (...) I did see it but only after they'd told me and when I look back. And I was pretty surprised you know that she sort of ... 'cause I've ... I don't know, I just thought it was normal. I don't how to explain it.

Nicole struggles with these changes in her personality. Several times during the interviews she uses expressions like 'you probably wouldn't expect this from me' and 'it was not something I would normally do', when referring to her periods of heavy substance use. Although she sees her substance use identity as a rupture from her previous identity, on the other hand she states that it will always be a part of her.

... it's always going to be a part of who I am and I think it's really sad but it's true. (...) I will always know that I was ... I have a drug problem or had a drug problem or that I'm on Suboxone and I think it's part of who I am and I think that worries me.

Yet, coming from a really good family, and being at university now, she wishes to keep this part of her identity hidden from her fellow students. Not being able to reveal her past makes it difficult for her to reconcile the different phases in her identity.

I find it hard to hide who I am and or where I've been or who I have been or what I've done.

The post-user identity she wishes for herself is strongly focused on being a good mother. This is a strong source of motivation for her, and is reinforced by the good contact she has with her son.

I don't want to be considered a drug user. You know I don't ... I want to be you know considered ... I want to try and do things like a mother would do, be a good mother

But, as described above, the transition in lifestyle from being a heavy user and a sex worker to being at university doesn't always go easily. Two interrelated issues play an important role in obstructing a strong sense of positive identity for Nicole. The first issue relates to the stigmatisation that surrounds substance users - the social aspects of her identity. The second issue relates to the way her body constitutes her identity and the way she considers her body as a source of stigma. These issues make her lose control over defining her identity. The stigma she experience, or which she fears she is been subject to, makes Nicole confused about her identity: am I a natural caring person and a good mother, or will I always just be considered an unreliable substance user?

Social and bodily aspects of identity and belief in the self

Constructing one's identity is not only a personal process, but one that happens in concert with others. If others describe you as shy, clumsy, brave, unreliable or punctual, it will influence your self-concept. Identity not only involves personal traits like character, values and virtues, but also involves one's physical appearance - for example, the markers of gender, race, and bodily deformities. Those around us read our bodies, and provide us with verbal and non-verbal feedback on our appearances. They also make judgements about our character that are based on our

bodies. When a person looks athletic, we usually assume that they possess self-control, while when someone is overweight the conclusion that they are lazy is frequently drawn. Charmaz and Rosenfeld (2006) describe our body as a looking glass through which the public stare penetrates the private sphere. Reactions of others to our bodies can spoil our identity. These reactions do not even need to be real, they can also be imagined. If I fear that other people will judge me because of my limping leg or my weight, this will already influence my self-concept. Authors like Goffman (1963) and Link and Phelan (2001) call this process self-stigma, or internalised shame.

Nicole's struggle with reconstructing and unifying her identity has a lot to do with her fear of being negatively judged, on the basis of her past, by her new social group at university.

I was very anxious during that year when I saw you because of uni. Yeah because I was worried about what other people were thinking about me and you know being an addict and ... I come from a good family and you know (...) I can fit in that group if I want to but I know that I'm an addict (...) I think that they can see it, you know? I think we said ... talked about that and really they can't. But I've lost a lot of weight too and I just felt like I looked like a, you know drug addict and that was more in my head, I think, that people can see your vulnerabilities, I think and they play on it.

Nicole felt penetrated by the public view of her body. Although she was doing well at university, she did not feel in control about constructing her own identity. With the people that knew her well, like her family, it already took her a long time to regain their trust, but in her new social group, she felt very insecure. These feelings of insecurity about her identity resulted in feelings of paranoia in social contexts, and Nicole describes a few very embarrassing incidents at university.

I was in the library and I felt like everyone was laughing at me which is really weird. And I think they probably were, not really but I don't know and it doesn't really matter but so I had an outburst and I told some ... another student off. I hardly ... I didn't even know the student and I got into a bit of trouble. I had the professor come up to me and say you know be careful how you speak to other people you know. So that was really a

bit of a wakeup call for me that I need to go and get help. (...) I was very embarrassed because I looked like a crazy person and it was my old self you know.

Although Nicole looks absolutely fine, she is afraid her body reveals a part of her identity that she wishes to keep hidden from the public eye. Goffman (1963) points out that the original meaning of stigma was indeed a mark on the body to expose something bad about the moral status of the person marked (criminals, slaves, traitors etc.). Stigma is not so much about the real attributes of a person, but more about the creation of a social identity that differs from a personal identity. While Nicole sees herself as a good mother, she is afraid that others only see her as an addict. In that sense, her preferred identity is spoiled by her fear of a negative social identity. Paradoxically, her fear of how others perceive her makes her act out of place in social situations. She describes having a 'poor perception' of herself.

Belief in self-efficacy

Our identity is a source of motivation. Nicole was determined to see herself as a good mother, describing herself as a naturally caring person. She was making great progress in reinforcing that image of herself with her family, by working on her relationship with her son and her parents. Yet, the fear of her social identity, her fear that people at university could see that she was a former user, and would judge her as selfish, created a nagging doubt as to whether she really was the good mother she wishes to be. Every bit of weight loss triggered her fear that people would see the 'junkie identity' that she carefully tried to hide. She lived in constant fear of being stigmatised. Link and colleagues (1997) explain that stigma can erode 'confidence, disrupt social interaction, and impair social and occupational functioning' (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997, 179). Although in her daily life the identity of 'junkie' was behind her, she still felt like her body was marked by her addiction and that other people would recognise those marks and evoke her old identity. This shadow of her old identity also influenced her belief in self-efficacy. The first way in which Nicole's belief in self-efficacy was impaired, was by the rupture in her identity caused by her former substance use, and her failure to exercise self-control. She did things she thought she never

would do, she repeatedly broke promises to herself, she managed to get her life together once before and relapsed again. When I complimented Nicole at the second interview about her progress, she tempered my enthusiasm, reminding me of her first turning point and the relapse that followed it:

Yeah, I thought everything was fine but then I got the eating disorder and it just mucked up my mental ... I don't know what it was. No, I just started using again which is terrible. (...) You know you promise yourself that you'll never, ever, leave your son, if ever. Just sick of making promises to myself and not following through.

The second way in which her belief in self-efficacy was harmed was by a series of negative experiences after the failed practicum. She felt these reinforced her failure, and reinforced her implicit judgment that she does not deserve the good life. Nicole labels the failing of the practicum as the crucial incident leading to her relapse, bringing her suppressed feelings of low self-worth to the foreground again.

I was just so disappointed with myself for failing that prac, (...) [it] just brought my confidence all the way down and I just felt like suicidal and I just wanted to give up basically and started buying drugs on the street at King's Cross here and that's a very dangerous area. And a few bad things happened to me and you know I got robbed you know and that sort of thing and so it wasn't very nice. But I ... but I'd sort of given up you know so I didn't really care. Yeah. Which is really sad, yeah.

She always had the nagging doubt that she could not do it, so when she did fail, she gave in totally. She describes the failing of the practicum as the tip of the iceberg for larger self-esteem issues and negative thoughts about herself.

...something I was really having problems with last year was negative thoughts about myself and really poor perception of myself, really negative thoughts

I just feel like I'm not equipped as well as another 32 year old might be, who hasn't used drugs.

I am surrounded by extremely intelligent people, so I do stand out. I'm not saying that I'm stupid but I'm saying that because I've been ... I'm not saying I'm extremely intelligent either, but I'm just saying that I'm probably average and it's because I've been through all this, I think, that it's really affected my attitude. (...) I mean I'm in a class full of people who are very ... have such a high confidence level so I think they really notice when I sit there and you know they can sort of tell that I've got a really low ... a bit of a low self-esteem compared to them.

This negative self-image, which she felt being reinforced by the extremely intelligent and confident people around her, made her doubt her own capacity for self-efficacy. Her loss of control over her identity made her lose her belief in self-efficacy. Is she a member of the university group, does she belong to this very good family, is she a good mother, or is she the selfish user, doomed to fail at anything in life?

if you concentrate on failing you're going to fail and that's what I did, I ... not ... I concentrated on worrying about failing and really I should have just concentrated on what I was doing, you know? I just didn't have any belief in myself unfortunately. But that just comes from low self-esteem and yeah. And I think that everyone saw right through me sort of thing and I didn't like it.

Nicole repeatedly stated that her feelings of lacking self-efficacy were reinforced by the people around her. What eventually caused her relapse was not a chronic relapsing brain disorder, but a failure to control her identity due to (self-)stigmatisation. She felt she lost control over how her body looked, and how other people would read her body and judge her as a person. She lost control over her 'self' and her belief in self-efficacy.

4. Conclusion

When we look at a real case of someone who is struggling with addiction in detail, we see that it is hard to apply the theories from the literature consistently across the whole trajectory of addiction. Although the cur-

rent theories can explain some aspects of the trajectory – aspects that many who are dependent on substances describe – they seem to miss a crucial aspect of self-control. I suggest that this blind spot is caused by the theory of motivation these theories hold. The liberal and rational choice models argue that people are motivated by what gives them the most pleasure or the least pain at a given moment. But, as we have seen in Chapter 1, this understanding of human motivation is too thin. Human beings are, unlike animals, not only motivated by pain and pleasure. Humans are also persons, and as such are also motivated by a self-concept and self-regarding beliefs: who I am, what I am capable of, and what seems a likely continuation of my life-story? This concept of the self is missing in the current theories, and that is why they cannot satisfactorily explain how self-control is lost in addiction.

Nicole's story illustrates that a complex, interactive set of factors underpin normative agency. Nicole names many factors that threaten her normative self-control that are not accounted for in the current models: the loss of self-respect she experiences, the feeling that her body is marked, the fear that others see a part of her identity that she wishes to hide, her fear of stigma, her loss of belief in self-efficacy, and the influence of her social context on her values, actions and choices.

What Nicole's story nicely illustrates is that self-control at all levels relies on the self, and that this self is embodied and embedded in a social context. Self-control is not only an internal, mental capacity, it is also determined by our body, our social context, and our narrative. In the next chapters I am going to focus on two aspects underlying normative agency that are ignored in the current literature: the body and our self-concept. I will show that they are linked in very significant ways.

CHAPTER 4. HOW THE SELF MOTIVATES BEHAVIOUR



1. Introduction

I began this thesis by describing the traditional debate on addiction and self-control, and outlined which standard views on loss of self-control are behind the different models. Self-control is often viewed either as a forceful effort to resist temptation, or as the ability to plan one's behaviour in order to reduce temptations so that they either will not arise, or so that it is harder for us to act on them. Most theories of addiction and self-control focus on how the capacities to exercise these forms of self-control are impaired. I argued that there are other factors that play a role in self-control which are overlooked in the current models. These factors have to do with our self-concept. Our self-concept determines what we think is plausible to happen in our lives, and makes certain options more likely to us than others. It determines whether we use the strategies and will-power that are available to us, and whether we take the opportunities that are presented to us.

Nicole's story reveals how her self-concept and lack of belief in self-efficacy have most likely contributed to the severity of her relapses. In the remaining chapters of this thesis I will closely examine how the self can motivate behaviour, so-called normative agency, as well as how normative agency can be impaired in addiction, and how it can be restored. In this chapter I will thus focus on literature concerning how identity can motivate behaviour. I will argue that most of the literature on addiction and identity focuses on *content change* in identity. These theories often present the issue of identity in addiction as if there are only two identities people can choose from: the identity of a user and the identity of a non-user. Recovery happens when people decide to become a non-user, rather than a user. This focus makes identity change seem like a mag-

ic bullet rather than hard work: once an agent comes to see his or her self as an abstainer, everything will be alright. As I shall argue, however, there is often a gap between one's actual self and one's ideal self, and this gap can be difficult to bridge. One reason this gap is hard to bridge is due to a lack of belief in self-efficacy, this is not taken enough into account in the current theories. Bridging this gap is not only dependent on internal motivation but also on external factors, such as the availability of opportunities and support from others, that are outside our control.

In a way, Nicole describes an identity change: on the one hand, she sees herself as a good mother, but on the other hand, she has a constant feeling that others judge her a junkie, and this makes it very hard for her to maintain trust in her identity as a good mother. Re-defining one's identity is an important first step in normative agency, but it is not the whole story. Whether a person succeeds in living congruently with their desired identity not only depends on a change in self-concept, but also on whether they can anchor this identity change and have it socially accepted. In the remaining chapters I will describe what factors contribute to people failing to anchor this identity change, and how successful normative agency can be exercised. Let us look closely now at how identity can motivate behaviour.

2. The role of identity in motivating behaviour

How does identity influence behaviour? Our identity is not singular, we do not have just one identity, rather it consists of different roles we simultaneously hold. Each of these roles can influence our behaviour differently.

Let us start with a simple example. When I enter a shop, I have the identity of a customer, and the woman behind the counter has the identity of a shop keeper. She will ask me: 'Can I help you, or are you just browsing?', and I will respond according to my identity of a customer. This form of identity is called situated identity, my identity and hence my behaviour is determined by the situation I am in (Hewitt, 2000). When the shop keeper asks me 'How has your day been?', I will give a different answer than if my friend asks me the same question, because I have a different

identity in both situations. Situated identities are short-lasting: they last as long as it takes to shop, or visit a GP.

We also have social identities, longer lasting roles that are defined by being part of a social group. These roles include being a church member, being member of a sports club, or graduating at a certain university. These social identities also shape our behaviour. When I attend a reunion of my old university I will dress, behave and speak differently to when I am going to play soccer or attend church.

We hold simultaneously different roles in our life. For example, I am a child, a mother, a wife, a philosopher, a student, a friend, and a Dutch person in Australia. Our identity is more than just the sum of the different roles we hold in our lives. We also have a personal self. A personal self reflects a sense of autobiographical uniqueness, a stable core in our personality that transcends the shifting roles in our lives (Hewitt, 2000). A personal self is a feeling of ‘this is who I am’, and creates a sense of unity between our different roles.¹⁸ For the stability of our personality, we organise the different roles we have in a hierarchy (Stryker & Serfe, 1982). How high an identity-role ends up in the hierarchy is determined by the availability of opportunities to act on an identity, and our commitment to that identity. The higher an identity is in a hierarchy, the more people are motivated to seek opportunities to act on that behaviour, and the more an identity gets reinforced (Hewitt, 2000). We choose certain roles over others. I might volunteer for helping out at a reading class at the school of my children, but not for organising a tennis tournament at my sports club. The hierarchy of our roles can change due to social pressure, changes in circumstances, or internal changes. When I have an important deadline at work, my role as an employee might be higher in the hierarchy than that of mother or friend. When we rework our identity hierarchy, we rework our behavioural pattern.

As we saw before, with certain identities come certain behavioural scripts. Our situated, social, and personal self also shapes our attention and impulses. When I am at the GP, I will be mostly focussed on information regarding my medical condition. If in the waiting room there is a magazine advertising holiday destinations, I will be less inclined to give

¹⁸ The personal self strongly interacts with the social self. We adopt identity materials from the social world, adjust them to our personal sense of self, and reflects them back to society to see if they are accepted (Koski-jannes, 2002).

that attention, even when I have a holiday coming up. Once one adopts a particular role, one has an identity that organizes relevant impulses and excludes those less important to the particular situation (Hewitt, 2000, 105). Every time one adopts a certain identity, consciously or non-consciously 'one reorganizes the self at a motivational level. That is, one reorganizes one's impulses and thus alters the environment to which one will subsequently be sensitive' (Hewitt 2000, 108). Our identity influences our attention, and hence determines our actions. In her research, Cordelia Fine gives numerous examples of how priming people's gender influences their behaviour (Fine, 2010). For example, when women were asked to specify their gender before a mental rotation test, they performed worse than when they were asked which private-college they attended (McGlone & Aronson, 2006). The studies Fine cites demonstrate that people adjust their behaviour according to the social expectations of their identity.

When our identities are challenged, we may lose control over our behaviour. Hewitt (2000) gives the example of a baseball pitcher on a losing streak, who starts to doubt whether he still has what it takes. During interviews the press explicitly doubt if he can still claim the identity of an A-league pitcher, and his performances further decrease. These doubts about his identity negatively influence his control over the game. Former champion Justin Gatlin described the 'fear factor' Usain Bolt instilled in his rivals when he beat so many world records at the 2008 Olympics. The experience of being easily surpassed by Bolt led many to question their identity as a world champion runner. 'Sprinting's about the alpha male, but you could see the fear he'd instilled in the others. Already before they took to the line, they had doubts in their minds and that's because of Bolt.'¹⁹ Bolt made people question their identity of 'alpha male', and this influenced their performances negatively.

Above I distinguished between situational, social, and personal identity. Two other parts of our identity are our ideal self and our actual self. Higgins (1987) describes the actual self as who one currently is, and the ideal self, or the ideal future self, as the person who one wants to be. The future ideal self also has motivational force: it can guide our attention, motivation and action (Markus & Nurius, 1986). Agents want to act in an identity-congruent way, they want to attain their ideal future self and

¹⁹ <http://gantdaily.com/2016/11/23/usain-bolt-the-man-behind-the-medals/>

avoid the future self they fear (I don't want to turn out like my parents; I don't want to still use drugs when I am 80) (Vignoles, Manzi, Regalia, Jemmolo, & Scabini, 2008). People often state that their future self is a truer version of themselves than their present self (Wakslak, Nussbaum, Liberman, & Trope, 2008). Our feelings of self-worth are thus closely linked to whether or not we manage to achieve our aspired identity (James, 1890; Oyserman, 2015). Unresolved, chronic discrepancies between our current and future self can result in depression and anxiety (Higgins, 1987). The future self, however, needs to be a logical continuation of the present and past self. The future self needs to be a logical continuation of our life narrative. We try to create a feeling of diachronic unity between our past, present and future self, we shape continuity in our experiences (Blasi and Glodis 1995; Hewitt 2000, 93).

Below I will discuss some empirical evidence supporting the idea that our identities can be an important source of motivation. I will briefly discuss some insights from the literature on moral psychology, and I will give a brief overview of empirical literature on how identity can play a role in recovering from substance dependency.

3. The role of the moral self in guiding behaviour

There is an interesting stream of literature in moral psychology concerning the ways in which identity motivates behaviour. What initiated this stream of inquiry was the observation that often people hold certain moral beliefs or reasons, yet fail to act on them. Although it is often presumed that a person judging a given action to be the morally right one will automatically trigger them to behave that way, moral reasons do not seem to have sufficient motivational force. This discrepancy between judgment and behaviour is called the judgment-action gap (L. J. Walker, 2004). To determine when moral judgments have motivational force, moral exemplars²⁰ were studied to determine why they acted so consistently on their moral judgments while other people did not. It was found that moral exemplars considered their morality to be central to their identity, and reported feelings of having no choice than to act the

²⁰ Colby and Damon asked a panel of experts to identify moral exemplars, people who are leading a life of moral virtue, integrity, and commitment.

way they acted (Colby & Damon, 1992, 1993; D. Hart & Fegley, 1995; Reimer & Wade-Stein, 2004). For moral exemplars, failing to act on one's morals is perceived as a 'fracture within the very core of the self' (Blasi, 1983). Two people can have the same set of moral beliefs, however, they may differ in to what extent it is important for them to be moral in a personal sense (Bergman, 2004).²¹

4. Evidence that identity plays an important role in regaining control over substance-dependency

There is evidence in the addiction literature that an identity change from user to non-user can provide a strong motivation to overcome substance-dependency. Biernacki's (1986) study is famous among these studies. Biernacki wondered why some people spontaneously recover from heroin addiction. He interviewed 101 ex-heroin users who quit their use without professional intervention, and found that fundamental to their recovery was an identity change. Biernacki describes how people hold several different social identities at the same time: being an addict, parent, thief, student, worker, sibling. These multiple identities must be actively managed, and they are organised in a certain hierarchy in terms of both how important they are for the person and whether they are socially supported. Biernacki found that in spontaneous recovery, participants reorganised the hierarchy of their identities: they devaluated the addict identity in favour of another identity or set of identities they hold. For some, the identity of an addict became non-existent while others still identified as an addict, but gave this identity a low status in their identity hierarchy.

Many qualitative studies on recovery have since supported the finding that identity change can play an important role in recovery (Hughes, 2007; Koski-jannes, 2002; Mackintosh & Knight, 2012; McIntosh & McKegane, 2000; Shinebourne & Smith, 2009).

So what does this identity change look like? Miller (2003) provides us with the following true story. A heavy smoker is about to pick up his children from school. It is raining heavily. When he is almost there, he notic-

²¹ For an overview of the growing body of empirical evidence on how moral identity motivates action see Hardy and Carlo (2005)

es that he is out of cigarettes, and although he sees his children standing in the rain waiting for him, he changes directions to buy cigarettes. And at that moment it hits him, and he thinks: ‘I don’t want to be the kind of person who leaves his children standing in the rain to buy cigarettes’. Subsequent to this he successfully stops smoking (Miller 2003; borrowed from Premack 1970). Miller points out that this man did not learn any new coping strategies, nor did his incentives or circumstances change, rather, his identity changed. The smoker suddenly noticed a strong discrepancy between his actual behaviour and his ideal self, and he decided to act on his ideal self. Miller argues that this kind of change is quite common in recovering from addiction: ‘Within a span of minutes or hours, the person’s *identity* changed from addict to abstainer. It is not merely behaviour change, they tell us.’ When people regain self-control in this way, by changing their self-concept, the change is so profound that they do not even struggle with impending relapse (Miller 2003, 64-5).

Flanagan (2013a) describes how many addicted people at a certain moment in their lives experience that their ideal and actual identity ‘are on divergent paths, likely far apart, possibly inconsistent’ (Flanagan 2013a, 2). He describes (2013b) how people can, to a certain extent, endorse part of their substance using identity. However, realising that this identity is incompatible with another, more cherished identity, can help to overcome addiction:

My brother decided one cannot be an addict and a rock/ice climber, serious bike racer, competitive half-marathoner, and ultra-marathoner. Hamill, who had great talent as a writer and aspired to be an accomplished one, used a conscious trick: drinkers are forgetters, writers are rememberers. ‘I had forgotten material for twenty novels’ (Flanagan 2013b, 876).

Flanagan used normative self-control to overcome his addiction by telling himself: ‘I really am the sort of person who can’t touch this stuff at all’. (Flanagan 2013b, 876).

Velleman (2002) provides us with a related example of a colleague who was trying to give up smoking. The strategy of this colleague was to think of himself as a non-smoker:

He imagined that he was not addicted – that he didn't like the taste of cigarettes, wasn't in the habit of smoking them, had no craving for them – and he then enacted what he was imagining, pretending to be the non-smoker that he wanted to be. (Velleman 2002, 99-100)

In playing the person he wanted to be, many of his former behaviours ceased to be options (Kennett & McConnell, 2013). This strategy is also known as 'fake it till you make it' to Alcoholics Anonymous (AA) and Narcotic Anonymous (NA), or 'living as if' (W. R. Miller, 1985, 2003). '*Fake it 'til you make it (...)* allows (...) participants in NA to try on aspects of the identity of recovering addict without "owning" that identity. (...) [These actions are] a valuable prerequisite for more sincere actions later' (Rafalovich 1999, 150). This strategy is supported by empirical research. One study found that smokers who identified themselves with the label of ex-smoker were more likely to be abstinent after 6 months than those who did not identify with the label of ex-smoker. Of those who after one week of treatment identified with the label of non-smoker, only 50% had relapsed after 6 months, while from those who did not identify with the label of non-smoker, 100% had relapsed after 6 months (unpublished research, cited by Pickard 2012 and West and Hardy 2006). Shadel and Mermelstein found similar results: smokers were more likely to be abstinent 3 months later when they entered treatment with a strong abstainer self-concept (Shadel & Mermelstein, 1996).

Several other prospective studies found similar results on the importance of identity in recovery. Weisz (1996) collected data from 45 people entering treatment who struggled with alcohol and cocaine use. She let participants choose from a list of 7 identities pre-treatment, and asked them to rate whether the identity was positive or negative to them, how important the identity was, and if that identity conflicted with their substance use. The seven identities were: (a) spouse or romantic partner; (b) family member; (c) friend; (d) worker, homemaker, or student; (e) group or team member; (f) person with a hobby; and (g) active or physically fit person. After 3 and 6 months, she evaluated their sobriety. She found that those who reported a great number or strongly valued (i.e., positive and important) identities had better treatment outcomes (abstinence) after 3 months, although the effect faded after 6 months. Respondents who reported a strong conflict between their substance use and their

identity pre-treatment were also more likely to be abstinent at 3 months, this effect also faded after 6 months.

The most impressive study on the role of identity in motivation to quit was done by Downey, Rosengren, and Donovan (2000). Inspired by Weisz's study, the authors aimed at testing the strength of identity-related motivation in achieving abstinence from substance use. They collected baseline data from 654 people who presented at a treatment facility for a brief motivational intervention, and followed them up after 90 to 180 days to test their sobriety. Ninety percent (587) provided follow-up data. At baseline, they filled in the Reasons for Quitting questionnaire, which had 3 sub-items which referred to identity as a motivation to change: wanting to like oneself more, wanting to feel in control of life, and wanting behaviour to reflect ideal-self standards. Participants were also asked to name five people who were most important to them, and rate how each person felt about their substance use. These data were collected to compare identity-based motivation to motivation from significant others. They found that motivation linked to identity predicted abstinence better than motivation from social influence, health and legal issues. Discrepancies between substance use behaviour and one's ideal self-guide can effectively motivate abstinence. However, this effect was strongest among cannabis users. Results for alcohol and cocaine were weaker, and for opiates it was not significant. Downey and colleagues conclude that the effect is probably strongest during early stages of recovery.

The above studies show some preliminary results that highlight the importance of identity in recovery from addiction. Identity can be a source of motivation to quit using substances. Some treatment modalities have incorporated these findings in their approach. Motivational interviewing for example, makes use of the discrepancy between a participant's current behaviour and their ideal self (Hettema, Steele, & Miller, 2005). One study even suggests that this is one of the effective ingredients of the treatment (Apodaca & Longabaugh, 2009). However, as the above studies show, the effect of the motivational force of identity is mixed for different substances, and overall the effects are relatively short lived. It is worth examining why this is so, which I will do in the next sections.

5. Are the studies on identity change too optimistic?

As the empirical studies underline, identity – or regaining control over one’s self – can play an important role in recovery. Retrospective studies like those of Biernacki might give the impression that once the motivational force of identity sets in, change is a done deal. The same conclusion can be gleaned from Miller’s example of the smoking father who changed his ways successfully in the blink of an eye, and without cravings. Miller calls this type of sudden identity change ‘quantum change’ (W. R. Miller, 1985, 2004). In quantum change, people experience a sudden epiphany. They feel like they passed through a one-way door: their change is sudden and irrevocable. This kind of transformation of the self is almost a transcendent event. Miller states that this type of identity transformation is quite common in addiction. Biernacki seems to support this finding, but his research might have a bias since he only interviewed people who successfully recovered without treatment and were in stable recovery for several years. In actuality, it is likely that this type of ‘quantum change’ is quite rare and that for most people changing their identity is hard work that must be met with some supporting conditions.

The relationship between self and motivation is not simple and straight forward. When people notice a discrepancy between their current self and their ideal future self, this discrepancy does not automatically herald change. And even if people suddenly feel strongly motivated by their valued future self, Weisz’s (1996) study shows that more is often needed to sustain this change in identity and motivation. The prospective studies of Weisz (1996) and Downey and colleagues (2000) show that the identity change does not always persist and is dependent on other factors. Weisz (1996) found that the motivational force of identity faded away after 6 months. Downey and colleagues found that the motivational force of identity on recovery was strongest for the weakest substances, and was non-existent for the stronger substances like heroin. Perhaps the weaker substances do not affect identity as intrusively as the more stigmatised substances like heroin. Weisz’s (1996) sample consisted of people from high socio-economic backgrounds, people who in general still had jobs and contact with family, people who still had identities to fall back on. Motivational interviewing is found to be most effective for

people who have not been addicted for a long time yet, and maybe this is because they still have much of their old identity left. The differences in the motivational force of the self between substances, and between early and late stage addiction, suggest that maybe addiction and identity are connected in a way that affects normative agency. However, the real question may be whether addiction influences *certain conditions* that must be met in order for normative agency to be effective. In the next section I will look more closely at literature that suggests that certain conditions must be met in order for identity to be motivating.

6. Conditions that must be met for the ideal future self to guide behaviour

The above empirical literature provides evidence for the fact that our identity can guide our behaviour. However, earlier I outlined that we hold several different kinds of identities at the same time: situated, social, and personal identity. Our different identities can have the same interests, or conflicting interests, or just different interests (Oyserman, 2015). How can we make sure that we are motivated by the right identity at the right moment? How can we make sure that we act on our ideal self?

Daphna Oyserman became interested in the question of how our ideal future identity influences current behaviour when she moved to a new city and learned about the concept of Devil's night. During Devil's night children were allowed all kinds of mischief, like throwing eggs at windows, or throwing toilet paper in trees. In recent years, the mischief on Devil's night escalated and some youths engaged in dangerous fire-setting. If these youths got caught, this had serious implications for their future prospects. *Why are these youths not more concerned about their future selves?*, Oyserman wondered. This led to a series of experiments in educational settings, because no matter what a person's cherished future self is, the path to most ideal future selves goes through education (Oyserman, 2015).²² Although people in general are motivated to act

22 Oyserman interviewed adolescents about their future self and measured the time they devoted to their school work.

in an identity-congruent way, Oyserman distinguished four conditions that must be met in order for the future self to guide behaviour.

- The future identity must be accessible (not clouded by other cues)
- The future identity must be seen as relevant to the current task (the future starts now)
- The future identity must be seen as achievable (not impossible)
- The pathway towards the future identity must be seen as fitting for ‘people like me’

I will discuss each of these conditions in more detail.

The future identity must be accessible: Most people are capable of acting in a future-oriented way; they are able to act in a way that will support the realisation of their future self. However, people also have the tendency to favour their current selves, and neglect their future ones (Oyserman, 2015, 5). We are most likely to act on the identity that is available at the moment we need to make a decision, and that is often the identity that is evoked by the cues in our immediate environment. The cues in our environment often implicitly attract our attention to our situated identities, to what is relevant in this moment and this situation. So although people are able to act in a future-orientated way, our future identity needs to be accessible and evoked at the moment of our decisions and not be clouded by environmental cues. We need to keep our attention on the right identity (Oyserman, 2015, 11-12).²³

The future identity must be seen as relevant to the current task: However, simply imagining our future self at the moment of our decision does not automatically lead to behaviour supporting this future self, we also need to perceive the future self as relevant to our current task, or current decision. Even if a certain future self is extremely important to me, and is strongly on my mind, this self can still feel irrelevant to my current situation. Oyserman gives the example of homework. Homework can either feel like a good investment in the future, or like a chore, de-

23 Levy has argued for a version of this hypothesis to be true in addiction. He argues that addicted people have a global perspective, they are motivated by it, however, due to their craving, they are unable to consistently act on it and exert their will across time. They experience preference reversals more frequently and more easily than most of the rest of us. Levy (2006) suggests that substance use disintegrates and fragments the agent: addicted people are less unified in their identity than non-addicts. Kennett and Matthews (2003) also state that individuals with serious drug or alcohol addiction face problems in achieving unity of agency.

pending on whether someone sees doing homework as relevant to their future self. Most students only perceive their homework as relevant to their future self just before a future-determining test; before that, it does not seem likely that skipping homework today is really going to matter to a self that is almost a decade away in the future (Oyserman, 2015, 12). However, scoring well on the final test requires long term investment in one's school work, and not only studying hard the night before. In a short intervention, Oyserman and colleagues primed children to believe that their current self was connected to their adult selves ($n = 141$ experimental, $n = 123$ control). In this condition doing well this year in school would contribute to fulfilling their future plans. As a result, students got better grades than those in the control group. They were also less depressed, and absences and misbehaviour declined. After a 2 year follow up, these effects sustained, and were reinforced by beliefs that their future-valued identity was getting closer in reach (Oyserman, Bybee, & Terry, 2006). In another experiment, students were encouraged to visualise their future as a path or a timeline that is connected to their current self. Students who visualised their future goals like this were more likely to take steps to realise their future plans rather than living in the present (Landau, Oyserman, Keefer, & Smith, 2014). In short, having access to our future identity is not enough: in order to act in a future-orientated way, we must also experience our future identity as relevant to our current task (Oyserman, 2015, 7).

The future identity must be seen as achievable: Oyserman did most of her research with children from low-income families, and noticed that many of them perceived their desired future identity as unachievable, hence, they did not even try. When our future identities seem impossible to attain, we give up on them (King & Hicks, 2007; Pizzolato, 2007). Now of course our plans need to be realistic, e.g., if I have bad eyesight, I cannot become a pilot. However, many of the children Oyserman studied did have a good chance in life; they only needed to believe in it. Because they had very few positive role models in their lives, however, they found it hard to see their future identity as achievable. Oyserman points out that when we have low belief in self-efficacy, we have a different response to obstacles compared to people who have a high belief in self-efficacy. We can perceive obstacles as a sign that our goal is unachievable and give up, seeing our efforts as a waste of time. We can also perceive obstacles

as a sign that our future self will be more valuable because it is harder to achieve: we come to the conclusion that ‘important things are difficult’, and double our efforts (Oyserman, 2015, 19). We need to believe in our self-efficacy, especially when confronted with misfortune.

The pathway towards the future identity must be seen as fitting for ‘people like me’: We do not only need to identify with our future self, we also need to identify with an identity-congruent path to our future self. Take, for example, a young boy who wants to become a veterinarian. He knows that to become a veterinarian, he has to do well in school. However, if effective strategies to do well in school, like writing difficult words on cards and rehearsing them, feels like ‘things girls or nerds do’, then the student will not use these effective memorization strategies, and he is likely to fail at achieving his goal. We do not only need to have a future self, we also need to identify with the path that will lead to our goals. Strategies need to feel identity-congruent. Oyserman and colleagues primed student’s gender or ethnicity with success, and found that they performed better than when not primed (Elmore and Oyserman 2012; Oyserman and Fryberg 2006; see also Fine 2010).

To summarise Oyserman, certain conditions must be met in order for our future identity to become a source of motivation. Whether our image of our ideal future self will motivate us or not, depends on whether we believe that (1) this future self is achievable for us, (2) that the path towards this future self is doable for people like us and (3) there is a connection between our current activities and our ideal future self. For example, if I want to be a vet, I will have to feel that doing my homework tonight will contribute to that goal, I will have to see myself as someone who will go to university, and I will search for role models, people with my background who became a vet. When we look at Nicole’s story, we see that she has an image of her valued future self (a mother, a health professional) and this future self seems relevant to her current tasks, such as studying radiology. However, she has strong doubts concerning whether her ideal future self is achievable, and whether the path towards it appeals to her. Her perception is that the other students are smarter and better equipped than her, and that they do not accept her as one of them. Although it is not unusual for students to fail a practicum, Nicole sees it as a sign that her future self is unachievable.

7. Addiction and the impairment of identity

Above I stated that our identity has a certain motivational force. Perceiving oneself as a certain person will motivate one to act in a certain way. Many studies show how this motivational force of identity can help to overcome addiction. When we focus on our ideal future identity instead of on our social or situated identity, we can change our behaviour. However, what these studies do not explain is why the motivational spark of identity often fades out so quickly and fails to sustain the change that is set in motion.

Normative agency can be disrupted in many different ways in addiction. Addiction can make us lose control over our social identity due to (self-) stigma. The negative reactions (real or imagined) of others on our appearance can have profound effect on how we view ourselves (Biernacki, 1986; Gibson, Acquah, & Robinson, 2004; Goffman, 1963; Hughes, 2007; McIntosh & Mckeganey, 2001; Shinebourne & Smith, 2009). The relationship between identity and addiction can be very ambivalent. Although most people do not identify with their addicted behaviour, they often deeply endorse some aspects of their drinking or using. For example, drinking is often associated with being a certain kind of person, a manly man. Drinking, but often not addiction, can be part of someone's deep self. It can be hard for people to admit that their drinking is out of their control, and that others see them as an 'addict' (Flanagan 2013b). It can be hard to depart from some aspects of our self that we endorse because in the long run they do not contribute to being the person one wants to be (Flanagan 2013b; Lewis 2015). Addiction can also fragment the unity of our identity due to the physiological strength of addictive craving. The craving undermines our resolutions and our commitment to them (Kennett & Matthews, 2003; Levy, 2006). If substance use starts in early adolescence it can disrupt a healthy identity development. Adolescence are formative years, and if we spend them only using we miss out on a lot of roles (Gibson et al., 2004; Kate, 2013; McIntosh & McKeganey, 2000). Addiction can also make our ideal self less accessible due to craving and incentive sensitisation (Levy, 2006). Craving and incentive sensitisation diverts our attention to substance related activities, rather than towards our normative goals. Persistent relapses or certain side effects of our substance use can also make our ideal future self either seem unachiev-

able, or make us feel that the road to our ideal future self is closed off from us. For example if I got a criminal record due to our substance use, if I got hepatitis due to sharing needles, or if I feel that no one will hire me because I look like a 'junkie'. If we do not believe that we can achieve what we value achieving, we will not be motivated to act on the values we hold dearest. In order for our future self to be motivating, we need to believe that we are reasonably safe from disastrous harm and misfortune, and we need to believe that we can exercise some control over the outcomes we would like to achieve (Calhoun, 2008). All these factors that disrupt our sense of self can lead a person to change the image of their actual self, what they are capable of, and how their life story will likely continue, in an overly negative way.

In the next two chapters I will look more closely at how the effects of addiction can erode our fundamental beliefs about our actual self – those beliefs concerning what we are like and what we are capable of.

8. Conclusion

In this chapter I showed how identity can play an important role in recovering from substance use. By regaining control over their selves, people can regain control over their behaviour. However, in order for my future self to be motivating, my ideal future identity must be accessible: it must seem relevant to my current life, it must appear to me as achievable, and the pathway to my ideal future self must be seen as fitting for 'people like me'. Bringing my desired identity to the foreground after I notice a discrepancy between my current identity and my ideal identity is not enough, I also need to bridge the gap between my actual self and our ideal future self. External factors like lack of social support and lack of opportunities can frustrate this process.

In the following chapters I will argue that many addicted people do have a strong, positive image of their ideal future self, but are lacking belief in self-efficacy – in particular, a lack of belief in their capacity to get where they want to be. This lack of belief in self-efficacy is partly caused by the harsh circumstances people with substance dependency face – by factors such as stigma and ill health. Belief in self-efficacy can be impaired by

different factors that are often overlooked in traditional interpretations of failure of self-control in addiction.

In the next chapter I will discuss how the effects of addiction on the body influence people's beliefs in self-efficacy. In order to achieve the future we value, we need to be able to trust that our body will carry us there. For this, we need to possess the energy and physical capacities required for action. In order to attain the future we value, it helps when other people believe in our potential, and treat us as if we are capable agents.

CHAPTER 5. THE INFLUENCE OF THE BODY ON OUR DIACHRONIC PLANS AND SELF-CONCEPT



1. Introduction

In discussing Nicole's case-study, I showed that agency is exercised in concrete existential situations. Examining these existential situations – focussing in particular on how a person makes sense of them and the manner in which they influence their beliefs – provides us with important information on how agency can be impaired. I showed that current theories can account for certain aspects of agency impairment in addiction. However, agency is not underpinned by one factor, but rather by a complex, interactive set of factors. I argued that it is at the level of normative self-control that we should understand how these factors interact.

The normative level of self-control is not only important to explain losses that occur on other levels, but looking more closely at the normative level of self-control also reveals losses of agency that occur for reasons that do not reduce to factors identified at the lower level. In Chapters 1 and 2 I argued that there are more ways to exercise agency than through will-power, cognitive control, or diachronic strategies. We can also exercise self-control via the constitution of our identity. If there is more to self-control than being strong or being skilful, there are also more places we have to look for impairments.

In the last chapter I highlighted how a person's self-concept is subjective, and entails many beliefs about them and what is likely to happen in their lives. If we do not feel that the future we value is within our control, we will not be motivated to act in a way that brings this future closer. What we saw in Nicole's case-study was that her self-concept played an

important role in her relapse. We also saw that her body, and the way others could perceive her body, highly influenced Nicole's self-concept. In this chapter I will examine how changes in a person's body changes their self-concept, what they think is worthwhile or possible in their lives, as well as their capacity to commit to their long term plans.

There is a vast amount of literature on how addiction changes the brain and these changes are viewed highly relevant for self-control. Although it is well-known from the medical literature that addiction also changes the body, these changes on the body are not seen as relevant for self-control. These losses of health are often viewed as a consequence of loss of self-control, rather than a factor that influences self-control as well. The respondents in my study, however, very clearly articulated that their substance use has resulted in substantial physical changes, and that these changes influence their agency in several ways. The experiences the respondents narrated with regard to their body and their agency bear striking resemblance to the testimonies of chronically ill people concerning the ways in which bodily transformations influence their agency. The respondents described how a lack of energy, feeling miserable, feeling marked by their substance use, seeing many of their friends die from substance-related issues changed their perspective on their future, their belief in self-efficacy, and reinforced a local perspective on their lives.

In this chapter I will begin by reviewing insights from the literature on disability bioethics and embodied agency regarding how both our agential capacities and our sense of agency rely on the body. I will then compare the testimonies of chronically ill people with those of my respondents and show the similarities in how their bodies impair their agency.

2. How the body constitutes agency

The literature on disability bioethics shows how our ability to live the life we value, be the person we value being, and engage in diachronic projects depends on a well-functioning body. As long as our body functions in the manner to which we are accustomed, this crucial aspect of agency often remains unnoticed (Mackenzie, 2009). However, once our body stops functioning the way we are used to, it becomes clearer how

our bodies shape our agency. ‘What happens to you, how it happens to you, how you understand and interpret it, and which responses are available to you, are all rooted in the embodiment that you have.’ (Scully, 2003, 278) Below I will describe the experiences of those who have encountered sudden, progressive, chronic illness, and how this affects their agency. I will discuss the experiences of Kay Toombs (2001) and Havi Carel (2008), and some of the accounts described by Charmaz (1991) in her qualitative studies on chronic illness.

At the age of 29 Kay Toombs is diagnosed with multiple sclerosis, which over the years results in a gradual deterioration of her bodily capacities. As her disease progresses, Toombs loses her mobility and becomes dependent on a wheelchair. In her early thirties Havi Carel is diagnosed with lymphangioliomyomatosis (LAM), a rare lung disease which rapidly reduces her lung capacity and hence severely limits her physical activities. The doctors estimate that she only has 5-10 years left to live. Both authors describe how they suddenly became aware of the extent to which their bodies determine their agency. Toombs states:

I don’t have a body – as I have an automobile, a house, or a pet – but I live or exist in my body. (...) My leg is not an object but the possibility of walking, running, playing tennis. (...) [M]y illness is the impossibility of taking a walk around the block, of climbing the stairs to reach the second floor in my house, or of carrying a cup of coffee from the kitchen to the den. (...) Over the past twenty-eight years (since the age of 30) my physical capacities have altered in a startling number of ways. At one time or another my illness has affected my ability to see, to feel, to move, to hear, to stand up, to sit up, to walk, to control my bowels and my bladder, and to maintain my balance. (Toombs, 2001, 254; 247)

Carel describes how after her diagnosis the life she had always known was suddenly limited in ways she had not experienced before. These limits were not just physical but existential (Carel, 2008, 53). As Carel (2008) describes it: ‘the experience of illness and its sweeping effect on every aspect of life shocked me.’ (Carel, 2008, 7)

Let us look a bit more closely at the aspects of Carel’s life that are influenced by her illness. Carel first notices that something is wrong when she is participating in group exercise and cannot keep up with the other participants. This strikes her as odd, since she is normally one of the fitter persons in the group. She is annoyed by the teacher, who treats her

breathlessness as a sign of her not being an active person. She thus first notices that something is wrong when she cannot do something anymore that she used to enjoy: exercising. After her diagnosis, and with her breathlessness increasing, many of her daily activities change, and her daily routines have to be adjusted to her breathlessness. We are used to doing certain things in a certain way, and at a certain speed. Now those daily routines which require physical activity suddenly become very time and energy consuming. A short walk with colleagues to the pub for Friday night drinks requires her to walk very slowly, out of sync with her colleagues, and with no breath left for conversation. Many of her leisure activities have become out of reach: playing with her dog, running, travelling, outdoor activities. Her illness also presents her with new routines. She describes how time-consuming her illness is: 'The endless need to arrange oxygen deliveries, attend scans, renew my prescription, pick up drugs, take drugs, attend consultations' (Carel, 2008, 30). We saw in Chapter 1 that daily habits usually conserve our energy, so we can devote that energy to our more long-term plans. However, Carel describes that her daily routines suddenly become so time and energy consuming that very little energy is left for anything else than getting through the day. Her illness thus forces her to adopt a local perspective on her life. Her day-to-day grind consists in attending to the illness-related problems her day presents to her.

Carel describes another factor that forces her to take a local perspective on her life: impending death. She describes how her attitude to time drastically changed. It changed, firstly, because her attention was needed in the present to manage her illness and perform her daily routines, and secondly, because her horizon dramatically shifted. Her life ceased to be a 'long, gently flowing river' (Carel, 2008, 123).

What would you do if you were told you have a year to live? A month? A day? You would probably have very different plans for each scenario. Our diverse attitudes to life stem, in part, from our different estimates of how much time we have. (Carel, 2008, 121)

Carel describes how she had to rethink her goals, aspirations, plans, and planning. Our image of the good life is linked to how much time we estimate we have left. Carel estimates she has 5-10 years left; she is forced

to take a more local perspective on her life. In one sense she experiences living in the present as liberating. For example, she no longer saves money or makes extra payments into her pension fund but starts to enjoy things in the present. On the other hand, she mourns the loss of her dreams of starting a family, and of travelling. She strongly focuses on those projects that are still possible and carries on with her life ‘while muffling out the existence of the iceberg’ of things she wanted to do (Carel, 2008, 47). Her future is no longer something to look forward to, but something to dread. What else will she lose once her lung capacity declines even further?

Carel also describes how her illness influences her relationships with other people. When she starts to give talks about her illness, she notices that the people in the audience seem puzzled; they try to determine whether she was an academic or a patient, and it seems very relevant to them to determine her identity in one of these ways. When her illness progresses and she has to walk with an oxygen tank on her back, she gets many intrusive questions from strangers. The most intrusive ones are about how long she has to live. ‘I was dumbstruck. The horror of it, and the casualness with which it was asked, was too incongruous for words’ (Carel, 2007). Carel feels stigmatised: ‘Once you are ill, I realise, you become fair game. You slide down an implicit social ladder. Others begin to perceive you as weak and unimportant, an object of pity and fascination’ (Carel, 2007). When a nurse is untouched by her crying after a test reveals she has lost more lung capacity, despite all her hard work, Carel wonders if people even see her as a person (Carel, 2008, 38).

The changes in her body also force her to re-evaluate her self-concept. ‘From thinking of myself as a young, healthy, promising life and body I had to start thinking of myself as fragile, damaged, unable.’ (Carel, 2008, 66). Her self-concept is threatened in several ways. Not only had her body changed, so too had people’s responses to her appearance: she has a different public identity, one she experiences as stigmatised. In addition, the loss of her previous daily routines changes her self-concept. ‘Our actions define who we are, give us a sense of potency and agency. But being disabled means being unable to do the things you love’ (Carel, 2007). Not being able to do the things you love erodes your sense of who you are. Lastly, the loss of her future self was for Carel a strong loss of identity. ‘Illness changes everything’, Carel concludes – it not only changes her

physical body, but also her relationship to time, to other people, and to her concept of self (Carel, 2007).

The changes in agency that Carel involuntarily undergoes due to her lymphangiomyomatosis are well-documented in other illnesses as well (Charmaz, 1991). These include multiple sclerosis (Toombs, 2001), cancer (Frank, 2010), heart attacks (Frank, 2010), HIV (Ciambrone, 2001). However, the literature on addiction and agency stays remarkably silent on the meaning of physical changes brought about by addiction.²⁴ Although it is well known from the medical literature that addiction changes the body, this is not deemed relevant for discussions on agency. This stands in stark contrast with the attention given to neuronal changes, which are considered highly relevant for agency. Below I will elaborate on the lived experience of substance users, which has a strong emphasis on the embodied side of addiction, and how it influences agency. I will compare the accounts of my respondents with those of Toomb, Carel, and the autobiographical accounts Charmaz (1991) collected in her research on chronically ill people. I will focus on three ways in which bodily changes affect agency, which have already been highlighted in the story of Carel.

The first way in which physical illness changes a person's agency is by disrupting their normal everyday routines, recruiting energy that would otherwise be devoted to future planning. Carel describes how time-consuming the management of her illness is, and how much effort her normal daily routines suddenly cost. Because her daily routine suddenly becomes so time consuming, Carel is forced to adopt a more local perspective on her life, simply because all her energy is needed to manage her day to day life.

The second way in which physical illness changes a person's agency, is that they cannot rely anymore on their body to carry them into the future. When pursuing our long term plans, we need to have trust in our future self - in particular, we need to trust that we will still be there in a few years' time and we will still possess certain capacities. This loss of horizon further enforces the local perspective physically vulnerable people have to take on their lives.

24 One of the reasons why this perspective is so absent in the current literature could be because there is still a moral view on addiction, in which the changes on the body are seen as self-inflicted, hence they deserve less compassion and consideration.

The third way in which physical illness changes our agency is by means of changes to our self-concept. The loss of habits and the loss of a future self present us with a loss of identity. In addition to this, however, direct physical changes and other's responses to them influence a person's self-concept. The bodily changes impose limits onto their situated and social identities, forcing them to take on a 'disabled identity'. This disrupts normative self-control because the agent's future ideal self is no longer the one they had anticipated

3. Disruption of daily habits

3.1. *Illness and the disruption of daily habits*

We saw in chapter 1 how habits free up our cognitive resources. We rely on our habits in order to preserve our energy, energy that can then be devoted to future plans. While we mindlessly brush our teeth, we plan the day ahead of us. However, illness 'rips apart taken-for-granted daily routines' (Charmaz, 1991, vii). Having a chronic physical illness disrupts our daily routine in three key ways: (i) managing our illness takes up a lot of time and energy, (ii) our normal routines become more time-consuming because of our physical impairments, and (iii) our physical suffering drains our energy. I will now discuss each in turn.

(i) Costly new routines in managing the illness

Having an illness often requires the addition of new and costly routines to a person's current ones: routines around medication, treatment, and doctors' appointments. Carel described how time-consuming her illness is. Her life becomes increasingly organised around, and orientated to her illness. Charmaz describes how these new routines can take over a person's life. Sometimes the only structure ill people have left in their lives is the regime of their medication, they have no other routines left (Charmaz, 1991).

(ii) Standard daily routines become more time and energy consuming

Chronic illness can also change a person's existing daily routines in the sense that they suddenly become very time and energy-consuming. Car-

el described her difficulties in walking to a pub with colleagues. Toombs describes how, when she became wheelchair bound, her day to day tasks and routine activities suddenly started to cost an immense amount of effort and devour time. She marvels at how easy it was before her illness to brush her teeth, shower, get dressed, get things from the shelves in a grocery store, or mail a letter. Now these routine activities have become a series of complex problems that 'demand unusual exertion, intense concentration, and an untoward amount of time' (Toombs, 2001, 258). Catching a plane for a work meeting poses her with the numerous challenges from parking the car, to checking in, going to the toilet, embarking in the plane. On top of that, she feels stared at by everyone around her (Toombs, 2001, 250-254). Toombs sometimes looks in admiration at people who can still perform these daily tasks effortlessly, who can walk the stairs taking two steps at a time. Toombs and Carel describe feeling 'out of synch' with normal people who could do these tasks effortlessly, and 'falling out of step with healthy people's activities and interests' (Carel, 2008, 51). Chronically ill people become isolated from their friends, family, and colleagues who have a more global perspective on their lives because their lives are dominated by a different cycle of time.

(iii) Feeling too miserable to do anything

Chronic illness also changes a person's daily routine by making them feel too miserable to have energy to perform them. Remember the last time you had a gastro-intestinal-infection. You woke up feeling miserable, and your normal morning routines suddenly costed a lot of effort: getting dressed, showering, brushing your teeth, taking the train to work. Chances are, you felt too miserable to perform any of these tasks at all. Imagine how an ordinary day looks like for an ill person, how do they spend the day? They simply try to exist (Charmaz, 1991,187). Doing anything, even resting, can be a struggle.

Exercising agency requires us to perform bodily actions, actions that promote our goals. When we feel miserable, in pain, or extremely tired, we are not able to perform these actions (Carel, 2008; Nordenfelt, 2007). Pain and fatigue frustrates goal-directed behaviour because we feel too rotten to do anything else other than to get through the day, or we are discouraged by the amount of time it takes to do things. Baumeister and colleagues outline another way in which feeling miserable threatens

our agency. They have found that when people feel miserable, the goal of just feeling better gets priority over other goals (Baumeister, Zell, & Tice, 2007; Tice, Bratslavsky, & Baumeister, 2001). Trying to alleviate distress before pursuing long term goals is a good strategy if there is an easy way to resolve our misery, by for example, eating, or taking a nap. However, when our feelings of misery are more persistent or even chronic, this local perspective we take can further frustrate our agency.

All these factors together – feeling miserable, a lack of energy, trying to alleviate suffering – force those who endure them to adopt a local perspective on their lives and threaten the fulfilment of their long-term plans.

3.2. *Addiction and the disruption of daily habits*

When we compare this account of how chronic illness negatively influences daily routines at the costs of future plans, some striking resemblances can be found in the conducted interviews. The habitual nature of substance use is often highlighted, but not the extent to which this relates back to self-control.²⁵ Before we proceed, it is important to distinguish between the role habits play in different phases in addiction. In early stages, substance use can be a harmless habit: for example, drinking wine while cooking, or drinking beer while watching a game. In later stages substance use becomes an all-consuming, relentless habit that has much in common with the imposed new habits chronically ill people see themselves confronted with. When substance use turns into an all-consuming habit, many people struggle to develop new daily habits after they quit their use. And without good daily habits, daily life becomes much harder. Let us look a little bit more closely at these different stages.

(i) Costly new routines in managing addiction

The aforementioned personal accounts in disability bioethics illustrated how chronic illness often requires new costly habits to manage the illness. For some people, their whole life becomes structured around managing their illness at the cost of their future plans. Respondents

²⁵ Although dual-processing models shed some light on how habits relate to self-control, the literature on disability bioethics show that there might be more in the relationship between habits and agency.

from my study described a similar experience in late-stage addiction. In late-stage addiction a person often does not experience much pleasure out of use anymore. Using has become a chore, a physical necessity, and a cycle of need that they cannot easily break. Lewis (2015) gives the following example of a man struggling with alcohol use who described his life as a 4-hour cycle. 'For nearly six months, every day had followed exactly the same pattern. He did not leave his apartment, except for occasional shopping runs. He no longer went to work. His job was now drinking. (...) The glass had to be in his hand from the first minute of consciousness to the last. But that was a span of only four hours. (...) The first half hour was a period of desperation giving way to relief. The next hour was pleasant, enjoyable. (...) Then, for the next two and a half hours, he became increasingly sedate. It was no longer pleasurable. Nor did he expect it to be.' (p. 115-7) Then he would pass out, and the whole cycle would continue when he regained consciousness. Flanagan describes a similar experience of how addiction can take over daily habits: 'alcoholism is woven into the fabric of their everyday lives' (Flanagan 2013b, 885). Drinking is no longer an external thing, but part of how one sees the world, and every action one does is related somehow to drinking (Flanagan 2013b, 871).

Many respondents describe similar experiences: substance use gradually changes from part of their routine to the primary – or even only – routine they have in life. For one of our respondents (R23) drinking is closely linked to every element of his daily routine. In the morning he goes for a walk to the beach to enjoy nature, but takes a bottle of wine with him. When he visits a friend, they drink together. He really enjoys cooking, but both cooking and eating are intertwined with drinking for him. Relaxing by listening to the radio is unimaginable for him without a glass of wine. He experiences a lot of discomfort from insomnia, so he often drinks himself asleep. When we interview him the first year, he seems satisfied with his life. But over the years, his drinking slowly takes over the other activities. While the first year he spoke at length about food and herbs and how he enjoyed cooking, after three years he hardly mentioned any rewarding activities in his life anymore, and his life seems to be reduced solely to drinking. Heroin-dependent people also describe how their daily routines became dominated by obtaining heroin, block-

ing out other more beneficial routines. Respondents state that at a certain stage substance use becomes the only structure their lives have.

Usually my routine is just to drink wine. (R45B)

I will sit there and drink it and drink it and drink and drink and then blackout, wake up, drink and drink and drink and drink, blackout, wake up, drink, drink, drink, every day. (R7)

waking up in the morning and not going I feel ... my body feels ... I got to get drugs. How am I'm going to get it, who am I going to rob, who am I going to rort, where am I going to get money. [Now that I am clean:] Best thing is waking up in the morning and I go take the dog for walk and do some exercise and some push ups and enjoy the day (R42B)

And then it just got to a point, as an addiction does, where it just became my life. (R34)

Your whole life revolves around amphetamines and speed. You have it when you get up and you have it (...) before you go to bed, and spend weeks or whatever not eating, you stay in your clothes all day every day. (...) after a while it becomes just a part of life, just a way of life. You use it like you clean your teeth every day. (R51)

Addiction is a very physical habit. Regular use can become part of 'the cyclic structure of usual body sustaining behaviours such as breathing, eating, or drinking' (Schlimme, 2010, 57). People describe how their bodies ache and crave for the substance. As Burroughs famously described it: their bodies are like an hour glass through which the substance runs, dominating their daily structure (Burroughs, 1993, 170). What started as an 'embodied custom' like eating, drinking and sleeping, soon even out-competes the other embodied customs of eating, sleeping, and drinking, until it 'dominates all customary situations in daily life' (Schlimme, 2010, 57). Respondents describe that this is a very stressful situation to find themselves in:

I used to wake up and go 'I just want to die', I just don't want to wake up because it was just everyday I'd have to wake up and you'd be sick hanging out, (...) and your body's just ... you're always no energy, you're always sick, you're always feel just no energy and just depressed and just ... yeah. (...) I wasn't comfortable in my own body. (R42)

One could argue that managing one's addiction is quite different from the medication regime Carel describes. Taking substances is a choice, and people can decide to quit, whereas Carel has no such choice. The stage of addiction I am describing, however, is when substance use ceases to be a choice. When people reach a certain quantity and frequency of use, physical dependency starts to very strongly rule their lives. At that point, quitting cold turkey can have dangerous physical consequences, especially when someone is alcohol-dependent (Carlson et al., 2012).

There is another parallel between the life-eclipsing medication regime Carel describes and the experiences of substance dependent people: maintenance treatment for opioid addiction. Many participants of the study who are on maintenance treatment said that although it is beneficial in reducing craving, this way of managing their illness seriously influences their planning and daily routines. They need to pick up their dose between certain hours at a certain place. This means that they are limited, for instance, in going to weddings in another state, or in accepting casual job offers with a lot of travel time. Some describe methadone as liquid handcuffs.

(ii) Standard daily routines get displaced and are hard to restore

As we saw before, chronic illness can also make it harder to perform our normal daily routines. In addiction the influence on daily routines is slightly different. Rather than the normal daily routines like eating, brushing one's teeth, taking a shower, becoming very time consuming, they get displaced. If they get displaced for long enough, people find it hard to restore them once they quit their substance use. In this way, addiction slightly differs from chronic illness, but there is nonetheless a strong disruption of standard daily routines which are hard to restore. So addiction influences daily routines in three ways: managing the craving becomes a dominant routine, standard daily routines get displaced, and there is a need to manage one's daily life in recovery by establishing new routines. I will now elaborate more on this last point.

When people manage to quit their substance use, they often describe a struggle with re-establishing daily routines. Especially for long-term substance users, for whom substance use became the only routine they had left in life, restoring daily routines can be challenging. The first weeks, and sometimes even months, of their recovery are dominated

with establishing new routines. Respondents name several challenges in forming these new routines. First, there is a large gap between their goals and their current daily routines, and it is hard for them to bridge this. They often do not know where to start. Second, many of our daily routines evolve around our physical need for rest and nutrition. When we do not meet these goals, we feel miserable. Respondents report that their physical habits have been disrupted by their substance use. They report having trouble getting new physical habits, often sleeping days at a time and feeling drowsy. During substance use they often forgot to eat, and now they have to develop new eating habits. Finally, when people's daily structures have been determined by substance use for years, they have often forgotten what their former routines were, what a normal day used to look like, what they used to enjoy in life, and what they used to eat or drink. One young man (R₄) with a heavy alcohol dependency suddenly remembers that before he developed an alcohol problem, he really enjoyed drinking milkshakes. Another respondent was amazed by how much he now enjoyed having a coffee in the sun, a pleasure he forgot about during his time of heavy substance use.

Respondents describe their new daily routines in recovery as very time and energy consuming, basically because they have to develop them from scratch.

It's hard, you know. You've just got to replace it and get in another routine sort of thing (...) it's a way of life since I was ... you know, before I was a teenager so if you're doing something all your life and then suddenly you got to change everything about it, it's really hard. (...) I've done that for 10, 15 years and I don't know anything other than that. Yeah and sort of got to get out there and see what life's about or something. (R₁₉B)

When I was clean I had lots of friends, I went out a lot, I'd have coffee at the movies or normal things that people do but yeah, when I'm drinking or using I just don't do those things, I don't talk to people, I don't do anything and I don't like it, so ... (...) I mean in rehab we have to work and we have to do all these things and just doing them makes me feel a bit more in control instead of just not knowing what is going to happen next from day to day. (R₁₈B)

I've got a program that I follow like as far as my personal program. (...) It's purely basic. It's get up have breakfast in the morning, make my bed, keep

my surrounds you know neat and tidy, the personal hygiene stuff, have a shower regularly. Physical activity (...) and regular meeting attendances and you know talking to people in recovery. That's pretty much my personal program. (...) Yeah taking care of myself is the priority, like I mean if I'm not doing that then getting out of bed is a struggle, staying out of bed is a struggle. (...) When I'm sticking to that I'm running pretty well. (...) If that goes out of balance, well I kind of find it a little bit harder to cope with life on life's terms. (...) if I'm not looking after myself then the thought of using can seem appealing (...) and in that comes (...) forgetting how to live. (R2C)

Respondents describe how rewarding it is to create new daily routines, but also how much effort it takes them to develop them.

(iii) Feeling too miserable to do anything

As I described above, the third way in which chronic illness disrupts our daily routines is by making us feel miserable. When we feel miserable, we often do not have enough energy to perform our daily routines, we do not care about the future, and feeling better gets priority over other goals. Respondents repeatedly described feeling miserable. Feeling miserable, physically, makes it harder to exercise self-control and pursue long-term goals, just when it is needed the most.

it's just too much (...) not being able to sleep and maybe not eating properly, all those things, being tired and stressed and the alcohol. (R4B)

When asked about his plans for the future, one respondent replied:

I can't really think that far ahead. I just want to try and get myself better and then once my head's clear I'll be able to think a bit clearer on what I want to do. (R33)

There are several pathways through which substance use can make people feel miserable. Of course there are the effects of withdrawal, but these are often relatively easy to overcome. There are also more long-term effects of substance use on the body resulting in feelings of anhe-

donia, disturbed sleep patterns and hormonal imbalances in the body (Ylikahri, Huttunen, & Härkönen, 1980). I will discuss these effects below. During substance use a high amount of dopamine is released in the brain. After repeated substance use, the dopamine receptors adjust to the excess of dopamine in the brain and the number of dopamine receptors decreases (Robinson and Berridge, 2008). These changes in the amount of dopamine receptors make it harder to experience pleasure. Natural rewards²⁶ fail to release enough dopamine to experience pleasure. These adaptations of the brain can continue for months or even years after abstinence, resulting in a state of anhedonia, or absence of the experience of pleasure (Hatzigiakoumis et al., 2011; Kalivas & Volkow, 2005; G F Koob & Volkow, 2010). As one respondent states:

I've tried, there's been very short times where I've been without drugs and I've been even more unhappy and miserable than when I'm on drugs and like I believe people when they tell me that this is like an interim period and after a while your brain starts to repair itself and you start to get better at it and whatever, I believe them but I've never made it to that stage, you know. (R47)

As we saw in section (ii), many respondents struggled with establishing new routines of eating and sleeping. Substance use – especially alcohol and amphetamine use – disturb sleep patterns, and this disruption can be long-lasting (Brower, 2001; Burke et al., 2008; Kühlwein, Hauger, & Irwin, 2003; Lin et al., 2000; Rechtschaffen & Maron, 1964). Feeling sleep-deprived contributes negatively to quality of mood and sleep deprivation is associated with relapse (Magnee, de Weert-van Oene, Wijdeveld, Coenen, & de Jong, 2015). Many respondents described feelings of low mood and low energy when they were in recovery. Feeling miserable demotivated them and made them care less about their future plans. Feeling miserable was particularly hard for the respondents who wanted to stay abstinent, since their main coping strategy for dealing with misery is to use substances.

There are three explanations of why substance dependent people feel miserable while abstinent. First, there is the explanation of anhedo-

26 Natural rewards are rewards from other activities than substance use: eating food, social intimacy, etcetera.

nia on a neurological level. Second, at a somatic level, anhedonia is explained in terms of the disruption of hormonal balance, sleep-patterns and nutritional habits. Third anhedonia can be explained at the level of the agent: people feel hopeless and do not feel very efficacious anymore. One respondent describes why he did not get to detox when things got out of hand:

I just wanted some Valium for the alcohol 'cause at Gorman House (the detox) you take your own medication in and they give it out to you, so ... and then she ... and I was trying to ring them and they were just constantly busy and they put me on hold and it was just ... it was really hard to do, but she said oh when you get in ring me and I'll fax you the script and I said no, I have to get a script and take it physically in with me, they don't ... she said no, no, no I'm not giving you ... (...) It's really ... they just never answer the phone. It's like you ring up and you're on hold for a half an hour and I've got no credit and it's crap like that. (...) it was just too hard basically that day, I felt really crap that day and I just didn't do it. (R18B)

Above I described how illness influences our daily routines, and forces us to take a more local perspective on our lives. I pointed out the similarities between the account of substance-dependent people and the accounts from the literature on disability bioethics. Below I will describe another factor that forces people with chronic illness as well as those struggling with addiction to adopt a more local perspective on their lives: living in the shadow of death.

4. Disruption of future self

4.1. *Illness and the disruption of the future self*

Both Toombs and Carel describe how their changed bodies altered their relationship to the future. In our normal experience of time, we are geared towards the future; our present self already anticipates what is to come. Bodily dysfunction disrupts this gearing into the future, since our future has become uncertain (Toombs 2001, 258). 'My wish list narrowed down to having one item only: I want to live', states Carel (2008, 31).

We think about time when designing our plans and projects. We normally have a good idea what we'll be doing next week, some idea what we'd like to do next summer and a vague five-year plan. We also have, possibly more implicitly, a more general life plan: where we would like to be in ten, twenty or thirty years. (...) All this changes when you are ill. Life ceases to be a long, gently flowing river. The future no longer contains the vague promise of many more decades. Death is no longer an abstract, remote notion. (...) All the rules that governed my life until now have been radically broken and nothing, nothing, remained the same. I had to overhaul all my plans, expectations, goals, projects and horizons. Most importantly, I had to rethink my idea of a good life. (Carel, 2008, 123; 61)

When Arthur Frank (1995) was confronted with a heart attack and cancer, he described this experience as a loss of the 'destination and map' (Scully, 2008, 120). Our ideas about our longevity influence our planning and what we should prioritise. People struggling with illness are often forced to restructure their planning (Charmaz, 1991). Toombs struggles especially with the unpredictability of her illness. She feels paralysed by images of a future wherein she would be even more disabled. This fear for the future makes her even more disabled than she physically is at that moment.

In thinking of goals and projects, one can never be sure what one's physical status will be at some future point in time. (...) This uncertainty can be extremely debilitating in the sense that it makes it difficult to continue to strive towards future goals. (...) The future is not only problematic but overtly threatening. The truism "Things could be worse" takes on a whole new meaning for those living with progressively incapacitating disorders. This change in the relation to the future contributes to personal meanings, in particular to one's sense of what is possible in one's life. (Toombs 2001, 259)

Both Toombs and Carel describe how their illness changed their sense of what is possible in their lives (Toombs 2001, 259); illness changed their belief in self-efficacy. Their sense of their own capacities is dramatically altered, so that in thinking of goals and projects the assumption "I can do it again" is always in question. They have to re-evaluate their possibilities and capacities on a daily basis, and in general they do not feel very

efficacious. This uncertainty about their future capacities makes future planning difficult. Not being able to trust that our body will function in the future means a serious loss of control over the future and our diachronic plans. Being confronted with our mortality and vulnerability, being confronted with the uncertainty of our future, diminishes our diachronic projects.

4.2. Addiction and the disruption of the future self

Again, striking resemblances can be found in the stories of the respondents. Many respondents feel like they are living in the shadow of death. Alcohol use is associated with more than 60 medical conditions, including several types of cancer (oropharyngeal, oesophageal, liver, laryngeal and breast cancer), other diseases of the aerodigestive tract, diseases of the heart (alcoholic cardiomyopathy, haemorrhagic stroke, arrhythmia, hypertension), addiction-related mental disorders, and nutritionally based neurological degeneration (Lokkerbol et al., 2013; Rehm & Bondy, 1998; Vaillant, 2009, 201; World Health Organisation, 2014). Several studies have outlined a high mortality rate amongst substance-dependent people (Ericsson, Bradvik, & Hakansson, 2013; Vaillant, 2009), some estimating even a 50 to 100 times higher death rate than the general population (Hser, Hoffman, Grella, & Anglin, 2001), depriving people of approximately 44 years of life, of which 29 are before the age of 65 (Degenhardt, Larney, Randall, Burns, & Hall, 2013). When I asked our respondents about their plans for the future, many expressed uncertainty about how long they had to live. This fear concerning their physical longevity was either informed by current health problems or expected health problems. Even when they were healthy at the moment, the participants in the study reported that they had seen so many of their friends die due to substance related illnesses, that they had no illusions about their own future prospects.

To pursue our long term plans, we need a body we can trust, and most respondents, just like Toombs, did not trust their body very much. This mistrust of their bodies was strongest during the first round of interviews, when many were in detox after hitting rock bottom. Either they already had impairing health problems, or they expressed the anxiety that they did not know when they will have to pay for their former life-

style. One respondent (R15) said that the major thing in his life he felt he had no control over was his health.

Maybe the damage I've done to myself in those periods, yeah, it'll come back to get me one day, it has to. (R2)

if I keep using I won't get to there [points at 40 on the timeline] but ... and that's a goal is sort of to hit 40 but I know that 'cause I'm lucky to be here as it is, I mean I don't know how I've gone ... used for 20 years and I'm still pretty with it, I'm still got ... I've still got all my teeth, I've ... you know what I mean, I've come through pretty luckily, unscathed, I haven't been in gaol, I haven't been in a psychiatric unit, I haven't ... they're all yet, they're all possibilities to come if I keep using, I know that. (R2)

Among the opioid dependent people was a strong fear of accidental overdosing. Indeed, many opioid users have experienced this: 'I overdosed myself three or four times. I was lucky I'm alive from that' (R15). Although they could be clean for a while or stable on the maintenance program, one binge or relapse can be fatal, and they were reminded of this fact every time a friend or acquaintance of theirs died.

I've been out of rehab whatever it is now, two, two and a half years, whatever and there's 10 people that I went through rehab with that are dead, that I know of. God knows how many others that I don't know of. And they were good people. (...) Some of them ... a guy that I had a relationship with that was absolutely flying, that I thought was going to make it, died, you know, took an OD last year. (R34)

Most respondents saw a lot of their friends and relatives die because of substance-related problems, and they have no illusions about their own long-term life prospects.

[A]nother thing that's affected me is so many of my friends have died of drug overdose, like my first friend killed herself in 1997 and since then I've been to like 30 funerals, 40 maybe. (R53)

[T]here's 12 of us started out together. And I think two are in institutions and the rest are dead, and I'm here. So I guess, yeah, I'm counting my blessings there. Any time that could have been me. (R39)

I'm still alive. Half the guys I grew up with my age, from my area, are all dead from either overdoses or other medical problems. (...) A couple of them from heroin and overdoses, but a lot of them were alcohol related. Another mate was on methadone for over 20 years and all his organs just packed in. He died only six, eight months ago in Liverpool Hospital. I saw him two days before he died when he had a heart attack. He was just a skeleton. It freaked me out, yeah. He was in a coma. I couldn't talk to him. (R15)

All my family died from grog, all my brothers, sisters, my mum ... I found (...) my mum dead on the floor from grog. (...) they wanted me to go home but I just don't know. There's nothing at home for me anymore. Back home they're all buried in Mount Gravatt. (R13)

One respondent (R39C) told us how many of his friends who are on methadone died of cancer. Methadone numbs bodily feelings of pain, so people on the treatment often do not notice that they have cancer until it is in a very late stage and spread out in their vital body parts. Seeing his friends die of cancer that way was a very scary experience for him. It prompted him to get off the methadone, which in turn made him relapse.

When asked about their plans for the future, some respondents expressed that their health problems prevented them from making long term plans.

[M]y medical conditions like my kidney problems you know, they could get worse so I just take it a week or so at a time at the moment. I'm not really planning the future at the moment so I don't think about it at all really. (R60)

[B]ut as far as long term goals, mate, I haven't got any at this stage, yeah, like to stay alive that's the main one. (R2)

When asked where he saw himself in a year's time, one respondent replied:

Alive. Alive, I guess. Even that I don't know if I believe so yeah, I don't know. No idea. (R17)

My empirical research showed that addicted people, even those in recovery, have very little trust in their longevity. This lack of belief in longevity can be caused by a variety of reasons: current health problems, the fear that their former lifestyle will suddenly take its toll, or else the experience of being confronted with their own near overdoses and the overdose-related death of friends – particularly those who were in recovery. This lack of belief in their own longevity affects their ability to engage in long term projects that are so important for meaningful and flourishing lives.

Perhaps, however, taking a local perspective on one's life does not always diminish one's agency. Charmaz (1991) argues that adopting a local perspective on one's life can also be a strategy to regain self-control. However, for most people it is not a strategy, they just do not have the energy to look further than the next hurdle. I will discuss this in more detail in the next sections.

5. Living or existing one day at a time

5.1. Illness: living one day at a time, or existing one day at a time?

Adopting a local perspective on one's life can be an effective strategy to manage a new situation one finds oneself in. Charmaz call this 'living one day at a time'. Rather than being discouraged by the unavailability of diachronic goods and dwelling in the loss of these goods, chronically ill people can focus on controlling one day at the time and focussing on immediate hurdles, and this gives them the feeling that their disease is manageable and not an unbearable life sentence (Charmaz, 1991, 181). Living one day at a time also helps people to let go of the past, and perhaps any past mistakes they made that led to their current disease. Charmaz states however, that for many of her respondents, it is an onerous strategy (Charmaz, 1991, 184). She narrates the story of a career-orientated man who found it very hard to let go of the future horizons that had always dominated his life. Carel describes a similar experience. For her, letting go of her possible future self was a loss of identity.

Although adopting a local perspective on one's life can be a good strategy, for some the local perspective on their lives is not a strategy at all,

but the only option that is left. Charmaz calls this ‘existing one day at a time’. Existing one day at a time occurs when crisis after crisis rips people’s lives apart, leaving them with very little opportunity to catch their breath (Charmaz, 1991, 185). It means living on the edge of what one can cope with (Charmaz, 1991, 189). It is especially the most vulnerable people, those without good support networks, housing, health cover, etcetera, who find themselves being forced to exist from day to day (Charmaz, 1991, 189). Charmaz asks us to imagine how daily life looks like for people who are existing one day at a time: ‘During a “bad” day, they experience chaos. (...) During a “good” day, they fill time. When people “fill” time, the day has large blocks of time, which haunt them. Filling time seldom involves structured activity. It means struggling to rest, worrying, watching television, perhaps, reading, but most likely, simply trying to exist’ (Charmaz, 1991, 187). When existing one day at a time one’s life becomes extremely chaotic on some days and empty on others. With this distinction in mind, are addicted people *living* one day at a time, or *existing* one day at a time?

5.2. Addiction: living one day at a time, or existing one day at a time?

In parallel with the literature on chronic illness, many substance dependent people also state that the ‘one day at a time’ strategy helps them regain control over their lives. ‘One day at a time’ is also a well-known slogan of Alcohol Anonymous (Valverde & White-Maire, 1999), and many respondents reported that this strategy was beneficial to them. The first way in which this strategy is beneficial is in the role it plays in controlling their substance use. ‘Sometimes I take, believe it or not, I take it minute by minute. (...) This morning I had a pretty hard time. I took it second by second actually, this morning.’ (R46) Many respondents said that if they just focus on not using today, or not using this hour, minute or second, resisting the craving seems more bearable than acknowledging that they might have to put up with this fight for a long time. Secondly, ‘one day at a time’ prevented respondents from becoming overwhelmed by the distance between their current situation and their future goals.

[I]f I plan for big things I find I get overwhelmed and I don’t do any of it, so what my caseworker and I are doing is baby steps, like at the moment we’re trying to get me on the disability pension, (...) in some people’s eyes

they may seem like trivial little things, but for someone whose life's been so chaotic like mine has, just being productive and just doing things and being responsible for my actions and being reliable and whatnot. So I have no big plan for anything other than like a month away. (R35)

I don't like to look too far ahead at the moment, I just want to look as far ahead as where I'm going to be going in the next couple of weeks, just so if I can get that much done well then that's a goal that I've achieved. 'Cause I don't want to set myself up to fail. I've done that in the past. (R20)

So for me it's about just relative goals like just taking a bit of pleasure from small improvements and trying to build on those improvements rather than committing to something that could not work out. (MHE15)

Because if I start thinking ahead too much it stresses me out a bit. (R65)

My goals are, I guess there's two goal ... one immediate. My immediate goal is just to keep doing what I've been doing, like just surviving essentially. Eat, have a house, food, go out, be entertained, just do whatever it takes to not get over you know to not take any drastic measures. (...) but I guess in the long-term ... I mean ideally I want to be at a point where I'm off my medication, where I don't have to be sort of chained to a pharmacy and on a register and that kind of thing. It means you can travel, it means you know all that kind of stuff but I know in my head that the way things have been going, that's not an option right now. That's something to look toward, like that's a goal I want to achieve ... (MHE-15)

The last respondent, along with several others, clearly expressed the hope that living one day at a time would help them regain control over their global goals as well. However, many respondents described their lives as *existing* one day at a time. One respondent, for example, expressed a longing for 'living a normal life, not just existing, but actually living, which I haven't done for such a long time.' (FHE045) Most respondents described their lives as empty, as a void, or as being on life-support rather than living. To conclude, although living one day at a time can be a beneficial strategy for recovery, most respondents described their lives as a constant struggle that left them with very little energy to work on long term goals. They were existing one day at a time.

So far we have focussed on the effect of illness on the availability of diachronic goods. The second way in which illness influences our agency is by influencing our self-concept. As we saw in Chapter 1, pursuing dia-

chronic goods contributes to self-constitution. By rendering diachronic goods unavailable, illness influences our self-concept indirectly. However, illness also influences our self-concept in more direct ways, as we will see in the next sections.

6. Disruption of self-concept

6.1. Illness and the disruption of one's self-concept

Charmaz contends that the most vile effect physical illness has on a person's life is that it changes their sense of self (Charmaz, 1983). In her words, 'The failing body diminishes the self' (Charmaz & Rosenfeld 2006, 42). Similarly, Scully (2013) reports that when her partner developed cancer, several operations led to a severe bodily alienation which affected her moral sense of self:

It was clear that for at least a time her self-concept lurched and shifted along with the shifts in how her body was and had to be treated. She still had the capacities of an autonomous and self-determining agent, but the transient yet radical instability of her body made problematic the self she was determining through her choices and expressed wishes'. (Scully, 2013, 27)

Our self-concept can change directly because our body changes, as is described in the above example. However, our self-concept can also change more indirectly when our body changes. Physical losses are often accompanied by other losses: for example, the loss of our habits and hobbies, the loss of our jobs and roles that define us (breadwinner, academic), the loss of our future self, financial losses, and loss of relationships. These losses influence our self-concept. In the following sections I will describe how the loss of habits and the loss of hope that an ideal future self is achievable, also influence our self-concept. I will also outline an additional way in which chronic illness influences our self-concept: by changing our appearance, and with this change, people's reactions to us.

(i) The effects of losses of daily habits and future self on identity

There is a close link between a person's habits and their identity (Aristotle, 2012). As I have argued in chapter 5, habits help shape our identities, and we identify with our habits. When we are asked what someone is like, we often describe their habits (Lewis, 2015). Dewey has said that 'character is the interpenetration of habits' (Dewey 1950, 38). Carel states that when she could not do the things she loved anymore – playing with her dog, travelling, and running – she lost a part of her self. The influence of illness on daily life, on people's work, their home life, their free time (if they have any), is a good way of measuring how illness affects the self (Charmaz, 1991, 6-7). It is through our 'bodily practices and habits of everyday life, that our experience of the body is organized.' (Scully, 2003, 272). As such, a different experience of our body results in a different experience of self. Our habits define us, and a disruption in our habits disrupts our identity.

Earlier in this chapter I described how chronically ill people have less energy to devote to their diachronic goods. On top of that, people with chronic illness feel more insecure about their future capabilities, and in many cases, their future existence. Along with an inability to pursue certain goals and projects that used to be important to her, Toombs also experienced a loss of the various roles she occupied: professional, lover, caregiver, student, mother, breadwinner. Carel describes how many of her dreams and plans are scattered by her illness, for example, her desire to become a mother. She describes this loss of her future self as a devastating loss of identity. We identify ourselves with our ideal future self: for example, I can see myself as a future manager, a future mother, or a future professor. For those living with chronic illness, the image they hold of their ideal future self becomes negatively affected by their illness. Their previously imagined future selves and diachronic projects become unavailable to them, and their identity changes. Although they may be able to imagine other valuable future selves that are compatible with their illnesses, the process is one of mourning, loss, and diminished options.

The loss of a hoped for and expected future self affects us in the present. The present self is dependent on reaching back and forward in time in order to, in the present, be the kind of self that it is. Chronic illness damages this capacity. Charmaz states that for many people with chronic ill-

ness their past self becomes irretrievable, their present self is unsettling, and their future self has been altered irrevocably (Charmaz, 1991, 229). One of Charmaz' respondents describes an immense loneliness linked to this loss of self: 'Now I am frightfully lonely because I am *not* my self' (Charmaz, 1991, 194). These examples illustrate the multilayered way in which the body influences our self-concept, by disrupting both our daily habits and our views on both our future self and its possibilities. There is however, another way in which, in illness, the body influences our self-concept: by altering our appearance.

(ii) Illness, stigma, and self-stigma: the body as a looking glass

Physical illness often directly changes our appearance, and this not only causes us to look differently to ourselves, but also results in other people responding differently to us. The negative reactions of other people to our appearance can in turn influence our negative self-image even further so that we get caught in a vicious cycle of stigma and self-stigma.

Our body provides surface information about our self: our identity, our roles, and our current state (Charmaz & Rosenfeld, 2006). A new mother often has bags under her eyes and milk stains on her clothes, a construction site worker may have dirty nails, and sweating can reveal something about our fitness or anxiety levels. Other people read our bodies: the body is a looking glass where the public view penetrates the private (Charmaz & Rosenfeld, 2006, 35; Cooley, 1902). We are self-conscious about it: we know that other people read our body, and their actual or expected perception of us influences our self-concept (Charmaz & Rosenfeld, 2006, 38-39). Our identity is formed in an interplay of first, second and third-person perspectives (Atkins, 2008, 57).

The knowledge that certain aspects of our private identities are revealed publicly through our body is not always welcome. The public gaze on our bodies can make us feel as though we have lost control over the definition of our identity. In illness, this normal tension everyone experiences between body, self and public identity becomes magnified. In illness, we lose control over our public identity. Losing control over one's public identity due to visible illness happens in two ways: through the direct responses of others, and through the way we imagine others may be responding to us.

The first way in which illness makes us lose control over our identity is by the direct responses of other people. Others project their images of us back on us, multiplied and magnified (Charmaz & Rosenfeld, 2006, 41). Both Carel and Toombs describe an intrusion of their personal space by other people that is triggered by their visible illness: the wheelchair in Toomb's case, and the oxygen tank in Carel's. Toombs found that other people responded differently to her after she became wheelchair-bound: they infantilised her by speaking to her loudly and slowly enunciating as if her inability to walk had affected her cognitive abilities; they stared at her; they spoke about her in the third person even in her presence ('where would she like to sit?'); and they invaded her bodily space by pushing her wheelchair uninvited.

Both Toombs and Carel suddenly find their private life becoming subject to public scrutinizing. For example, strangers ask Carel how long she has to live. Similarly, Charmaz and Rosenfeld, (2006, 40, following Nijhof, 2002, 191) describe the awkward experience of a man with Parkinson's disease, who as a result of his disease has a stiff face. When sitting in a crowded bus, the boy sitting opposite him asks his mother why he looks so angry, thus misreading his facial expression and discussing it publicly. The man's private emotions are suddenly the subject of public interest. Carel describes this intrusion in her life by other people as 'an attack on you as a person whose life trajectory is different; as someone who looks different; as a stigmatized individual whose condition is feared and denied by those surrounding you' (Carel, 2008, 48). She concludes: 'People lack empathy for the diseased. The pain, disability and fear are exacerbated by the apathy and disgust with which you are sometimes confronted when you are ill. There are many terrible things about illness; the lack of empathy hurts the most' (Carel, 2008, 41). People with serious illness, especially illnesses with a stigmatising potential, suffer from other people's judgments and intrusive questions. This often results in feelings of diminished worth (Charmaz, 1991, 2).

The second way in which illness makes us lose control over our identity is by how we imagine other people will react to our appearance. When our bodies change, we also start re-evaluating the image other people must have of us (Charmaz & Rosenfeld, 2006, 46). Toombs says that when she tries to imagine how others must see her, it makes her feel ashamed of herself. She labels it an irrational feeling, since she has done nothing

to be ashamed of, still she sees it as ‘an integral element of disordered body style’ (Toombs, 2001, 256). Our culture strongly celebrates being young and healthy, and there is no place for deviant bodies. Even when we do not know what people think of us, the judgment we imagine they have can be confronting and evoke strong emotions of fear and shame. We imagine how people compare us with others, with our former selves, or with normative standards (Charmaz & Rosenfeld, 2006, 38).

Encountered stigma easily results in self-stigma. Self-stigma occurs when public stigma is internalised (Buchman & Reiner, 2009; Corrigan & Watson, 2002; B G Link & Phelan, 2001). In self-stigma, people feel like they deserve the negative treatment other people give them. This self-stigma can cause people to self-isolate to reduce unwanted visibility (Charmaz & Rosenfeld, 2006, 37). In these cases a person’s agency is threatened, because with the loss of control over their body, they lose control over the way in which they are defined; they lose control over their identity (Charmaz, 1991, 5). Charmaz points out that this loss of self due to illness is especially bitter because there are hardly any positive identities available for chronically ill people.

As we saw above, our body and identity are not identical, but our body is a crucial aspect of our identity. Our identity is negotiated in an ongoing process of representations of, and beliefs and attitudes towards, our body, in which the reactions of others play an important role (Mackenzie, 2009, 117). Our inner and outer existence are tightly and complexly interwoven; our identity is neither purely physical, nor purely cognitive or psychological, but is a result of the interplay of those forces (Atkins, 2008, 66).

6.2. Addiction and the disruption of one’s self-concept

(i) The effects of losses of daily habits and future self on identity

When we recall Nicole’s case-study, we see that during her addiction she lost many of her former habits and core projects – these included working and taking care of her son. During her addiction, a separate identity developed that reflected her daily reality during use, the identity of a working girl, and that of someone who has hepatitis C. During recovery, she takes up her former activities, but the disruption of her identity hinders her in fully believing in these projects. She keeps wondering: what

if I do not belong to this social setting? What if I will always fail in life? Many respondents describe this self-doubt when trying to recover and rebuild their lives, especially when one of their former attempts has been disrupted by a relapse.

Although addiction can be described as a habit that gradually takes over the real person and his normal habits. Flanagan (2013b) however outlines that the relationship between addictive habits and identity are often more complicated, especially for drinking. He argues that people often identify with certain aspects of drinking. Drinking – but not addiction – makes them a certain kind of person they endorse being: for example, a manly man. They endorse many of their drinking habits. Drinking is part of celebration, a reward after work, an important aspect of sexual encounters. Although at a certain point they realise that their drinking is not contributing anymore to being the kind of person they endorse being, changing their habits changes the way they are.

Their personhood, their character, is constituted, in part, by a history of drinking, by a set of identifications and practices that involve alcohol, and that make these individuals who and what they are. Alcoholism, of this sort, (...) involves the deep-self. (...) alcoholism is an absorbing, full-time way of being in the world. Undoing alcoholism as a form of life, and not more narrowly as just a drinking problem, involves fairly radical undoing and then redoing of oneself. (Flanagan 2013b, 885-886)

As Flanagan outlines, people do not endorse their addiction, but certain aspects of their drinking life. Changing one's addictive habits entails a re-evaluation of how one's habit constituted one's identity.

(ii) Addiction, stigma, and self-stigma: the body as a looking glass

The respondents strongly suffered from stigma and self-stigma. Their substance use altered their appearance and, in doing so, made them lose control over their identity. We asked respondents if they saw themselves as the same person as before their substance use or as a different person. Some people explicitly describe themselves as a physically different person.

M: I think I'm different.

I: Clearly you're the same physical person.

M: Well not really, I've got Hep C now, didn't have it before. Probably my veins aren't as good. I mean I'd looked after myself, but ... am I the same person? (P4)

I feel different from everyone 'cause I have all this ... all kind of sickness in my body (...) the heroin is gone, but the sickness stays there. (R59D)

this is not the person that my wife married you know? I know I'm luckier than a lot of other people (...) I got genetics that have you know kept me looking reasonably okay you know? (...) But yeah, it's ... it affects you in a lot of negative ways. (R49B)

when I was using drugs (...) I wasn't comfortable in my own body I hated myself, I wouldn't even look in the mirror, I hated looking at myself. (...)

like I'd look in the mirror and I'd see like a drug addict (R42B)

I mean of course it affects your identity at the time of when you're under the influence, or someone's identification of you. (R49)

Some described being worried about the marks their using has left on their arms. They literally felt marked. Being marked is, as we saw in Chapter 3, the original meaning of stigma (Goffman, 1963).²⁷ The Greek term stigma refers to the sign criminals, slaves and traitors got burned or cut in their flesh in order to identify them as immoral or tainted people. Many substances users felt marked in a similar way:

I look at my arms and I think God blimey, who wants to go out with that? (...) But that affects me, do you know what I mean? Like I can't wear short tops, I can't ... just can't be a normal person anymore. (...) I'm repulsed by what I have and it's a scar that's going to be with you for the rest of your life and you'll always be reminded of it every day you want to put clothes on. (R63)

I just want to be able to do what everyone else does, (...) and unfortunately I've got marks from my using (...) if I was doing customer service for example a doctor would know that I used to use and I don't know if it would help me get a job, I'd have to wear long sleeves every day and there's a

²⁷ As Buchman pointed out, proponents of the disease model hoped that conceptualising addiction as a brain disease would reduce stigma among users, since they now could count on the same compassion as people with other physical illness can count on (Buchman, Illes, & Reiner, 2011; Buchman, 2008). However, by marking addicted people as being neurobiologically different, this approach created a new stigma (Kvaale, Haslam, & Gottdiener, 2013).

lot of things I'd have to do to make myself feel presentable enough.
(R53)

Some people state that they see themselves as a different person because other people treat them differently, and this was related to the fact that their appearance changed.

I'm different because people on the street they look at you different.
(R27C)

Sometimes I go outside and I really feel hated, (...) I thought it must be how I dress or [the] expression on my face or something. You just constantly feel like you've got a big neon sign on your head saying 'loser', you know, 'contemptible loser'. So when someone actually (...) in a shop or something they'll actually smile at you or act like you're a normal being, human being, it's really restorative, it cheers me up for days. (P1)

I'm conscious of the way you get treated in the pharmacy, the way you're put in a separate queue and so ... I'm conscious of the fact, of the way people obviously regard what I am. (P1)

I know I stand out a bit and when I go to say Westfield ... (...) I mean I've got on first name terms almost with security there and security in my local area (...) I know I look different and maybe a bit suss and you know they probably know a little bit about me but it comes with being different but yeah I ... yeah did struggle I ... about that a little bit. I have pulled some of them aside and said look mate, I know you're watching me, like I'm not ... (...) I'm not looking to cause any trouble I'm just doing what I've got to do (R4B)

People look to you ... a different way to you and they judge you, they're scared of you, lots of things. (...) Different from oth ... normal people. And just feeling really low, even though you get stoned for using but inside of you if you feel really ... you're really low, you're just like nobody. (...) 'Cause you have nowhere to live, no money and you're dirty and no one trusts you. (R59B)

Toombs described feeling ashamed of herself, although she knew she had nothing to be ashamed of. As I described in the case-study, Nicole's appearance was not affected by her substance use. Yet, she felt as though everyone could see it and would judge her negatively. Hence, she often

judged herself negatively. This negative self-judgment influenced in turn her belief in self-efficacy. The self-stigma Nicole experiences is a phenomenon that is often described in addiction (see for example: Buchman & Reiner, 2009).

7. Why the bodies of addicted people matter

Although there is a vast amount of medical literature that emphasizes the physical changes due to substance use, there is almost no literature on the lived experiences of substance users with regard to their bodies, and how their bodies influence their agency.²⁸ Why are the bodily experiences of substance users ignored so much? The lay opinion of most, including scientists, is that substance users do not care about their health. Why else, after all, would someone continue to use substances, while knowing the risks for their health? In addition, somatic changes strike observers as self-inflicted. The change wrought on the body caused by substance use, and the negative effects on health are just a price users are supposed to pay for their choices (Foddy & Savulescu, 2010). Yet with many other disorders – for example, anorexia or self-harm – we take the harm that the disorders cause to people’s bodies very seriously. One can speculate that the moralistic condemnation of substance users can explain this neglect of the body in debates concerning addiction.

There is another reason why there might be so little attention given to the bodily experiences of substance users. As I argued in this chapter, health constitutes our agency; a healthy body enables us to live the life we value. Although people in poor health or with disabilities can still have meaningful lives (Scully, 2008), having a healthy body makes achieving the life we value a lot easier. However, some have criticised this close connection between health and the good life. De Maeyer, Vanderplassen, and Broekaert (2009) criticise the fact that quality of life is often

²⁸ A literature search on the role of embodiment in addiction revealed a very limited use of this concept. Most literature can be found in the literature on symbolic interactionism, which looks at how the embodiment of addiction changes the relationships to others (Duff, 2007; Hellman, 2012; Weinberg, 2002). There is another small stream of literature that focuses on addiction as an embodied custom (Nettleton, Neale, & Pickering, 2011; Schlimme, 2010), but the emphasis is on addiction as a custom, rather than embodiment. A third stream of literature describes the addiction neuroscience as a turn to embodiment (Netherland, 2011), but the neuroscientific literature focuses only on one part of the body: the brain.

measured in relation to health (so called Health Related Quality of Life). They explore what quality of life means for substance users, apart from being healthy (De Maeyer et al., 2009). Their research revealed three key domains of quality of life of substance-dependent people that seemed more dominant than health problems: personal relationships, social inclusion, and self-determination. The inability to change one's life was associated with lower quality of life. Having at least one good friend and a structured daily activity had a positive impact on quality of life (De Maeyer et al., 2011). However, as we saw in the first part of this chapter, the three domains of quality of life the authors distinguish from health are partly mediated *through* health. Being in bad health makes it harder to have personal relationships, to be included in society, to have structured daily activities and to determine one's life. This might explain why substance users in general report very low quality of life compared to non-addicted people, and to people with mental illnesses (Bogart, Collins, Ellickson, & Klein, 2007; De Maeyer, Vanderplasschen, & Broekaert, 2010; Sirgy, 2012).

However, after examining the many parallels between the experience of substance users and the those of people confronted with chronic illness, it does not seem plausible anymore that bad health is just a price substance users are willing to pay for the pleasure of their use, or that they just have another concept of the good life.

8. Conclusion

In this chapter I demonstrated how our agency is importantly dependent upon, and is constituted by, our body. I showed – much in line with what we know from the literature on disability bioethics – that the bodily effects of addiction impact profoundly on the agency of addicted people. This change to agency happens in two ways: by forcing substance users to take a local perspective on one's life, and by changing both their self-concept and their beliefs about what they are capable of.

Changes to the body due to addiction push people towards a synchronic focus on their lives: because their daily routines get disrupted and because they are uncertain if they can trust their body to carry them into the future. Although there is much literature on how people with addic-

tion tend to be more now-orientated (Marsch & Bickel, 2001), this is often only attributed to the effect of substance use on the brain. That people feel like they are living in the shadow of death, that they feel physically vulnerable, or that they feel too miserable to make future plans, are overlooked.

Changes in our body also change our self-concept in several ways: through changing our capacities, our appearance, and people's responses to us. When our body is not functioning well, when we do not have energy or are in pain, it affects our physical capacities. Being confronted with a loss of these capacities, we have to revise our concept of what we can and cannot do, and what is likely to happen. As Carel states: 'I had to start thinking of myself as fragile, damaged, unable.' Although we have to adjust our self-image when our capacities change, we need to do it in an accurate way. However, as Toombs described, people who are confronted with their malfunctioning body risk being overly pessimistic for two reasons. The first reason is that losing control over one's capacities is quite an overwhelming experience, which leads to a loss of belief in self-efficacy. Toombs described how being confronted with her physical vulnerability triggered a fear of the future in her that made her more disabled than she in fact was. The second reason why people can become overly pessimistic about their efficacy is that other people are condescending when faced with a marked body. Toombs described how when she got in a wheelchair, people suddenly started to treat her like she was mentally disabled as well. Stigma, or a forced negative social identity, makes people revoke their self-concept not necessarily based on what they are and what they can do, but based on what other people think they are and can do. These factors result in people adjusting their self-image and their ideas about what is possible in their lives more negatively than is necessary.

The agency of addicted people is not only influenced by changes in their capacities, but also changes in their self-concept that heavily relies on their bodies, how they experience their bodies, and how others respond to their bodies. People struggling with addiction lose agency because they change both their own perception of themselves and what they are capable of in a negative direction. Because they have seen so many people die, because they feel stigmatised, they feel like their horizon becomes limited, and they change their view of what is even possible for

them. Many addicted people might have the capacities to pursue their dreams but will not even try because they do not feel efficacious. They see themselves as incapable; they fear they are incapable, even when new possibilities present themselves in their lives. In the next chapter I will describe how this loss of belief in self-efficacy can become severely engrained and pose a distinctive threat to normative self-control: the threat of resigning.

CHAPTER 6. THE RESIGNED ADDICT: ‘WE ARE JUST NORMAL PEOPLE LIVING VERY COMPLICATED LIVES’



1. Introduction

We saw in the previous chapter how the body shapes feelings of efficacy. In this chapter I will look at other circumstances that shape our beliefs about the life we can have, including whether or not it is worthwhile to pursue it. In this chapter I will tell the story of another respondent, John, someone with many capacities and normative goals. However, external circumstances make it very hard for John to enact his goals, to the point that he gives up on them. Although John has a strong image of what his ideal life would look like, he gradually loses his belief that this future is achievable. In this chapter I will show how a certain kind of life erodes feelings of self-efficacy. Belief in self-efficacy is often regarded as an attitude an individual can attain. However, a person’s belief in self-efficacy is also determined by the degree to which their environment facilitates their efficaciousness.

In Chapter 1 I illustrated how external factors can force us to abandon our plans. I might plan to pick up my children early from day care to spend some extra quality time with them, but a flat tyre can derail my plans. I can organise a surprise party for my partner, but the surprise is ruined if one of my friends accidentally spills the beans. I can train hard for the Olympics, but my training is wasted if I break my foot. While everyone is vulnerable to adverse external factors such as these, some people are disproportionately vulnerable to them. When agents are disproportionately exposed to adverse circumstances, this might not only affect their current plans. Rather, if the adversity persists, it may also lead

them to stop forming diachronic plans altogether. They stop striving for the life they value living, they give up on normative plans. When adverse external circumstances keep occurring, we are inclined to give up on our plans.

I will argue that people struggling with substance dependency are disproportionately vulnerable to these adverse circumstances. During the follow-up interviews, I asked the respondents to tell me how their year had been. I was always shocked by how many adverse life events they had in one year (compared to my own life): violent incidents they experienced, loss of loved ones, severe financial stress, house evictions, stressful lawsuits, etcetera. These adverse life experiences sometimes caused them to give up on their plans. However, this resignation is often poorly understood in terms of loss of self-control. This resignation is often viewed as a choice-based, justified change of normative outlook (Foddy & Savulescu, 2010), rather than a forced abandonment of their normative outlook. Resignation is often viewed as a plan B instead of a persistent loss of belief in self-efficacy.

In this chapter I will argue that there is a subgroup of people struggling with addiction, from whom their main failure of agency consists in resignation from their normative goals. I will argue that this loss of self-control is distinct from having no normative goals (like the wanton addict), or endorsing one's addiction (like the willing addict).

2. Resignation as a form of loss of self-control

It is often thought that either people endorse their substance use, or they do not. People who endorse their substance use are in control of their lives; their substance use is in line with their image of the good life. People who fit this category are often referred to as willing addicts.²⁹ Unwilling addicts are people who do not endorse their substance; rather, their substance use is in conflict with their image of the good life. When the unwilling addict uses, nevertheless, he or she suffers a loss of self-control

29 In a forthcoming article I argue that it might be better to refer to willing addicts as willing substance users, since it is hard to understand what the willing addict is exactly willing (Snoek, forthcoming). As Kennett (2013) and Flanagan (2013) have pointed out, they have never met a willing addict. Although in a more recent article Flanagan (2017) gives some examples of willing addicts. From an empirical view, the category of the wanton addict can also be met with some scepticism.

caused by irresistible cravings that deplete will-power. Wanton addicts are those who do not have an image of the good life at all; they just act on whichever local incentive arises, without reflecting on the desirability of their desire. Wanton addicts are often denied agenthood since they do not have normative goals (Frankfurt, 1971). In this typology, only the unwilling addict fails at self-control, and the view of self-control that is reinforced by this typology is a strength model, wherein an agent's will-power is worn down by their desires.

Kennett (2013), however, has argued that this typology is incomplete: it omits what she calls the *resigned addict*. The resigned addict represents another form of loss of self-control in addiction that often goes unnoticed and is poorly understood. The resigned addict has an image of a good life that conflicts with their substance use. However, they 'have little confidence in their ability to exert control over their external circumstances and shape the life they would value having and the person they would value being' (Kennett, 2013, 144). Hence, they give up on their normative goals. Resigned addicts continue their substance use because they see no point in controlling it. Quitting will not necessarily make their lives go better. The resigned addict gives up on their image of a flourishing life and the person they desire being. They adopt a local perspective on their life and stop planning and deliberating. The resigned addict gives up on exercising their agency and exercising diachronic self-control.³⁰

In this chapter I will show what the loss of self-control in the resigned addicted person consists of, and I will debunk two myths about the resigned addicted person.

The first myth about resigned addicted persons is that they are secretly willing addicts. What is confusing about them is that they do not describe a struggle with substance use. This lack of struggle with their substance use makes it easy to confuse them with the willing addict; however, resigned addicted persons do not endorse their addictive desires. It is an intuitive idea that when people give up on a certain goal, they must endorse an alternative goal (Calhoun, 2008). However, as Cal-

30 It is important to note that people will move in and out of these different type of "addicts" through their lives and drug-using careers. It is unlikely that a single label would sufficiently capture an addicted person.

houn argues, it is possible to just give up on one's goal without replacing it with some secret alternative goal (Calhoun, 2008).

The second myth about the resigned person is that resignation is a rational choice. On this view, resignation represents a rational plan B rather than a pervasive loss of self-control. We saw before in Chapter 1 that our normative plans need to be realistic. On the rational choice interpretation, it is possible that the resigned addict legitimately changes his plans. Maybe in his circumstances adopting a local perspective and forgetting about one's global goals is the best thing to do. However, I will argue, drawing a parallel with poverty studies, that the resigned addicted person does not only adopt a local perspective when it is best to do so. The resigned addict person adopts a local perspective in general, including in situations where others would shift to a global perspective. If the resignation is strongly entrenched, they will not only fail to actively try to improve their circumstances, but they will also fail to re-adopt a global perspective when their circumstances improve.

When our view of self-control is dominated by the strength view – which claims that self-control is exercised through the forceful application of willpower – we might find it hard to see how the resigned addicted person loses self-control. The resigned addicted person seems to be in control of his actions; however, his actions no longer reflect his normative goals. When we look more closely at why someone resigns from their normative goals, it becomes clearer how this is a loss of self-control. Loss of self-control is often viewed as an individual problem, yet there are also external factors that determine what a person can and cannot do. When people find themselves in hostile environments with very few opportunities to improve their situation, their external situation can shape their self-concept and their beliefs concerning what is possible for them. As I already outlined in Chapter 5, our image of our ideal future self needs to be accompanied by certain fundamental beliefs about our agency. We need to believe that our future self is available to us: we need to believe in our own capacities to achieve the desired outcome, and we need to feel reasonably safe from 'disastrous misfortune' (Calhoun, 2008). In this sense, the resigned addicted person differs from the wanton. Unlike the wanton, they do not suffer from a loss of self through a loss of their normative outlook. Rather, they lose belief in their self-efficacy, in the achievability of their normative goals.

In the following case study, I will show how holding these positive beliefs are easier said than done for some people struggling with addiction. Belief in self-efficacy is often seen as an individual responsibility (Diclemente, 1986; Marlatt, Baer, & Quigley, 1995). However, as Bandura shows, belief in self-efficacy can be constructed or undermined through certain experiences (Bandura, 1994). Bandura distinguished four sources of self-efficacy. The first source is performance: when we experience success it enforces our belief in self-efficacy, while failure diminishes it. The second source is role models: seeing someone 'like us' perform well enhances our belief in self-efficacy, while seeing someone 'like us' failing, diminishes it. The third source of self-efficacy is social persuasion: encouragement from others enhances our trust in our own abilities while discouragement from others diminishes it. The fourth source of self-efficacy is physical and emotional states (Bandura, 1994). We use physical and emotional cues to judge our capabilities (Bandura, 1994, 72). When we feel tired, or in pain, we can interpret these feelings as signs of physical inefficacy (as is described in detail in Chapter 5). Our mood also affects how we judge our efficacy. Some days we wake up feeling like we can take on the whole world, while other days we feel pessimistic and insecure. Bandura argues that we can enhance people's belief in their self-efficacy by enhancing both their mood and how they interpret their physical states (Bandura, 1994).

In chapter 5 I described in detail how our body can influence our feelings of efficacy and our trust in the future. In the following case study, we will see how other external factors can shape our belief in self-efficacy, up until the point that someone resigns.

3. Case study: uncontrollable external factors make people give up on their goals

Respondent John is a gentle man in his early forties. What immediately stands out in his story is that he is a motivated person who is always looking for opportunities to develop himself. John has normative goals and is highly motivated by them. However, what also stands out in his story is the high proportion of negative external factors that have hindered him in enacting his goals. When I interview him over the years

and listen to his life-story, I notice that at least three times in his life he has tried to build up his life from scratch. The first time is as a young adolescent, when he tries to live an adventurous life after his parents abandon him. The second time was as a young adult: during this time, he was sick of the violent life he was living, he was taking responsibility for the care of his young daughter after his wife left him, and trying to build a career as a professional fighter. However, hepatitis C shattered this dream. The third time that he tries to rebuild his life was as an adult man trying to find a job as a tattoo artist. The last time that I interview him, these dreams are shattered as well, and his feelings of self-efficacy start to erode.

3.1. John's attempt to live an adventurous life

John had a good childhood. A turning point occurred when his mother remarried and he did not get along with his step-father. At 14 he moved out of the house, and his family moved overseas shortly after without him. Although he was doing well at school, he had to start looking for work to sustain himself. At 15 he had a little flat, a girlfriend, and a job at the dry cleaners. However, he was young and adventurous, and that life did not seem to fit him. As such, at 16 he moved to Kings Cross to pursue a more glamorous life. The glamorous life that John is after, however, soon becomes a violent and substance-using life he does not endorse. As we will see next, social pressure had a lot to do with his life turning from glamorous to violent. A failure to live the life he values living, due to social pressure, seems to be a recurrent theme in John's life. As John had no family or other social support around, he joined a group of punk rockers. However, to be part of this group, substance use was inevitable. At 16 he started to experiment with pot, heroin, and speed, but he liked drinking best. John described how he never liked substances like heroin that much, but thought it was part of a glamorous life style. He always thought that heroin would make him addicted immediately, and when that did not happen, he never really gave his use a second thought. For several years John used heroin and other substances recreationally. Some of John's punk rock friends were also into criminal activities. To fit in with his group of friends, he builds up a violent reputation. He becomes a bouncer and briefly spends some time in jail. He mostly cultivat-

ed a violent persona to impress others, including his girlfriend, who he married when he was 18.

I was always trying to impress her and that you know 'cause fighting was so important to her and having a ... being with a guy that's fit and has a reputation and that like that means a lot to her.

The violence started to escalate: 'I smashed my best friend's head in with a hammer'. His friend has just been released out of jail, and staying at his place. The pair became very drunk and got into a fight.

I didn't really want to do it like but he just got out of jail and he was standing over me and I was trying to show him how tough I was (...) Like I'd seen when he stabbed someone.

John called an ambulance for his friend, who survived. Although he almost killed his best friend, he still felt that this was not enough to sustain his reputation as a tough guy. He realised that no amount of violence was enough in the world he was living in.

when I hit the guy on the head with the hammer, I sort of thought, oh yeah I've done like ... like all my friends are violent and I've got this big rep now and all that. But I'm not really living somewhere where anyone remembers or no-one will know like it's not going to make the next person think twice before they try and stand over you or ... (...) like I thought people would see me and go, oh yeah wow oh there goes a punk rocker oh ... like (chuckles)(...) and I thought I was living a ... adventurous life and ... but (...) it just ends up being lonely, like you can't trust anyone and ... well I don't know, that's how it ended up for me anyway, like you're better off being dead if you're just going to live a miserable life.

John started to become more and more dissatisfied with his life. His lifestyle conferred other disadvantages: at 24, he was diagnosed with hepatitis C, His response to this was to stop drinking and get on methadone, although he still used heroin regularly on the side. The relationship with his wife became rocky. Due to the costs of their substance use, she started working as a stripper. When John was 26, she fell pregnant and

managed to turn her life around. She quit using substances and they had a baby girl. However, John still uses, and on his wife's birthday he talked her into using again. She relapsed and had to return to working as a stripper. She worked nights, and slept during the day, so most of the care for the baby was left to John. Their marriage began to dissolve and comes to an end when his wife fell in love with another man. She left John, who was left with the responsibility of caring for their now twelve-month old daughter.

3.2. John's attempt to become a professional K1 fighter

John experienced a crisis after his wife left. Although he did a lot of things to try to impress her, she still left him and called him a loser. He had a hard time getting over it. A turning point occurred when he met an indigenous man at the gym who became his mentor. His mentor encouraged him to pursue a career as a professional fighter. He was making huge progress. He started to find peace in himself, and was taking good care of his daughter. However, he soon confronts new setbacks. He finds out that he can never get a professional fighting license because of his Hepatitis C, and he has to quit his career. His mentor dies. His ex-wife wants her daughter back and he loses the custody battle, mainly because of his violent past.

He goes through a rough time for a while, but then he collects himself again. He finds a new partner, a beautiful woman with a generous heart, who is a former user and on methadone as well. He starts to develop a passion for art and finds that he is talented at it. He meets a new mentor, an art teacher. He starts painting and sells quite a few paintings, and is developing his tattooing skills.

3.3. John's attempt to become a tattoo artist

When I interview John for the first time, he is very enthusiastic about tattooing, and he hopes he'll find a job soon.

I've developed my art like my skills and that and I taught myself a trade. I haven't got a job yet but I'm close to it like ... and the people say I'm good at what I do and that so I've got ... like it's good to have a future you know like a goal or whatever.

I've been learning, reading up as much as I can and I've got someone in America that I email and they tell me information and stuff. (...) I've got four books full of tattoo designs that I've been doing over the years and that and I think eventually something will come up if I just stick at it.

John states that he probably achieved more in the last six years than in his whole life put together. During the first interview, John's future seems promising. He is incredibly motivated and full of plans. His capacities do not seem to have been afflicted by his substance use at all: he is intelligent, and talented. In his own words: 'I am not as screwed up as I thought I was'. He is seriously investing in his future: 'all the spare money I've got I put into buying art stuff'.

When I interview John for the third time, he has indeed found a job as a tattoo artist. However, as I follow his development over the years, a few persistent issues appear. These issues that mostly have to do with his physical identity and the clash between his social identities and his ideal future self.

3.4. Conflicting social identities and lack of social encouragement

As already described, one of the problems John highlights in his life is that he feels there is a mismatch between the image others have of him and his own vision of his valued self. He encounters very little support from his social environment. For example, he does not feel supported by his family. Although he is doing well in life, he cannot measure up to his siblings. He once met his biological father, but it was a bit of a let-down: 'he got other kids and stuff and I can't really compare to the other kids you know.' When he was 17, his mother, who is a fashion designer and a writer, moved to the United States. She took his siblings with her, but decided to leave him behind because 'they [his family] thought I was bad'. Although I got to know John as a very driven and ambitious person, who might take after his mother, he describes himself as the odd one out in the family. He does not feel supported by his family because he can never achieve as much as his siblings. He feels rejected by his mother.

At the different jobs that he holds over the years, he also feels like he has to hide the part of his identity that is stigmatised: being a heroin user, being on methadone, having Hepatitis C. Just like Nicole, he constantly

fears that people at work will find out about his substance use, and that they will not accept him.

I started doing some bricky's labouring and stuff like that and just here and there like cash-in-hand work and one day's work in there and all these blokes ... oh my mate there he said oh you if get that Hep C you might as well stick a gun to your head and pull the trigger you know like ... and like they didn't know I had it of course (...) so I didn't feel like I was good enough to talk to anyone or anything.

'Cause there's a lot of stigma I guess attached to being on methadone you know and like in my area like you're a marked person if they know you're on methadone.

I met my mum a few weeks ago she took us out to dinner and that and she said, oh look at the big hole, the big scar down your arm and that and bloody like oh (...) I guess it's just that stigma you know and I know too I've got to be careful where I work.

it's a small world in a way and reputations follow you and that. Yeah, that could probably make or break my career just like if people know you're an addict, you know what I mean, or if they knew I was on methadone or whatever they probably wouldn't want come and see me (...) people are coming to the shop and got NA tattoos and stuff and I've done it and I've been stoned. I feel really guilty, you know what I mean, I've thought 'oh, I hope they don't realise'.

people would come in and go 'oh you're still on 'Done' and stuff like that, like people off the street and that that I knew or ... like 10 years ago or something like that you know and they'll say right in front of the boss and so things like that don't help, you know? (...) I think it definitely changes people's perception of you and that, you know? And ... like every ... everybody has rights except an addict.

Some of the guys notice things, like one guy notices I perspire sometimes and for no reason and things like that.

Although at work he is scared that people might find out about his substance use, among his (former) using acquaintances he stands out because of his ambition. People from the using scene do not like him doing well.

the other addicts aren't really supportive like ... like they don't want to see someone get on with their life 'cause then ... oh this is what I think, then it's saying to them, 'maybe you can do this' but they don't want to ... they're comfortable. I don't know it's kind of like misery loves company and even in ... like I live in a housing commission area you know like oh you can have so many friends when you're miserable and everybody wants to hear all your problems and they're all so consoling you know but sometimes I wonder if they're not being patronising and they really like to ... 'cause I notice when I'm going well, no-one's that happy. And it's like no-one wants to give you a shot when you're hanging out but when you've been clean for six months everyone wants to give you a shot, it's things like that I've notice, you know. But then again like if I go and have the shot it's up to me but it does make it harder than it has to be you know.

His partner and children are also not very supportive of his ambitions. His partner has a teenage son who lives with them, and John's daughter moved back in with him when she became a teenager. His partner is afraid that he will lose his pension and their subsidised housing if he starts working. When I ask him if he feels in control over his life now, he answers:

No, not really. (...) these people like my girlfriend they're supposed to love me (...) and it seems to me like, whenever I get a job ... whenever I go and go for a job it's not like 'oh great, that's good', it's like 'oh what would you want to do that for, oh you'll lose your housing commission' (...) they just sit there and watch cable TV all day and I reckon it's a big waste of time, waste of life you know. (...) it does wear off on you and I just think sometimes I wish they had more ambitions or something other than just being comfortable all day or relaxed or whatever it is. (...) Everyone is always saying to me, 'oh, what would you want to do that for?'

I know that whatever I'm doing everyone else is just going to be lying there watching telly or whatever like not really interested (...) I didn't get off drugs just ... well, like I'm still on drugs but I'm not getting off them to just sit there and watch telly or whatever all day and sit in bed, you know?

He wants to be a good role model for his children, but his children are more interested in experimenting with drugs. He describes how his

partner, daughter and step-son spend much of their days smoking pot. He tries to quit smoking pot because he is attempting to get his driver's license and he needs to be focused for that, but it is hard with the whole family smoking.

The people around him – friends, family, co-workers, partner, children, substance users – all except for his mentors, reinforce the identity John wants to depart from, and challenge his ideal identity, the future identity he invests so much in. This lack of support makes it extra hard for him to realise his goals, harder than it should be. As John states: 'And sometimes it's other people don't believe in your dreams or I think people try to push whatever they think on to you.' Nevertheless, John is very devoted to his plans.

3.5. Lack of security in his core projects

John is very committed to his plans, and for the first two years that I interview him, he seems to be able to achieve them, regardless of his lack of social support. However, during the third year that I interview him, other adverse external factors start to arise. Although John has found a job in a tattoo shop as a tattoo artist, it seems his luck ended there.

The first thing he struggles with is to fit in amongst his colleagues. He does not find his work environment encouraging at all; he feels constantly criticised by his colleagues. Although they are all younger than him, and although John has been tattooing from home for several years, they treat him like a first year apprentice. He gets no acknowledgment for the work he did at home, and is not allowed to put it in his portfolio. He suddenly has to compete with international artists. He does not get along with many people at work, and he is scared they will find out about his substance use. He keeps to himself, however, part of his job is to sell himself. He really struggles with this social part of the job. John gets paid for every tattoo he makes, not for the hours he is at work, so it is important for him to recruit clients.

However, more disrupting for John's future plans is the fact that new regulations are announced. In order to become a tattoo artist, he needs a license, and he is probably not eligible for that because of his criminal record. The license is also very expensive, 900 dollars, which will not be refunded if he turns out not to be eligible. He feels like his dreams have been broken, and that he is not in control of his life.

the tattooing and that, like that was going to be my big way to make something of myself and that, you know what I mean?

He describes not wanting to get too attached to the tattooing business, in case he needs to give it up. He finds it hard to motivate himself to again change his career path and invest in new skills.

Yeah and I'm thinking so maybe I can master something else like ... I guess I'm angry with myself for not ... I should have done all this earlier.

After the licensing issue came up, John's substance use increases to almost twice a week. In many ways he is a functional user, but he feels like he could do his work a lot better if he did not use heroin. He is afraid that people at work will find out. Now three factors make it hard for John to quit his self-sabotaging substance use.

The first factor is his fear that he will lose his job when he seeks treatment. In the past he benefited from NA, but he is afraid that if he goes to meetings, he will run into someone from work or a client – as John remarks, 'it is a small world'.

The second factor that makes it hard for him to quit is that his wife relapsed simultaneously, and he feels like she is sabotaging his attempts to get clean. She often suggests using 5 minutes before he has to go to work at 6 pm, so it feels like his efforts to resist using all day have been in vain. The third factor is more complicated. One word that keeps coming up in the third interview is 'sabotage', or 'self-sabotage'. It seems that because his plans over time have continually been derailed by external factors, he now seems to sabotage himself. As he stated earlier, he is afraid to become too attached to the tattooing business, in case he has to give it up. He finds it hard to quit, not so much because the heroin itself is very appealing to him,³¹ or the craving irresistible, but 'because it's safe to be an addict for me, you know.'

I guess it's just the fear of the unknown and fear of the future and that. I find myself getting clean but be scary too, I know people that have got clean in their later years in life and it ... I know they feel like they've wasted

31 He describes his substance use as pleasurable, but also as repetitive and monotonous.

their whole life, you know what I mean, to get clean and then get old or whatever.

Now objectively, John is doing well when I interview him for the third time. He achieved many of his goals. He found a job as a tattoo artist, he is still working on himself: he is learning Photoshop, and he has obtained his driver's license, which was an important goal for him. However, his morale is very low. The insecurity about the new regulations and whether he can continue to be a tattoo artist makes him depressed and anxious, and he sometimes even thinks of suicide. Although John is achieving things on his list, his identity as a tattoo artist is constantly challenged: by regulations, his co-workers, and his loved ones.

3.6. Loss of belief in self-efficacy

At the time of the third interview John seems to start to lose confidence in his plans. On the one hand, he is not ready to give them up yet; he constantly expresses a need to be useful and feel worthy, he wants to do something in life, have a goal, and get more out of life than just using or watching television. He feels like he has a lot more to offer than he is allowed to give. On the other hand, he gets increasingly fatalistic about whether he will be able to fulfil his dream. Although he is not willing to give up his dream, he is also afraid of giving it his all. So although he keeps making steps to fulfil his dreams, he does not do it wholeheartedly.

While in the years before, John was very clear about the steps he needed to take in order to achieve his ideal future, during the third interview, he is very vague about his steps, or the future. Although he ordinarily makes a list of things he wants to achieve, he has not done so this year. He has adopted a more local perspective on his life again: planning his days, but foregoing any long term plans. He has no image of where he sees himself in one year's time: 'I am a bit unsure at the moment what's going to happen'. A few years ago he was diagnosed with spondylitis, a type of inflammatory arthritis that targets the joints of the spine. Although in prior interviews he mentioned a few times that it hinders his work, especially in winter, he is now increasingly insecure about his future. 'I could wake up tomorrow and not be able to move or something so I just not try and think about the future at all'. His physical condition

does not seem to have worsened; rather, his expectations of the future have seemed to. In general, John expresses a low belief in self-efficacy: this is clear in the first interview, but his belief gets stronger during the third interview. Below are some quotes from the four interviews I did with John:

I've been trying to change my life heaps but I haven't ... I always end up back on ... back here, you know?

I'm still kind of ... and I guess no matter how much I feel like I've changed my life, I haven't ... like on paper I'm still bad, I'm still ... like I don't know what it would say on paper but it wouldn't look very good and I don't know I just ... look, it's hard sometimes like really I've been thinking about it and as good as I think I go or whatever I'm dependent as well on other things like on Centrelink and stuff like that.

I keep trying things and I'm fairly good at them and I see other people that are just as good or whatever and they're doing a lot better than I am. I'm getting a more realistic picture of my life, you know what I mean, it's easy sitting in a housing commission down in W., sitting there painting and you think you're like this great artist and that and then like I got out and seen other stuff and I just was a bit egotistical probably and thinking I could do all this stuff through art and that and change my life and that and then I have but ... like I thought I'd just have to get into a tattoo shop and that's all I have to do and then I'd be set for life and it wasn't kind of like that, I got into a shop, I guess it's just life, hey, you ... and then there's another step and you've got to take another step and you never quite there.

I think that's just life, there's always something that's going to nag at you or get you down. (...) But that's just life, isn't it? Like you feel fear all the time or like ... don't know, doesn't sound like it's pretty good world really you know like it probably is for some people, maybe I just attract it to myself, you know?

I made up a want list, and I got most of those things. (...) [But] I'm not enjoying life. Like I've been thinking I should be really happy 'cause I've done all these things but it's just wanting more and more. (...) I don't know, there's something wrong with me, I think, to be like this, you know.

During the years that I interview John, he always expresses doubt about his self-efficacy. But especially during the third interview, he describes feeling powerless, regardless of all his efforts. He seems depressed and mostly avoids eye contact. He acknowledges that some of his misfortune is due to his own doing, but he is frustrated that every time when he tries to improve his life, he encounters setbacks.

4. External sources of belief in self-efficacy

During the third year I interview John, he seems to increasingly fit the profile of what Kennett (2013) calls a resigned addict. He seems to have lost belief in his self-efficacy; he progressively gives up on making plans for the future. What brings him down is that the core projects that constitute his valued life and identity are constantly threatened by external factors: work policies he cannot meet because of his hepatitis or criminal record, health problems, his spondylitis, his marked body getting in the way of his plans.³² These external factors interact with internal factors: his fears of being unmasked at work as an ‘addict’, his shyness in selling himself. What brings him down is that his valued identity is constantly challenged by the people around him: his colleagues, and his family. We saw before that in order for a person’s identity to be motivating, they need to believe that their ideal future self is achievable. We need to believe in our own capacities to achieve this future, and we need to believe that we are reasonably safe from misfortune (Calhoun, 2008). When we look at John’s story, on the contrary, we see that after encountering many adverse events he does not feel safe from misfortune at all. Although he started with a good deal of belief in his capacities, when all his efforts do not seem to bring him closer to his valued future, he starts to doubt his achievements as well. In the next section, when we return to Bandura’s four sources of self-efficacy, it is easy to see how they are undermined in John’s case.

32 Some of these factors are directly addiction related and some factors might have occurred regardless of his addiction. These addiction-independent factors however, aggravate the harsh situation he is already in.

4.1. Performance

The first source of self-efficacy is performance: being successful in one's goals. Although John has experienced quite some success in achieving his goals, for some reason his failures weigh heavier for him. Since John feels that his life is dominated by failure, every failure seems to reinforce this impression, while every success seems to be the odd thing out. The same can be said for Nicole. Although she might not be the only student who failed her practicum and although it is not unusual for even top grade students to fail an exam once in a while, for Nicole the failure reinforced her image of being a person who always fails at things.

If experiences of success are important for our belief in self-efficacy, it is easy to see how this source is undermined for most people struggling with addiction. Most people recovering from addiction find themselves in disadvantaged situations, both financially and socially (Biernacki, 1986). Not only do they have less options to engage in activities through which they can build positive experiences with success, they are also more likely to fail due to external hurdles when they find projects to engage in. Many respondents struggled to find a job due to their homelessness, criminal record, health issues, or because they lost their drivers license due to drink driving. Many also state that what they lost control over is not their cognitive control, but the options in their lives – they describe having 'very few options' (P6). Having limited resources to rebuild one's life is associated with relapse (Mackintosh & Knight, 2012), and my study shows that this could be mediated by the fact that addicted people lost belief in self-efficacy.³³

Some have argued that loss of belief in self-efficacy in addiction is mainly caused by a failure to successfully control one's substance use. After repeated relapses people give up trying, and if they do not control their substance use, they cannot reach their normative goals (Diclemente, 1986; Marlatt et al., 1995). Although there is a particular group for whom this factor plays a significant role in eroding their belief in self-efficacy, there is nonetheless another group for whom this inability to control their substance use is not their main problem. When we look at John's

33 We saw in Chapter 1 how important core projects are to constitute our identity and live the life we value living, however, for many addicted people in recovery their possibilities to engage in those core projects are very limited. See also Koski-jannes's (2002) study on the importance of core projects for recovery, and Macintosh and Knight's (2012) study on the importance of stable housing as 'a sanctuary within which to reclaim the self' as a central element to recovery (Macintosh & Knight 2012, 1094)

story and Nicole's story, escalation in substance use and their relapse (respectively) occur *after* their normative goals are threatened rather than the other way around. John quite easily quit his drinking when he was diagnosed with hepatitis C, even though it was his preferred substance. John hardly describes any uncontrollable craving for his substance use.³⁴ During the second interview, when she had her life sorted out, Nicole describes a similar experience: substance use is so distant to her that she hardly experiences any craving.

4.2. Role models

The second source of belief in self-efficacy is the availability of role models. When we see those who are similar to us succeed in things, we gain trust that we are also able to achieve these things. When we see people fail, on the other hand, it reduces our belief in self-efficacy. John described a friend who was a role model for him. This friend was his training partner, and very successful in K1 competitions, winning prizes overseas. He now (during the time of the third interview) owns his own gym. This friend was a non-user and when he found out about John's struggle with substance use, he was at first very supportive. However, as John's addiction continued, the friendship fell apart. Further, his estranged training partner became successful but John was left behind struggling with his Hepatitis C and his addiction. John does not describe any role models from the using world; success among his using friends amounts to being a successful dealer, and this is not the kind of success John values. He describes a friend who has become a very successful drug dealer: 'he's always got a big pile ... wad of cash on him, about 10 grand or something, and he's always flicking it at me'. However, that life of violence and adrenaline is the life John wants to depart from, yet he envies his dealer-friend's success as he himself plods along. John has no positive role models of 'people like him' who succeed. In his world, people who succeed are drug-free, and his only option for success is becoming a dealer.

34 A quote from the qualitative study of Weinberg and Koegel (1995) underlines this point that the problem is not quitting substance use, but believing that quitting substance use will bring the desired future closer: '...first and foremost is I'm extremely lonely...I'm totally unemployable. I'm over the hill, got no references, no appreciable skills, patchy work history at best, former alcoholic and addict, homeless...it's very depressing. I mean [participating in treatment] is not the answer to all my problems. Recovery is not going to make my problems go away' (Weinberg & Koegel, 1995, 217).

Many respondents I interviewed did not have any positive role models. A respondent whom I was not able to follow up because he died from his substance use after the first interview states:

I've been out of rehab whatever it is now, two, two and a half years, whatever and there's 10 people that I went through rehab with that are dead, that I know of. God knows how many others that I don't know of. And they were good people. (...) Some of them ... a guy that I had a relationship with that was absolutely flying, that I thought was going to make it, died, you know, took an OD last year (R34) (also quoted in Chapter 5).

Seeing someone die of an overdose who was doing really well in overcoming his addiction was a discouraging experience for this respondent.

4.3. Social encouragement

The third source of belief in self-efficacy is a person's access to social support. Lack of social encouragement might be the main eroding factor in John's belief of self-efficacy. Although he is relatively successful, he does not receive any encouragement for it. His wife and children are not supportive because they feel threatened by his achievements since they are afraid to lose the pension they receive. His parents and siblings are not supportive because they live overseas and do not relate much to his life. His using friends are not supportive because they find his changes confronting them with their own failures to change their lives. Although he did receive some encouragement from his mentors, it was not enough to compensate for the lack of encouragement he received from the people in his daily life. With Nicole there was another issue. Due to her self-stigma, she mainly focussed on negative social reinforcement. Although she did get quite some social support: from her family, from her psychiatrist, she was very upset by the feeling that her fellow students always doubted her.

There is some evidence from qualitative studies on identity change that lack of social encouragement hinders recovery. We cannot just rewrite our own story, or our identity; other people must be willing to support this change (Hughes, 2007, 688). 'Nonaddicted others must come to accept the abstainers as people who are no longer addicted and act toward them in terms of the new, 'ordinary' identities that they are presenting'

(Biernacki 1986, 141-2). Several studies found that relapse is linked to significant others continuing to label the recovering person as an addict, while abstinence is linked to significant others confirming the non-addict identity (Stephens, 1971; Tuchfeld, 1981; Waldorf, 1976). The support an individual receives from those around them is an external factor that is only partially in their control. When their social environment does not support their attempts to change, they may have very little choice left aside from remaining an ‘addict’ (Kellogg, 1993). Or, as John described it, ‘it is safe for me to be an addict’. This statement of John could easily be misread as that he likes it to have the identity of an addict. It is sometimes argued that addicted people feel most comfortable having the identity of an addict (Anderson, 1998). In these cases people who resign to the identity of an addict are presented as willing addicts rather than as resigned ones. However, having very little choice left than to just be ‘an addict’, is different from being a willing addict and endorsing one’s substance using identity.³⁵

Many respondents described a lack of social encouragement. They had many experiences with social discouragement in the form of stigma.

4.4. Physical and emotional states

The fourth source of belief in self-efficacy is a person’s physical and emotional states. We saw in chapter 5 how physical states can influence our belief in self-efficacy. For example, John’s Hepatitis C derailed his plans to become a professional fighter, and his spondylitis makes him insecure about his future abilities to be a tattoo artist.

A person’s moods can also affect how they judge their own efficacy. Calhoun describes depression as an internal state that can threaten our self-control. Depression paralyses the will and depletes our reasons of motivational force. Depression renders us disengaged from our reasons, we stop deliberating on our reasons and planning for the future, we stop engaging with our projects.³⁶ Calhoun states:

35 Catriona Mackenzie has outlined the importance of social relationships in being autonomous. Autonomy is often associated with being self-sufficient, however this concept of autonomy has been criticized as been too individualistic, and solely focusing on self-government. Autonomy also has an important relational dimension. Persons are embedded in social structures that form their identity and determine their options, both positively as negatively (Mackenzie, 2014; Mackenzie & Stoljar, 2000). The case of John illustrates Mackenzie’s thesis. To extensively discuss the concept of relational autonomy is beyond the scope of this thesis.

36 What complicates the matter is that the relationship between depression and low-belief in self-efficacy is bi-directional. Depression can be a result of a discrepancy between the ideal self and the

Depression is one of an array of psychological conditions in which persons disengage from the agential activities of reflecting, deliberating and choosing (...). Rather than causing the internal defeat of an engaged will, the volitional disabilities of depression, demoralization, and so on, are states of disengagement of the will and, consequently, disengagement from the project of being an agent and leading a life. (Calhoun, 2008, 196)

If mood and physical states inform one's belief in self-efficacy, it becomes clear that for people struggling with addiction this source of belief in self-efficacy is often diminished. Many people struggling with addiction also have a mood disorder. Substance abuse increases the risk of depression by a factor of 5 (Volkow, 2004), and around 40% of the people seeking treatment for substance dependency are also diagnosed with lifetime depression (Swendsen & Merikangas, 2000). Almost one third of the people struggling with depression also struggle with substance use disorders (Davis, Uezato, Newell, & Frazier, 2008). Both Nicole as John describe feeling depressed.

One can argue that the feelings of low self-efficacy preceded John's misfortunes. However, when looking at his life story, it is easy to see that from an early point in his life he did not get very much encouragement and opportunities to build his feelings of self-efficacy.

As we saw above, external factors that are beyond the control of the agent often erode their belief in self-efficacy, resulting in resignation. Addicted people are especially vulnerable to an impairment of these sources of self-control.

5. The resigned addicted person

When our belief in self-efficacy is eroded, and we do not feel safe from disastrous misfortune, we are likely to give up on our normative goals. I showed above how addicted people are especially vulnerable to a loss of belief in self-efficacy. John is not the only person that I interviewed who fits the 'resigned addict' category. After her latest relapse, Nicole

current self (Higgins, 1987). As we saw with John, he becomes increasingly depressed when his attempts to improve his future keep being frustrated. However, depression can also be an independent source of making people lose belief in their self-efficacy and give up on their normative framework (Calhoun, 2008).

also shows signs of resignation. Many other respondents also describe their lives as a revolving door, a merry-go-round that they cannot get off. Marc Lewis has described the lives of those with addiction as an hour glass. We all start unique in life, with a wide range of possibilities. However, as a person's addiction progresses, they gradually withdraw from non-drug related activities like work, sport, social contact, and become solely focussed on consuming drugs. At the middle of the hourglass, people's lives only revolve around using, and all their lives look the same; they feel like they have lost the wide range of possibilities that life offered them before. Lewis calls this the 'hollow tube of mindless repetition'. At that stage people are in the midst of their despair, and they find it hard to imagine that their lives will ever blossom again, or that their uniqueness and creativity will ever be restored. They find it hard to imagine that that hollow tube will ever fan out again into a million possible ways to live their life. They think that substance use is their only option left in life (Lewis, 2012).

Let us look at some other quotes from people who have resigned from their normative goals –people who express that the life they value feels unavailable and unachievable.

I don't know, since about 30 onwards I've just sort of given up, I've just gone fuck it, I'm going to be an addict, I'm just ... my life's stuffed, I haven't spoken to my kids in four years or something. (R58)

When I'm in the throes of addiction and I'm trying to stop and I can't stop, my head's going: 'this is who you are.' I can accept that, you know what I mean? That's ... as weird as that sounds I can accept that I'm a junkie. I'm ... my life is over and this is what I'll be until I die. It's the only way I can stop is to die. (R2B)

I: You have any ideas about the sort of person that you want to be these days, things that..?

M: Not really no. I don't think I really care all that much. Yeah I just go from day to day basically, just whatever happens, happens and because I spent so long struggling with mental illness and alcohol and other substance addiction, and I've got ... not really got anywhere, that I just don't bother having any aspirations or anything because I can't really do anything and I can't hold down a job because of my mental illnesses and my drug use. The same with study so anything ... if there was really anything

that I did want to do, I wouldn't be able to do it anyway and hence why I'm on DSP (disability pension) yeah. (...) No there isn't really anything I can do so I don't bother having goals because it will just be disappointment 'cause I can't achieve them so. (FAL-01)

Yeah, got tired of thinking and tired of coming up with all these ideas, I just somehow deep down knew they weren't going to happen and I don't know why but so I just gave up. (R14)

I don't want to keep making goals and then have to break it 'cause then I'm setting myself up for failure and it's just no good me doing that, so I've been doing ... a lot of that's been happening through my life. (...) [I] don't try to do something that I can't do otherwise I'll basically fail. (R29B)

It just seems like a circle. Like my mind in one part of me says to me 'oh well it's going to happen again eventually'. Because when I look in my past for 15, 18 years ... 20 years, it's just been the same thing. So I tell me ... my mind tells me 'well how long's it going to be before something happens?'. (R50)

I've thought that by this time in my life I'd have it together, but I seem to start to get it together and then it slips back. (...) just every time I get to a good stage in my life, I think things are starting to happen, and something happens and then I'm back into it. (R50)

I: Where do you see yourself in 1 year's time?

R: Maybe dead, dead or still doing this same bullshit in and out of places, on methadone, using. Or clean or in a rehab, clean doing the right thing or just on the methadone, picking up, going there each day picking up. There's a few images I see and I don't ... a lot of them I don't like but when you're doing ... when you've been doing this for so long you just think well that's the reality, come on, don't bullshit yourself, don't sugar coat it, let's just get to real. (R58)

We can infer, on the basis of these extracts, that addicted substance users cease long-term planning because the life they value living seems unachievable to them. For some people their ideal life became unavailable due to the damage caused by their substance use. What John's story nicely illustrates is the process by which addicted substance users become resigned.³⁷ Most of the other resigned addicts we interviewed

37 For some people, misfortune in their lives led to resignation and substance use. One respondent described how his first wife and child died in a car accident. With his second partner, he lost three

were already so extensively resigned that they had no story left about their hopes and ambitions. In John's story it is clear which factors make him lose his normative self-control, while in the cases of people who are totally resigned, we are tempted to conclude that they do not have an image of the good life at all, that they might be wantons. With John we see how his image of the good life gets frustrated over and over again until he gives up.

What does this resignation look like? One aspect of resignation seems to be a feeling of unworthiness. Resigned people often describe feeling unworthy of the life they would value living, or feeling unworthy of other people's help. Many people reported that once they let other people help them, their lives would get much easier to manage:

Part of my use was to punish myself and when I did use I would punish myself more by ... because I would be regretful and thinking 'oh why did I do that?' and then it become a prolonged punishment and 'oh well you don't deserve any better' (R39)

Oh yeah like myself like being felt like you're worthless. It's hard to come back from that being drummed into your head as a kid. And then like when we're older, we're told oh even now it's your choice to make your life better. But ... and I completely agree with that but it's hard when you know ... when all we've ever known we're just meant to change that so. (FCA-01)

I had low sort of self-esteem and like I struggle a lot with things like that like I'll choose this one [these values on the value scale] where other people might choose ... 'cause they've got high self-esteem they might choose something different, you know, 'cause the drugs take all that away from you, you think you're useless and not worthless or anything, I'll pick the thing that mean like something to me, you know. (R44)

I struggle of people offering me help, I still think that I'm not worthy of it 'cause they ... everyone's been offering me to help move and I said no, no, it's alright man I'll get a taxi or I'll carry it or whatever, and yeah the guys the guys at Redfern said the other day he sees it as me being ... me myself thinking I'm not worthy of anyone's help. (R44B)

children in five years due to stillborn or sudden infant death syndrome. Recently his partner died of lung cancer, and that was the straw that broke the camel's back. 'Life had got me', he said (R3). He describes his ex-wives' surprise when she found out that he is homeless now, since he always was a high achiever.

Another aspect of resignation seems to be self-sabotage. Recall that John stated that he feels like he is sabotaging himself. His partner, who is also a respondent in the study, claims that John sabotages himself: 'He will get somewhere, but he's not going to let himself. He's going to ... what's the word, he's going to sabotage himself' (R63). Other resigned respondents expressed that they were sabotaging themselves.

Even if I do fuck it up..., see here I am with my self-sabotage, I don't believe what I'm saying. But I do believe ... I got to keep believing in myself because if I don't I might die here. (R53B)

One respondent stated that he was self-sabotaging because he did not feel worthy of the good life.

I was making like \$30,000 a month for 10 years and you know buying properties and land and that. I had a lifestyle I guess that a lot of people would give their right arm for yet I sabotaged it. Why? Was it 'cause I didn't feel worthy?

Another respondent reported that self-sabotaging made her feel in control over her failures.

I missed the last three classes, the last one was just going to be a party so really I missed only two and if I had of gone to those two classes I would have got my certificate and then I would have been able to do my social studies course, which is I what I wanted to do next and I think it's self-sabotage, every time I nearly get somewhere I fuck it up and I don't deliberately do it but that's what happens and I ... like I sort of ... my counsellor didn't really say that to me but in talking to her I sort of realised every time I almost get somewhere something dramatic happens or I'm a drama queen in some way and I don't know what it is, it's fear I think, fear of whether or not I can hold it together to do something because if I fail at one more thing I'll just be even more ashamed of what I can't do. (R53)

When people strongly lack a belief that their valued future is available to them, they will not only fail to actively strive for that future, or seize any opportunities to improve that life, they will even actively destroy the

opportunities they have to achieve this life. This is because they feel unworthy, or because they feel that control over their failures is the only control they have left in life.

There is a persistent view in contemporary literature that resigned addicted persons are secretly willing addicts (Dalrymple, 2006; Foddy & Savulescu, 2010; Peele, 1987). In the next section I will outline the key differences between the willing addict and the resigned addict. In the last section I will also argue that resigning is not a rational choice. I contend that although resignation is understandable, it is still a loss of self-control because resignation also extends to situations wherein it would be better to adopt a global perspective on one's life. I will draw a parallel with poverty studies to illustrate this point.

6. The resigned addict is not a willing addict

Some seem to be suspicious about the difference between a willing and a resigned addicted person. Calhoun highlights that we often think that people must have some sort of normative framework. Given this, it can be difficult to comprehend that they can become estranged from their normative framework without adopting another one. A common mistake is 'to think that because a person has ceased to identify psychologically with her normative outlook, there must be something else – some other hidden or silenced or ignored normative outlook with which she really does identify' (Calhoun, 2008, 203).

Some commentators do not see a difference between the resigned and the willing addict, claiming that once a person resigns from their image of the valued life, and accepts that the life of an addict is the best available to them, this becomes their picture of the good life. Because the addicted life is now their view on the good life, they count as self-controlled in a normative sense (Dalrymple, 2006; Schlimme, 2010). Take, for example, Waller's or Dalrymple's description of the willing addict:

... all his fondest hopes and dreams shrivel away. Ultimately he is left with only his addiction, and he deeply fears the loss of it. He is an addict, wants to remain an addict, and wills to be an addict. If he felt his addiction weakening, he would take whatever steps he could to sustain it. He

clutches his addiction as a drowning man clutches a straw, terrified to lose this last source of comfort. (Waller, 2003, 538)

Most of Britain's 300,000 addicts are drawn from broken families, have a poor education, are without much hope for (or for that matter fear of) the future and have no cultural life, intellectual interests or religious belief. Delusory euphoria – the paradise at three pence a bottle that De Quincey described in his *Confessions of an English Opium Eater* – is the best that they think that they can hope for in life. (Dalrymple 2006, 4)

We can read Dalrymple's statement in two ways. We can indeed see it as an indication that addicted people value their addiction, and that the life they are living is their preferred life. They are who they want to be. Or we can conclude from it that – due to external factors, like poverty and lack of opportunities – addicted persons give up on their valued identity, because their valued future self seems unachievable. In this second explanation resigned addicted people do not endorse their addictive desire or endow it with normative force (Kennett, 2013). It seems like John and Nicole's case better fit this second explanation, they are not particularly thrilled with their addiction and their identity of an addicted person.

7. Resignation is not a plan B but a persistent loss of belief in self-efficacy

Dalrymple's quote also seems to belie another assumption. Maybe given their circumstances, resignation is the best option for many addicted people. Our normative goals need to be realistic, and perhaps if our goals tend out to not be realistic, a resignation from them is a rational choice. However, as I will argue in this section, resignation is not best construed as a viable plan B, but as a persistent loss of belief in self-efficacy. To see how this is true, important lessons can be gleaned from poverty studies. There are a few studies on how poverty impairs our agency (Blacksher, 2002; Morton, forthcoming; Summer, forthcoming), these studies show that adverse external circumstances do not only influence our plan of the day, but persistent adverse external circumstances also have an accumulative effect: they influence our perception of what is possible in our lives.

As we saw in chapter 1, external factors can derail our plans. For example, I am saving money to buy a bicycle so I can save money on commuting. However, just before I have enough money, my washing machine breaks down, so I need to spend the money on repairing the washing machine. In this example, an external factor has a singular effect on my plan: it only influences my ability to enact my current plan. However, there is another, more pervasive way in which external factors can disrupt agency: by making us give up on our goals. Imagine that I save money again, but just before I have enough money the family dog gets hit by a car, and we need to spend the money on medical bills. Next time when I nearly have enough money there is a dental emergency. And so on, until I give up on my intention to buy a bike or to save money all together. Let us look more closely now at the lessons we can draw from poverty studies.

Chronic scarcity makes it harder to commit to diachronic plans simply because we cannot spare the resources to make small sacrifices now for a better future. We cannot spare the money needed to attend a course that will upgrade our job prospects. We might also find it hard to find the energy to devote to future plans, when all our energy is needed to survive at the current moment (Summer, forthcoming). But scarcity also has a more profound effect: it influences our self-concept and what we think we can hope for in life:

Children born into these circumstances, not unlike those born into more advantaged circumstances, learn how and what to be, what to expect of themselves and others, what to hope for and aspire to. (...)The deprivation stealthily settles in, coming to characterize not only one's circumstances but one's sense of self, possibility, and aspirations. (Blacksher, 2002, 465; 459)

In that sense, long term scarcity influence one's ability 'to make a life plan that reflects one's values, interests, and hopes for a future' (Blacksher, 2002). People confronted with chronic scarcity will stop trying to change their circumstance because they lose hope (Summer, forthcoming).

In 'on being poor and feeling poor' Erika Blacksher narrates the life story of her mother, Sally, who grew up in a poor, abusive family, who married an abusive husband, and lived with poor health and poverty. How

is the agency of her mother to be judged – why did she not try harder to change her life? Blacksher argues that we cannot assess her agency without taking in to consideration the circumstances she lives in:

These early experiences and environments shaped, or more accurately misshaped, Sally's capabilities to avail herself of future opportunities and resources – the means that could have helped to make her free, healthy and well. Sally could have, for example, studied for and obtained her GED, left a bad husband, and found a place in the workforce that would have welcomed her work ethic and creativity and helped her achieve economic independence. But she didn't. She did not know she was capable; she did not think she deserved a better life. Although she possessed the skills to survive (to avoid malnutrition and escapable morbidity and mortality), she lacked the more complex human functioning (self-esteem, imagination, and hope) that would have enabled her to see and stretch for opportunities. (Blacksher, 2002, 467)

Although one might think that Sally rightfully adopted a local perspective on her life, Blackser argues that Sally might have had more opportunities to change her life than she thought. Her circumstances 'misshaped' rather than shaped her expectations. Chronically economically disadvantaged people do not only adopt a local perspective on their lives when it is wise to do so (not starving today is a precondition to any future goal), but they often also fail to adopt a global perspective on their lives when they have most reason to do so (Morton, forthcoming). So although poverty or lack of opportunities might have caused Sally's low belief in self-efficacy, her lack of belief in self-efficacy became an additional threat to her agency that might not have automatically resolved once her circumstances improved.

When we return to John's story it is easy to see the parallels with poverty studies. The real loss of self-control that John is suffering from is not a lack of right circumstantial conditions but a failure to be moved by his own reasons and a lack of interest in deliberating on what to do. Although John at first is motivated by his future plans, as the hindering external factors accumulate, he starts to become resigned. He describes not wanting to become too attached to the tattooing business; he describes not making plans for the future anymore. In general, he adopts a

local perspective on his life. He shifts from feeling in control of his fate, to feeling like a bystander within his own life. Now everyone is vulnerable to adverse external factors. However, some people are disproportionately vulnerable to them. These people risk losing belief in their self-efficacy, they might stop trying to improve their lives, and if their loss of belief in self-efficacy is very severe, they will even fail to grab the opportunities once their circumstances unexpectedly change. We see with John that although it is understandable that he gets discouraged, on the other hand he might be overly pessimistic about the achievability of his future. He could for example try to find a job at another tattoo shop, and see if he fits in better there.

It is often argued that if we improve a person's environments, give them better opportunities and perspectives in life, that most of the problems associated with addiction will be solved (Alexander et al., 1978; Alexander, 2008; Hari, 2015; C. L. Hart & Krauss, 2008; C. L. Hart, 2013). Although providing people with opportunities and resources to improve their lives is essential, as John's story shows, it might not be sufficient if loss of belief in self-efficacy is highly entrenched. When we recall Nicole's story, we see that poverty cannot be the only factor that explains resignation. Nicole is at university, her family has money, and she lives in reasonable accommodation. Nicole's low belief in self-efficacy comes from the internalisation of social stigma. In addiction, poverty is just one of a wide range of internal and external factors that can cause someone to give up on their normative plans. Improving people's opportunities is essential, but belief in self-efficacy needs to be targeted as well or else they will fail to pursue opportunities that are presented to them. In Calhoun's words, 'Those who are estranged from their normative outlook lack the desires to pursue what they value, including what they most deeply value, even when their lives afford them opportunities to do so.' (Calhoun, 2008, 198).

8. Conclusion

John's story nicely illustrates that agency is not only about the right capacities, but also about the right environment. John has the right morals: he wants to do what is right. He has a clear view of the life that is valu-

able to him and the type of person he aspires to. He has many capacities and achieves some of his goals. What gets in the way of his self-control is the fact that he does not have a supportive environment. Although he is committed to his projects, external factors make it hard for him to stay committed to his plans: new regulations at work that he cannot meet, his health problems, sabotage from his wife. Although people can have a strong motivation to act in a desired-identity congruent way, they need both opportunities to act on this motivation, and support from those around them.

Most theories of self-control focus on whether or not a person achieves their goals, but fail to look at why they set certain goals for themselves, and the extent to which their goals reflect their values (Horstkötter, 2009). In this chapter I have outlined the ways in which addiction influences the psychology of the agent. I illustrated how people can stop forming intentions that are in line with their values, and how this constitutes a failure of agency. This failure of self-control due to loss of belief in self-efficacy precedes other forms of self-control. A person can have will-power and strategies. However, when that person fail to be motivated by their values and valued identity, their agency will only be exercised on an intentional level. The current theories on addiction and self-control do not acknowledge this effect that addiction has on an agent's psychology. Because of this, none of the current theories can explain how the resigned addicted person lost self-control.

I argued that harsh external circumstances may make addicted people abandon their plans. The real toll addiction takes is on people's self-concepts and meaning and purpose in life (Singer, Singer, & Berry, 2013, 379). Although most respondents have the same desires as the rest of us – aspirations to work and be loved – their plans are often derailed by the complicated external circumstances they have to face. As one of the respondents said: 'We are just normal people living very complicated lives'. Or, as Kellogg states: 'Identity change is, in the best of circumstances, no easy thing to accomplish. As this process is complicated by personal psychopathology and the social ills of poverty, violence, and degradation, one can see that it may be an enormously difficult undertaking' (Kellogg 1993, 243).

For some people their belief in self-efficacy will be restored once their external circumstances changes and they receive opportunities to take

on core projects that reflect their desired identity. For other people however, their lack of belief in self-efficacy might be so entrenched that even when presented with opportunities, they will fail to take them.

The precise causal relationship between loss of belief in self-efficacy and addiction is contested ground: is an agent's loss of belief in their own self-efficacy caused by substance use, or vice versa? Perhaps poverty is the common cause of both loss of belief and addiction? The answers to these questions might differ across different groups of addicted people: for some a low belief in self-efficacy (caused by poverty or another factor) might precede substance use, and their feelings of self-efficacy are further eroded when they become addicted. For others, substance use might itself cause a low belief in self-efficacy. What I mainly argued is that loss of belief in self-efficacy is an independent factor that impairs people's agency. Loss of belief in self-efficacy is not just a temporarily side effect of external circumstances or substance use. We should acknowledge loss of belief in self-efficacy as an independent factor that can cause impairments of normative agency in addiction.

In the next chapter I will explore how normative agency can be exercised.

CHAPTER 7. NORMATIVE AGENCY EXERCISED



1. Introduction

In the previous two chapters I showed how normative agency can be impaired. I demonstrated how physical changes and external circumstances can change a person's self-concept, or their beliefs concerning what is possible in their lives. In chapter 6 I argued that if people find themselves in persistent hostile environments, they are in danger of becoming resigned to their addictive situation and stop believing in their self-efficacy. Those who end up resigned to their addictive fate cease believing that the future they value is available to them. They stop forming intentions, plans, and deliberations that reflect their values. I argued that for a subgroup of addicted people, this might be the primary loss of self-control they encounter. The stories I sketched in Chapter 5 and 6 offered little hope for the future and the agency of addicted people: the narrators of these stories confronted serious health problems, adverse external circumstances, a lack of social support and stigma.

In this chapter, I will show how normative agency can be regained, and argue that by exercising normative agency, people can regain control over their lives. In this chapter I will narrate the story of another respondent, Tom. Tom had a heavy addiction for almost 35 years; he was homeless most of that time, and I am sure that if I had interviewed him a few years before, he would have fit the profile of a resigned addicted person. However, a few weeks before I interviewed Tom for the first time, he had a moment of clarity. After this moment of clarity, his ideal self became strongly motivating. In the three years that followed, I witnessed Tom work hard to reshape his life in an identity-congruent way. He regained control over his substance use, and even managed to quit his maintenance treatment. He found a job, developed core projects, and situated

himself in an environment in which he has strong social support and his old identity is not called on anymore. But what Tom considers the turning point in his recovery is his sudden belief in his own efficacy. This feeling of self-efficacy helped him counter the adversities which inevitably occurred and threatened his emotional stability which triggered relapse. As we will see, John and Tom have many similarities. Both endured a long term substance dependency. Both have strong normative goals, they want to do the right thing in life. Both have many talents and capacities, and both confront opportunities and adversities. However, the difference between Tom and John is a strong feeling of belief in self-efficacy that John lacks and Tom possesses.

2. Case study: the importance of belief in self-efficacy

2.1. A moment of clarity

Tom is an intelligent, good looking man in his late forties who has been addicted to heroin since he was 16 years old. When he was 14 years old, his parents split up because of domestic violence. From then on, he started acting up – smoking pot, stealing a car – until his father threw him out of the house. Since he was 14 he has been living on the street for most of the time. In his thirties he briefly matures out and starts a family, but he relapses again in his late thirties. When he is approximately 44 years of age, his life regains some stability again – he finds housing, gets on methadone, remarries – but his substance use is still not really under control. When I interview him for the first time, at age 48, he tells me he recently experienced a moment of clarity. For the past 5 years he had been working on his recovery. While he had been clean for periods, he relapsed regularly. A few weeks prior to our meeting he almost died of an overdose. In the weeks following the overdose, he started contemplating:

I was sitting there and I started to ... I wasn't under the influence at the time. I was between shots, so to speak, and I was sitting there thinking, and thinking about what I've done and how I've done it and who was involved, and I guess it was just a moment of being able to think deeper, past the want, and seeing needs, I guess.

Tom describes it as a moment of clarity, and how at that moment, his values started to come back, values that had been clouded by his heroin use.

I had a moment of clarity, I guess, and I started to think... I have a wife and she came into the place... no longer about myself on my own, it's, somebody else is there that I have to value and I want to value (...) I thought, I'd better do something about it. (...) I guess that moment of clarity was a great moment. It was a good, great moment of realisation. It sort of slammed home that somebody else was involved and I was hurting people around me, whereas before that, it never concerned me.

He suddenly notices a strong discrepancy between his core personal self and his current behaviour. There is one story about his childhood that keeps coming up in his interviews. When he was young, one of the neighbourhood kids used to wet his bed and had to go to school in his soiled clothes. The boy got picked on for that reason, and Tom took pity on him and gave him his spare school uniform and made sure he was not picked on anymore. He also took in stray dogs, and offered children from a boys' home to come and live at his place. Tom describes himself as a helper. 'I want to help others. I want to contribute to others' lives who are disadvantaged and stuff.' Helping people who cannot help themselves is an important value to him. As a child he always wanted to join the Air Force. During the time of the first interview he is involved with various homeless organisations, where he is an advocate for homeless people and negotiates their rights and needs with policy makers.

In his moment of clarity, he realises that his current behaviour does not align with his core identity of a helper. He finds his current behaviour very selfish towards his loved ones, mainly his wife and his mother. Suddenly his life seems ridiculous to him. He says that before his moment of clarity, he already knew cognitively that his behaviour was selfish, however, he reports that 'it never concerned me'. The type of knowledge he gains in his moment of clarity is of a different order, however: suddenly, his selfishness does concern him. Tom describes that suddenly this knowledge evoked a strong motivational force.

My mother's been a major influence. She's still in the picture, and it was actually her that said quite a few years ... probably several years ago - 'you're selfish, how can you do this, you're so selfish to yourself and other people'. That actually rang home, and the penny dropped, yeah, four weeks ago. It was, 'wow, yeah, I have been ... yeah, I left four kids behind, I left all sorts of things, and all sorts of great opportunities, and yeah.' But that's not said in a guilt trip, that's said in realisation that I just can't continue that way anymore, it's just ridiculous, yeah. (...) I've known it, but for the first time I've actually, yeah, realised it.

Three things stands out from this quote. The first thing is that Tom's moment of clarity seems to be a distinctive kind of knowledge: 'It slammed home'; 'the penny dropped'; 'I actually realised it'. The autobiographical facts that he was already well aware of suddenly seem to be personally relevant to him. When I ask Tom if he has found his purpose in life he replies:

No well I wouldn't say I've found it, I knew it. I've unlocked it and I've allowed it just yeah, absolutely just become the forefront, the future and it ... like the present and the future of my life is my purpose, yeah.

Tom always possessed normative goals. However, it is not until recently that these goals have gained motivational force for him, and come to the foreground of his life.

The second thing that stands out in Tom's testimony is that he explicitly distinguishes a sense of realisation from feelings of guilt. Most people describe guilt as a counterproductive emotion. Guilt is a negative emotion that reinforces use and resignation.

Part of my use was to punish myself and when I did use I would punish myself more by ... because I would be regretful and thinking 'oh why did I do that?' and then it become a prolonged punishment and 'oh well you don't deserve any better'.

His moment of clarity is not a guilt trip, but has a strong positive motivational force arising from the discrepancy between his behaviour and ideal self. In this situation his ideal self is brought into the foreground

rather than his fear of his negative self. He realises he cannot continue this way anymore, and that things have to change. And this leads us to the third thing that stands out: the strong motivational force of Tom's realisation; his using life suddenly seems ridiculous to him, things need to change, 'I cannot live like this anymore'.

During the first interview, Tom has very detailed plans for the future. The first step is to stop using. He has detoxed and is on suboxone now. His goal is to be totally abstinent: 'I cannot use. I cannot pick up once, not even once.' He plans to go to NA meetings and start counselling to 'deal with stuff whatever I haven't dealt with so far'. His second step is to keep occupied, because boredom is a recipe for relapse. He plans to work, maybe study, and focus on purchasing a unit with his wife.

Now if we used Miller's model of quantum change as I described in Chapter 4, we would predict that Tom is set for a quick and speedy recovery. Miller argues that the motivational force that comes from the ideal self is strong enough to guide the person to successful recovery. But as I speak with Tom over the following years, it becomes clear that his recovery is a hard fought battle. The focus in Tom's story is not so much battling craving or regaining control over his substance use, the focus in his story is rebuilding his life, in an identity-congruent way, through core projects. As we saw in Chapter 1, we constitute our identity through core projects. Tom develops two kinds of core projects. The first centre around developing a normal life: having a job, saving money to buy a place to live and enjoy life with his wife. These projects of building a normal life are meant to replace the substance-using life, and keep him occupied so relapse is less likely. The second group of core projects revolve around his identity as a helper. As we will see later, Tom is successful in developing core projects that reflect his valued future identity. One can say that this is the main difference between John and Tom: Tom is just a little bit luckier in how his core projects work out. One could argue that these successful core projects are the main factor of success in Tom's story. However, Tom explicitly states that the major factor in his recovery was a regained belief in self-efficacy. Let us now take a closer look at the core-projects Tom developed.

2.2. Core projects normal life: capacities and opportunities

Although Tom has been a heavy heroin user for around 30 years, his capacities and his appearance do not seem to be affected so much by his substance use. Although he dropped out of school in year ten, he is very intelligent, an autodidact in many ways.

I consider myself pretty blessed in the sense that I haven't lost my faculties on drugs. I've sort of ... a lot of people sort of say, look, you're very lucky that you can still function and ... as an example there's 12 of us started out together. And I think two are in institutions and the rest are dead, and I'm here. So I guess, yeah, I'm counting my blessings there.

The only thing I lost was one tooth and, you know, I was very lucky, people don't have any teeth in their head anymore, they're all false and people have circulation problems from injecting all the time and stuff like that. I've got one collapsed vein but my arm's made up for that and stretched other vessels.

I have my faculties, thank God I still have all my faculties after the years of abuse.

She said to me yesterday, 'you've got a great brain. You can use it.'

What stands out in Tom's testimony is that other people also tell him that he functions well. This reinforces his belief in his capacities. Tom describes himself as a jack of all trades. Every year when I interview him, he has a job: in a retirement village, as a cook, driving all kinds of machinery, in the export business. With most of the jobs he sticks with them for quite a while, and he has good reasons to quit them when he does. When I speak to him the second year, he has been on a cruise with his wife, the first holiday he has had since he was a child.

When I ask Tom if he feels in control of his life, and if he has an example of that, he says that having control over his money again made him regain control over his life. Further, living a normal life reinforces his feelings of self-worth.

I mean, to find self-worth again is, you know, to be able to just make the decision of get up and cook a meal and know that I can get up and cook steak and eggs or I can roast a chicken or, you know, just having those life skills again and the place and the ability to do that.

Above I described the importance of core projects for Tom that helped him rebuild a normal life. But his new life is not only a normal life, it is also one that is built around his identity as a helper. To be a helper, he needed to be drug-free, hence the strong focus on work. But Tom also develops other core projects around his helper self-image.

2.3. Core projects helper

We saw previously that during Tom's moment of clarity, he notices a strong discrepancy between his current selfish behaviour and his core identity of a helper. Tom is not only lucky in his opportunities and capacities, he is also lucky that he has rich identity-material. He still has a vivid memory of stories of his childhood, narrative threads he can pick up and develop further. During the years that I speak to him, his relationship with his mother also improves, and she regularly tells him stories about his childhood in which he acted like a helper. He describes how his values have always been there, locked in his heart, and he now wants to act consistently on them:

I was always a caring person and always wanting the best for the underdog but I locked that up with this [the addiction], I locked the door [of my values] and didn't practise it. Now I'm finding that that's who I am. That's what I was all about, even through that time of working with the homeless for 14 years. You know like that's who I was, reaching out to that person who's absolutely urine-stained and you know sometimes excrement in their pants.

In that moment of clarity, when he realised that his core value was to be a caring person who helps other people, he also realised that he was already working in an identity-congruent way in his work for the homeless people. Tom emphasises that the moment of clarity was just one step in his recovery, and was preceded by 15 years of hard work in getting himself to this point. His values were more easily accessible because he already worked on them.

Tom's identity-congruent transformation seems to have happened in two phases. The first phase mostly happened before the moment of clarity. In this phase he turned his negative social identity of a homeless drug user into a positive identity of an advocate for people on the street. He

describes himself as a pin-up boy for the homeless. During the periods in his life where he had his substance use under control and off the streets, he featured in documentaries and inspirational material to help other people change their lives. I quoted Charmaz in Chapter 4 that there are not many positive identities available for ill people, the same can be said for addicted people (Fry & Buchman, 2012). Tom took one of the few positive identities that are available: the redeemed addict, and he added to that his own mission to help people. However, the second phase of his recovery was to break with this identity of ‘helpful addict’ as well and just become a helper. As he describes it, he does not always feel comfortable in groups of non-addicted people:

there’s a time in my life where I’d be paranoid about sitting around other people’s possessions you know ‘cause if anything went missing generally nine out of ten people in the room would be dismissed and I’d get the blame you know (...) there’s a lot of discomfort within yourself after coming out of that lifestyle or existence.

When I ask him if it was hard to make new friends, he replies that the biggest challenge was to change his self-stigma:

Only hard because of my own views like you think people you know, know about you (...) mistrust you but that’s only ... (...) that was from my own personal ... that was from myself, not because of the way I was being treated or anything in any way, so yeah but I’ve become a bit easier about it that people are accepting and you know they see change and they’re willing to encourage you in that change.

I think you know those battles within yourself about yourself honesty your truths and I think that’s where a lot of other addicts really, really struggle ‘will people accept me for who I really am or is it easier to be seen as the user or the struggling ex-user?’

We saw that Nicole encountered the same issues with self-stigma and fear of being acknowledged in her new identity. Tom gradually gets more confident at being around non-addicted people. He is most comfortable in his role as mediator between both worlds. He describes an incident in church where a substance-dependent person is asked to leave

and not come back to sermons anymore, because some people in church are afraid he will steal their wallets. Tom defends this person:

I thought every Sunday you get up and say we're here for these people and now you've just shut the doors on one of the very people you say you're here for. (...) The people, the very people you are supposed to be supporting you know the very people you say Jesus came for.

Tom becomes an advocate for people who are homeless or struggling with addiction. Important in his work as a helper is to see the worth of people; to see the person behind the problems. And, in a way, this helps him to see his own self-worth.

However, after his moment of clarity, Tom feels like he needs more distance from his identity as an ex-user. He describes it as an elastic cord, or an umbilical cord that keeps him connected with the substance use world, and the triggers that might arise from there. He describes a confronting moment when his counsellor asks him: 'what would you do if you went to your grave not knowing yourself as a drug-free person?' That really challenged him: 'I'd never known myself as a drug-free person.' In this stage of his recovery it is important for him to develop an identity that is not just the helpful, redeemed ex-user, but as a helper *simpliciter*. When I ask him in the second year how hard it is for him to stay off drugs, he says that at first it was difficult, but it became easier when he started to distance himself from the drug using scene:

You know once you get a bit of distance from it you start to make different network groups and you don't go back to where you know where you were and back to the networks that you hung around. I think it's very important to change that whole aspect, the whole aspect of it you know like friendships, going to church making friends there and stuff is great you know 'cause they're all people who just want the best for each other and stuff so yeah.

So I guess the more distance I put between me and the behaviour back then the better I feel about myself and it becomes easier to just keep distancing myself.

When he gets offered a job in the North of Australia, he sees it as the ideal opportunity to start fresh again in life:

The move to far north Queensland, yeah, it's good. I needed to get away from the association. Everywhere I went in Sydney somebody knew me or was you know pressuring me in some form or another to you know because I'd associated myself in the drug network, it was very, very difficult to you know meet with people and stuff who weren't in that network 'cause somebody would tap me on the shoulder at the coffee shop or ... so I needed to reduce off my done and get off the done before I came here so it was a clean start in the sense ... the clean ... clean geographical 'cause it was ... I didn't want the association up here and I was very clear with that with my doctors and counsellors that it was just no good to be up here and reducing 'cause I ... you just you know you meet people and you don't want to, you know?

I mean being able to walk freely without the pressures of the drug network catching up with you and that sort of thing. I think it allows you to walk more freely in what you hold valuable, yeah.

Nobody knowing of my past has been a real benefit too, you know. Before, living and working in the homeless sector and stuff, you know, always discussing my past with different groups and stuff like that it was, you know, forever there but it seems as though now it's comfortably left behind.

Through his work at the church, he is getting new opportunities to develop his identity as a helper. He is planning to go to Papua New Guinea to do some community work with a friend of his who is a pastor and who has erected a church there. He is also involved in supporting local Aboriginal communities. He is offered a paid position as a mentor for homeless people, although no one knows about his own experiences with homelessness and addiction. Sometimes one of his clients might suspect that he has personal experience as well, but when they start the conversation on drugs, he always plays dumb.

I just absolutely play dumb when it comes to drugs, 'oh, I don't know what you're talking about' and 'oh, I don't know, what are you asking me for?', you know, yeah, it's just the best way to be.

One could argue that Tom just had more luck in his external circumstances than John or Nicole, and that this is the reason his core-projects worked out better. However, when we look closer at the adversities Tom encounters, we see that they are similar to the adversities John and Nicole encounter. Tom just handles them with more confidence. According to Tom, what is crucial in his recovery is a regained belief in self-efficacy.

2.4. *Belief in self-efficacy, and coping with adversities and failure*

Tom reports that it is not so much the opportunities for core projects themselves that changed his life, but his attitude towards these opportunities. He describes that he has always been surrounded by opportunities:

But it's taking those opportunities which is key, Anke, right? It's a key you're given ... you're given opportunities in your life and you have to take them. There's many times where I denied those opportunities, right? It was choice and I denied those choices because I didn't think that I was able to get off heroin. (...) we all want to be a part of something positive. But our lack of belief in self is what can cause negative impactful choices.

What made the difference was not so much that his external circumstances changed, but that he started to respond differently to them. The same counts for his capacities. He says that he already possessed many of the capacities necessary to get clean and stay clean, and to take the steps towards the life he values living, yet, he never used them because of his lack of belief in self-efficacy:

I gained a lot of strategies before and ... that ... I gained a lot of tools, as I like to call it, a lot of tools in the toolbox years ago in rehab and through different programs that I'd done. I guess now, later, it's more reaching in and grabbing those tools rather than leaving them sitting in the box, reaching in and utilising that you know so remembering oh hang on when I was told 'always make sure like in the morning you eat, make sure you you've got a full stomach because sometimes being hungry can give the deception of hanging out or you know the feeling of hanging out', so making sure I'm fed properly now and I'm eating properly and you know making sure there's time for clear thought and you know making that

time for clear thought. So yeah utilising all those tools in the box that I've grabbed, but I am getting new stuff as I go along too as I go along, I guess as I mature the more I start to utilise things that are useful to me so yeah.

Tom describes a very strong belief in self-efficacy:

when I was sitting there with my doctor and wife, (...) and he sat there and said that ... to my wife 'you know you realise Tom will have to be on this [maintenance treatment] for the rest of his life'. And that just convicted me, 'no, no way, I am not going to be a part of the 20% that you call so-called successful, I'm going to be a part of the 1% that actually make it off this stuff', you know?

I claimed in the last chapter that success reinforces one's belief in self-efficacy, while failure impairs it. However, this model might be too simple. It is hard to determine who encounters more success and failure in their lives: Tom or John. Tom encounters relapse, his wife leaves him, and he has to abandon jobs several times. However, Tom seems to interpret his failures differently to John. Both John and Nicole seemed to interpret adversities and failure as a sign that the life they valued is not meant for them. However, Tom reinterprets his failures as providing him useful information on how to succeed next time. Tom's strong belief in self-efficacy extends itself to a reinterpretation of the hurdles he encounters in life. Recall Oyserman's model of the circumstances under which the future self is motivating (discussed in Chapter 4). One aspect of person's motivation to pursue their future self (or lack thereof) related to their interpretation of adversities they face. Do people see adversities as a sign that their ideal future self is unachievable, or do they see adversities as a sign that their future self is worth fighting for? For Tom it seems the latter, while for John and Nicole it seems to be the former. Success and failure are not simply objective measures, but are subjective experiences as well.

Let us look closer at the adversities Tom encounters. Tom's life mostly goes according to plan, and he hardly feels craving anymore. However, a few adversities do occur, and handling them is the real test of his sobriety. In handling them, he states that it is crucial to focus on his belief in self-efficacy to counter an emotional reaction of hopelessness or self-

blame. Tom describes a conflict with his boss. While normally he would blame himself for the conflict, thinking it must have been something he did wrong, but now he acknowledges that he did everything right, and his boss is just a very hard person to work with. A real test arose when a legal charge from 30 years ago was brought against him, and he risked losing everything he built up.

A charge from 30 years ago in Melbourne crept up and came at me and oh every cent I was earning was going to this lawyer in Melbourne (...) here I am I've built up my life, I've got a wife, I've got a new home and I'm paying ... I'm working and here I am paying all this ... now every cent of my wage is bar rent money and food money is going straight to this lawyer and I'm starting to get into this woe is me attitude 'oh now I'm going to go jail in Melbourne, I'm going to lose my wife and ...' but it's really hard I understand how hard it is to maintain a positive attitude about something that is so negative you know.

Luckily the charges were dismissed, but that was not the end of it. At an earlier court case, Tom was threatened with losing his visa as well, and during this court case he is afraid the same issue will appear again:

And there was many ramifications from this court case (...) I'm only a permanent resident (...) Department of Immigration were going to throw me out of the country, under 501 of the Immigration Act (...) what a nail biting experience.

Tom came to Australia as a child on his parent's visa. Although his parents secured citizenship for themselves, it did not occur to them to arrange this for their children as well, or to keep the paperwork necessary for their children to obtain citizenship. Luckily Tom has a friend who is a lawyer who helps him out with his visa application.

All these things come up in your life and you can either give up and run and jump into your old life behaviours or what I'm choosing to do is stand up and not to say I don't feel the fear of it you know or feel you know like some ... a little bit ill when you first find out you think 'oh no not another brick wall' but I try not to see it as a brick wall anymore. What

I try to see it as is alright, another situation let's assess it I've been through similar things before where can I where can I obtain help where can I you know or do I need to walk through this one on my own you know who can I use, who can I ask to support me in this? So I guess yeah sitting back assessing the situation for what it is and not collapsing and falling over and giving up.

The second serious adversity occurs when Tom gets offered a job in the North of Australia. He decided that this is a good moment to get off the methadone and start a new life without any associations in his new environment with the substance use scene. But in order to be methadone-free when he starts his new job, he needs to reduce his dose more quickly than is recommended, and he relapses twice. When he stops with the methadone too quickly, suddenly his physical and emotional sensations become very strong, stronger than they have been for years, and they are hard to control. He self-medicates with heroin. Although the relapses are brief, they result in a lot of trust issues with his wife, and end up costing him his relationship with her. They are still in contact however, and Tom is positive that in the future they might reconcile. Another important strategy in handling this adversity is to not let it erode his belief in self-efficacy. He fulminates against the NA or AA system that counts your sobriety in consecutive clean days:

I don't want to believe in a system that 'oh if you screw up you're back to square one'. You're not back to square one! What about all that work you've done already? It doesn't take you ... (...) a lapse to me isn't as bad as relapsing and fully jumping back into it you know. So I guess it's how I gauge things for myself and not becoming a part of a network of people that say 'oh you've mucked up again and that's it you're back to square one you're going to always do it, you've got to start again'. No! Alright I had a lapse and I get back on top and ... well not back on top I'll get on my feet again and start walking you know dust myself off and keep moving forward.

Self-condemnation, loss of self-worth and judgement from others is the worst thing that can happen to you through these things.

Tom repeatedly states that he thinks none of his experiences go to waste. All his experiences are situations to learn from, to grow, to develop. The key to Tom his recovery is to keep believing in his self-efficacy, even when he is confronted with adverse situations and relapse.

Tom's story is a story of success. 4 years after his moment of clarity, he has rebuilt his life in an identity-congruent way. He managed to stop using heroin and get off the methadone as well. In Tom's story of recovery three elements stand out. The first one is that Tom had capacities, capacities to find work and to control his substance use. His memory, cognitive abilities, social skills, and physical health were pretty unaffected by his substance use. The second thing that stands out in Tom's story is that he had a supportive environment: a non-using partner, support from his mother, friends that could help him with his legal issues. He always managed to find jobs, despite having a criminal record. But the third and most important thing that stands out is that, during his moment of clarity, Tom's belief in self-efficacy was restored. He suddenly believed that his ideal future self, a non-using self, a helping person living a normal life, was achievable. He suddenly started to use his capacities, and take on opportunities. The more things succeeded, the stronger his belief in his self-efficacy became – strong enough to help him through the adversities and challenges that arose. Tom was lucky that he had a chance to change his environment, and when this opportunity presented itself, he grabbed it with both hands.

There are many similarities between the stories of John, Nicole and Tom. All three of them have strong normative goals, and numerous capacities to reach them. All three are presented with opportunities to develop core-projects important for the life they value living. They differ in the amount of social support they get: Nicole gets the strongest support, John has some social encouragement, but mostly discouragement, and Tom encounters some encouragement, and very little social discouragement. The main difference between the three cases, however, seems to be belief in self-efficacy, and this reveals itself most strongly when adversities are met. All three respondents do meet adversities, hurdles to their normative goals, but they differ in how they respond to these hurdles, whether they see them as a challenge, or as a sign that their ideal future self is unachievable.

3. The role of belief in self-efficacy in recovery

Tom's story seems to be supported by the stories of other respondents: a restored belief in self-efficacy plays an important role in recovery, a belief that the life they value living is available to them. When I analysed the stories of respondents who were in stable recovery while I interviewed them, this regained hope in the future being available to them was also an important aspect in their recovery. When I asked if there was any advice they would like to give to people who were in a similar situation as them, respondents in stable recovery strongly emphasised this thought of 'there is a better life out there for you':

I would just tell people that here is so much more to live for (...) and to just say that if they hang in there things will get better. You know, they will get their life back. (R40C)

Life is not too bad. (...) You are worth more than what you think you're worth and just got to give yourself a chance to find out who you are and give yourself a go. (...) I've started to enjoy life, like there's some ... not hope, there's ... yeah there's some sort of hope I suppose that I can have a half decent life. (R44C)

Don't beat yourself up if things don't go too well. You know, don't think that you've only got one chance at this. (...) And, you know, there is a future. (R10C)

A quote from another qualitative study (Hughes, 2007) also supports this view that a belief that the future one values is achievable is an important factor in recovery. In this qualitative study a participant, Pete, outlines what the turning point in his recovery was:

I think it was treating you with a lot of compassion and a lot of understanding and treating you like a fucking human being not like a criminal or a fucking drug addict. To give you hope that there's a fucking life after heroin. I think it were my key worker and staff, constantly telling me that 'there's hope, you're too good for that fucking shit, you know, there's a fucking life out there for you if you want it', which in 10 years of heroin no-one's ever told me. (Hughes 2007, 687)

In the context of addiction, many people lose belief in their self-efficacy, but also, many people around them, understandably join them in this. Yet, it is very important for addicted people to be reminded of their capabilities and possibilities. With regard to treatment, Hanna Pickard (2012) also makes a strong argument that treatment must appeal to a service user's belief in self-efficacy. In order for people to regain control over substance use, they have to believe they can do it: they have to believe that their agency is going to have an effect. Pickard has reported that people who comply with treatment often manage to stop. But in order to comply, they have to *think* that they can stop. Hence, we have to treat them as agents, and hold them responsible for their behaviour (although without blaming and shaming them – I will discuss Pickard's theory in more detail below in the section 'releasing shame and guilt'). Appealing to a person's belief in self-efficacy is a bootstrapping process: it encourages them to identify factors in their lives they do have control over, and helps them to slowly take control over their lives again.

4. Implications for treatment: how to restore normative agency

In the last section we saw how restoring belief in self-efficacy can play an important role in recovery from addiction. In this section I will suggest ways in which normative agency can be restored. In 4.1 I will outline several treatment methods which have a strong focus on reinforcing normative agency. These are not new therapies: most are already used in addiction treatment. I will also outline how these therapies map onto the hierarchical account of self-control. Although I link the therapies to the different levels, this division is not very strict, since the levels are interconnected. Interventions can affect multiple levels of self-control, directly or indirectly. I will begin by discussing how normative agency can be restored by restoring intentional and instrumental self-control. In section 4.2. I will turn to treatments that directly target normative self-control.

4.1. Restoring normative agency by restoring intentional and instrumental self-control

The focus in this thesis has been on how normative agency can be impaired and exercised in addiction, since this is where the hiatuses in the current literature are. However, as I noted in Chapter 1 and 2, all three levels of self-control are important for successful self-control. Intentional control helps us to control our intentional behaviour, instrumental control helps us to reach our goals, and normative self-control ensures that we normatively endorse the goals that we pursue. The levels interact with each other, and to restore agency in addiction, a level other than that at which the impairment originated can be targeted for intervention.

We saw in Tom's story that for a significant part, his self-control was exercised top-down: by regaining normative self-control through an epiphany. However, we also saw that Tom used bottom up interventions like pharmacological treatment to reduce the craving and regain intentional self-control. Maintenance programs, like methadone or free heroin programs, provide heroin dependent people with a tool to regain intentional control, by making sure their actions are not strongly determined by cravings.³⁸ There are also pharmacological treatments for alcohol, like Antabuse. Antabuse (disulfiram) blocks an enzyme that is involved in metabolizing alcohol intake. If a person consumes alcohol while on Antabuse, they experience very unpleasant side effects like nausea.³⁹

A treatment that contributes to restoring both intentional and instrumental control is contingency management. Contingency management helps a person overcome the now-appeal of substances by providing small incentives for every clean urine sample. These incentives grow exponentially the longer they stay clean (Prendergast, Podus, Finney, Greenwell, & Roll, 2006). With the help of contingency management, people find it easier to commit to short-term goals.

38 Valium is often used to alleviate withdrawal symptoms during detoxification, and in the case of alcohol, to prevent seizures. However, Valium is a highly addictive medicine, so often practitioners are cautious in prescribing it to substance dependent people for treatment of anxiety (Snoek, Wits, & Meulders, 2012).

39 Antabuse however, is not used widely because of concerns with safety and effectiveness (Fuller & Gordis, 2004; Krampe & Ehrenreich, 2010). Antabuse also differs from methadone maintenance because its goal is not to numb the craving, but to make alcohol use directly physically unrewarding. However, one can argue that at that stage of the addiction, alcohol is probably already very unrewarding for people. As we saw in Chapter 5 alcohol sometimes does have immediate bad effects and is unrewarding but that does not deter the users.

However, as we saw in the chapter 6, sometimes addicted persons do not lack intentional self-control. However, due to poverty and lack of perspective, they are not motivated to exercise it. For these agents it can help to change their circumstances (Alexander et al., 1978; C. L. Hart, 2013; Robins, 1974; B. F. Henwood, Padgett, Smith, & Tiderington, 2012). Once they become aware of the new opportunities presented to them, they will be motivated to exercise their intentional self-control to pursue their goals. Providing addicted persons with proper housing and career opportunities can contribute immensely to restoring normative agency. One obstacle to fulfilling normative goals was having a criminal record. Morse (2011) has suggested that we at least decriminalise the purchase and possession of substances for personal use. Many countries, like Portugal and the Netherlands already hold very little legal sanction for the possession of drugs for personal use (see also Hari 2015). A step further would be to give people the chance to remove small offenses from their criminal record if they comply with a treatment program. Such a move would be comparable to leaving the offences of minors off their criminal record.⁴⁰

We can help addicted persons overcome their craving and the now-appeal of substances, and we can provide them with opportunities. However, they also need to reconnect with their image of the good life, and to believe this life is feasible. So although it is important to restore people's intentional and instrumental control, addiction treatment should also involve the assessment of a person's normative agency to determine whether or not it is impaired.

4.2. Restoring normative agency directly

In this thesis I have discussed several threats to normative agency that people struggling with addiction can encounter. Below I will address how the impairments of normative agency can be minimised. Subsequent to this, I will describe the importance of tackling issues of guilt,

⁴⁰ A few respondents stated that being confronted with the legal system, or doing jail time, provided them with a new, more global perspective on their lives. One respondent told that after some time in jail, he returned to the street where he usually got his drugs, and he noticed that all his friends were still there, doing the same thing as if no time had passed. This realisation how much time passes unnoticed while using substances, made him adopt a more global perspective on his life. One respondent told how he was offered to participate in a treatment program after his jail time, and how this treatment program changed his life. So although doing time could contribute to a more global perspective on one's life, having a criminal record on the contrary was very counter-productive to rebuilding one's life.

shame and low self-worth in restoring normative agency. After that, I will describe a lesser-known treatment, narrative therapy, that shows promising results in restoring normative agency.

4.2.1. Preventing impairments of normative agency

I have, in the course of this thesis, outlined several ways in which normative agency can be impaired: by change to the body, by loss of belief in self-efficacy, by mental illnesses like depression. In section 4.1 I explored how a person's loss of belief in self-efficacy can be restored in recovery. I will now look closer at the other two factors that can impair normative agency.

In Chapter 5 I outlined how addiction changes the body, and hence changes a person's self-concept. This change is either direct, or it else is mediated through the responses others express toward their physical appearance. Many people with addiction or chronic illness describe a loss of self. This impairment of normative agency could be prevented or minimised by harm reduction programs that minimise the negative effects of substance use on the body. For example, programs that provides users with clean needles and syringes, methadone programs, free heroin programs, or health care programs for substance users all help to mitigate the ill effects of substance use. Respondents often reported that they felt they were not treated seriously by health professionals once those professionals are led to suspect that they are substance-dependent. Due to stigmatisation from health care professionals, addicted people miss out on good quality investigation and care, and hence the opportunity to better preserve their normative agency (Bartlett, Brown, Shattell, Wright, & Lewallen, 2013; Livingston, Milne, Fang, & Amari, 2012). Good quality health care, performed by non-judgmental health professionals, contributes immensely to the normative agency of those struggling with addiction by minimising somatic damage and damage to the self.

In Chapter 2 and 5 we saw how mental illnesses like depression can make people lose interest in their normative goals. In cases where normative agency is impaired, psychological treatment, or pharmacological treatment like anti-depressants, can be supportive. Tom described how anti-depressants helped him regulate his emotions after coming off meth-

adone led him to be overwhelmed by feelings that have been numbed for years while taking methadone and illicit substances.

Treatments can also target impaired normative agency directly. Before I examine a very promising therapy of this kind, I will first outline another issue that needs to be addressed in treatment: releasing shame and guilt.

4.2.2. Releasing shame and guilt: responsibility without blame

It is often thought that if people learn that there are consequences to their behaviour, and that if those consequences are serious enough, they will have a strong incentive to control their behaviour. This assumption is the basis of many punitive treatments of addiction, as well as of a lay view on addiction. In our everyday understanding of guilt, when we regret something, we change our behaviour. However, if people already struggle with feelings of low self-worth, shaming and blaming them will only aggravate their negative self-image. As we saw in Tom's story, and as was also expressed by many other respondents, feelings of guilt are very counterproductive for those who have low self-worth and low belief in self-efficacy. Recall that Tom described his moment of clarity as one in which he started to take responsibility over his life in the absence of self-destructive feelings of guilt and shame.

There is a longstanding discussion in the addiction literature concerning whether we should hold those struggling with addiction responsible for their behaviour. Proponents of the responsibility view state that a person's agency cannot be restored if they believe they are powerless over their behaviour (Morse, 2011; Pickard, 2012; K D Vohs & Baumeister, 2009). The risk of this position, however, is that people struggling with addiction will be subject to blaming, which will aggravate their condition because it reinforces feelings of failure and inadequacy. Another risk of treating people like agents and responsible for their failures is that they become resigned to their situation when they notice how many factors they cannot control despite being held responsible for their failure. Opponents of this view believe we should not hold people struggling with addiction responsible for their behaviour due to all the mitigating factors they encounter: the neurobiological changes due to substance use, the hostile environment most people find themselves in. Proponent of this position believe that releasing addicted persons from moral guilt,

by offering an explanation for their addictive behaviour, will stimulate them to seek treatment and change their lives (Fiorentine & Hillhouse, 2003; M. J. Walker, 2010). However, the risk of this position is that it might lead addicted agents to lose belief in their self-efficacy. When we treat people as though they are not agents, they might give up on their normative goals.

A promising alternative to these two positions – enforcing people’s belief in self-efficacy or acknowledging the hardship and impairments they face, and not blaming them for failing to achieve their goals – is Pickard’s approach of responsibility without blame (Pickard, 2011). Pickard argues that recovery from addiction always starts with one’s belief that change is within the person’s control. If the agent believes he is powerless, he will see no point in exercising his agency. A key approach in treatment is to hold people responsible for their behaviour and choices. However, often responsibility is accompanied by blame. When we hold people responsible for their behaviour, we blame them when things go wrong. But, Pickard argues, responsibility and blame are not necessarily linked. We can hold people responsible for their behaviour, yet acknowledge the factors that diminish their agency, and not blame or punish them for failure.

This approach of responsibility without blame will encourage addicted persons to use the fragments of agency they still retain. By making them accountable for their decisions, they are encouraged to employ their agency. This approach affords addicted persons a safe environment to practice strategies, learn from their mistakes, and develop their agency. As I have argued elsewhere, this approach has at its core ‘the Kantian notion of respect for persons, which it aims to promote and to foster by treating people as responsible for their misconduct (without at the same time blaming them for it) in order to help them to develop the mental capacities that agents need to possess’ (Kennett, Vincent, and Snoek 2014, 1083).

Many treatment facilities already work with this notion of responsibility without blame, but it would be interesting to try to extend it to other public domains, like the law, the workplace, the social support networks of people struggling with addiction, and maybe even the lay population in general. For example, Lacey and Pickard outline how the idea of responsibility without blame can reform the law with regard to disorders

of agency: ‘sentencing and punishment can better avoid affective blame and instead further rehabilitative and related ends, while yet serving the demands of justice’ (Lacey & Pickard, 2013, p.1). An example of this approach is found in Drug Courts where addicted people are offered a choice between treatment and prison. But also loved ones of people struggling with addiction could try to adopt this approach. One respondent described how his son told him in a very non-judgmental way: ‘Dad, I don’t mind if you start drinking again. It doesn’t matter, I will still visit you, because I know who you are, and you always have a good attitude. I will love you just as much, only you will not be able to experience much of my life. Since if you keep drinking, you will only have three years left to live.’ (VZO R5) The son does not blame his father in any sense, yet, he holds him responsible for his drinking. The man described how this attitude of his son was very motivating to him.

The approach of responsibility without blame could also play an important role in reducing the harm of relapse. Respondents who felt very guilty about their relapse often experienced a more prolonged and severe relapse than those who acknowledged that they slipped, yet saw it as a bump in the road rather than an all-compassing failure.

Acceptance and commitment therapy also works with this tension between accepting one’s losses, yet committing to the future. In Twelve step approaches, there is also a strong emphasis on asking for forgiveness. This practice of forgiveness can release respondents from feelings of shame and guilt.

In the next section I will look at how normative agency can be repaired directly in treatment.

4.2.3. Narrative therapy

We saw in Chapter 4 how the strong now-appeal of substance use can derail people’s normative self-control. The ideal future self is not accessible to addicted substance users, and sometimes this state lasts for a prolonged period. In Chapter 4 I discussed motivational interviewing as an intervention that can help people connect to their ideal future self again after a period of heavy use. Motivation interviewing helps people to become aware of a discrepancy between their current behaviour and their ideal future self (Apodaca & Longabaugh, 2009; Hettema et al., 2005; Wagner & Sanchez, 2002). It can play an important role in restoring

normative agency. However, motivational interviewing is most successful among people who have not been addicted for a long time (Rubak, Sandbæk, Lauritzen, & Christensen, 2005). For long term users, who are low on identity material, narrative therapy can be promising.

Narrative therapy focusses on rewriting fatalistic, rigid scripts that substance users may have developed. There are not many effect studies on narrative therapy, but there are a few case studies (Butt, 2011; Man-kwong, 2004; Poole, Gardner, Flower, & Cooper, 2009; Singer et al., 2013). Much of the treatment seems to work by restoring a belief in self-efficacy.

Clients are asked to recall a situation in which they handled their addiction in a self-controlled way. An example of this would be a situation where they were able to resist craving. The counsellor then encourages the client to thicken the story, to describe in detail why this attempt was successful. Describing one successful attempt often evokes the memory of other successful attempts (Man-kwong, 2004).

When focussing on episodes in their lives where they were successful, people reconnect with different aspects of their identity, and they enrich their self-concept so that it is broader than being an 'addict' (Poole, Gardner, Flower, & Cooper, 2009, 293). The client is asked to explicitly link back their experience to their identity: they are asked, what does this incident tell you about yourself as person, about your talents and capacities?

These insights on the subject's resilience and identity are then used to develop an alternative narrative of their life in which their resilience and capacities rather than their failure to control their substance use is made central. Clients are encouraged to view themselves as 'multi-storied, multiroled individuals with teams of friends, family, and supporters; a lifetime of accomplishments; and a set of tools to fight back against and resist the problem' (Poole, Gardner, Flower, & Cooper, 2009, 293).

Lastly, these insights the person achieves with regard to their capacity and identity is explicitly linked to their future. The questions posed to them are: how will this trait, or this ability in resisting the problem, help you in the future? How does this alternative life story continue? (Man-kwong, 2004). When addicted persons become sensitive to episodes in their lives where they coped successfully, it becomes possible for them to imagine 'new endings to painful and repetitive stories' (Singer et al., 2013, 389).

Butt (2011) describes how he asked a client, with whom no other therapy worked, to write two stories of his life. One of the stories was dominated by his failure to control his alcohol and drug use (the rigid, self-fulfilling life narrative), the other story focused on positive aspects of his character and life, and his hopes for the future (the redemptive narrative). This story was very motivating for the client, and at six months follow-up he had positively changed his life.

The findings in the case studies on narrative treatment are supported by many theoretical and empirical accounts in the literature (Diamond, 1997; Dunlop & Tracy, 2013; Hänninen & Koski-Jännes, 1999; McIntosh & McKeganey, 2000; Taïeb, Révah-Lévy, Moro, & Baubet, 2008).⁴¹ Narrative treatment seems to be very relevant for people who are low on identity-materials and low on belief in self-efficacy, for example resigned addicts. Narrative treatment does not only make the valued self available, it also makes it seem achievable. As Oyserman (2015) points out, the ideal future identity is only motivating under certain conditions: when it is accessible; when it seems connected to the present self; when it seems achievable; and when the road towards it seems to be fitting for ‘people like me’. Narrative therapy can enhance all four of these conditions. Given the promising results from the case studies, effect studies should be designed to make narrative treatment more appealing to practitioners.

5. Conclusion

What is required for the successful exercise of normative agency? In the last three chapters I have used detailed case studies to argue that what hinders the agency of some addicted people is not a lack of capacity for

⁴¹ Although these studies do not focus on narrative treatment specifically, they do outline the importance of narrative change in recovery for addiction. When comparing the narratives of newly sober alcoholics, Dunlop and Tracy (2013) found that those with self-redemption narratives were more likely to stay sober over time, compared with those who did not have a self-redemption narrative. Using Ricoeur’s notion of narrative identity, Taïeb and colleagues (2008) argue that addicted people are in need of inspirational narratives to make their lives intelligible and to help them change their lives around. (Diamond, 1997; Dunlop & Tracy, 2013; Hänninen and Koski-Jännes (1999) explored narratives of 51 people recovering from addiction. They distinguished 5 self-narratives that helped people understand their addiction and work towards recovery: the AA story, the growth story, the co-dependence story, the love story and the mastery story. Diamond (1997) describes in *Narrative means to sober ends* how narrative techniques can help in achieving recovery. He calls this treatment, which makes use of letter writing and is inspired by twelve steps methods, re-authoring therapy. McIntosh and McKeganey (2000) explore based on a qualitative study among 70 users, how they constructed a non-using identity and how this aid their recovery.

control, or having the wrong values, but a lack of belief in self-efficacy. Anxiety about failure undermines their agency.

Just as there are many factors in addiction that can negatively change a person's self-concept – their beliefs about themselves and what is possible in their lives – there are also many different ways in which normative agency can be restored. For some people normative agency is restored bottom up, by regaining gradually control over their substance use, their living situation, and their social relationships. From there, they see the possibilities in their lives re-appear, and they start believing again that the life they value living is available to them. For others, normative self-control is restored in a top down fashion. They experience a strong internal psychological change, wherein they change their beliefs about themselves, or else bring to the fore positive beliefs about themselves and their lives. They suddenly realise how much their current self diverges from their ideal self, and they start taking steps to close the gap.

However, top down normative agency is not a magic bullet, it is a slow and laborious process. Restoring belief in self-efficacy is not just a matter of the person telling herself she can do it. As we have seen, successful normative agency depends upon a variety of other internal and external factors: physical and emotional health, opportunities, role models, as well as social support. Respondents describe how important it was for them to believe, or have someone tell them, that the life they valued living is available to them, that there is hope, even after repeated failure.

A hierarchical account of self-control in addiction can help to assess how the different levels of self-control interact, and how normative self-control can best be supported.

CHAPTER 8. CONCLUSION AND SUMMARY OF MAIN FINDINGS



The importance of distinguishing hierarchical levels of self-control

Addictive behaviour is puzzling because, on the one hand, it seems intentional: it requires a good deal of effort, for example, for a person to obtain and use illicit substances or alcohol. Addictive behaviour seems to require a high level of rational planning and control. On the other hand, substance dependent people often describe their use as involuntary and life-ruining.

The current models of addiction and self-control are dominated by this tension. Either behaviour is intentional, and hence self-controlled, or it is not intentional and thus not self-controlled. The brain disease model defends the view that addictive behaviour is unintentional. Supported by neuroscientific findings, it describes substance use as strong cue-driven behaviour that evades cognitive control. However, as the choice models have outlined, this seems to contradict the many instances in which substance users respond to local incentives. Choice models focus on the intentional part of substance using behaviour, outlining the many local reasons people have to use substances.

When we use a hierarchical account of self-control, however, this dichotomy between compulsion and intentional behaviour disappears and addictive behaviour becomes less puzzling. In line with work from Kennett and Horstkötter, I have proposed a hierarchical account of self-control, with intentional control at the bottom, instrumental control in the middle, and normative control at the top. Intentional control is about doing what one intended, instrumental control is about reaching a goal (whether we normatively endorse that goal or not), and normative self-control is about living the life one values and being the person one

aspires to. Although all three levels are important for successful self-control, the account I have proposed is nonetheless a hierarchical account, with normative agency on top. What ultimately matters is not whether we possess intentional and instrumental self-control, but whether these forms of self-control contribute to living the life we value and being the person we value being.

With this model it becomes clear that while people can act intentionally, their behaviour is not necessarily self-controlled in the normative sense. A person's intentional action can fail to be normatively self-controlled if it contradicts the values they set for themselves. Intentional self-control, or doing what one intended, is just one level of self-control.

The hierarchical account I have argued for shows us that self-control in addiction can be impaired on more than one of three interconnected level of self-control. Because of this it is necessary to identify both the level at which the initial impairment occurs, and how the impairment affects other levels on the control hierarchy. Sometimes a failure on one level of self-control also erodes another level. For example: if my intentional control is impaired I will, in turn, lack instrumental control. Sometimes, however, a failure on one level can be compensated at another. In Tom's case we saw how he regained control over his substance use (his intentional control) after his epiphany when his normative goals suddenly became motivating to him.

An agent's self-control is often equated with will power, or their capacity to resist proximate temptations. Distinguishing different levels of self-control widens this overly narrow conception of how self-control can be exercised and the factors that can threaten it. There are in fact three distinct ways in which we can exercise self-control: we can wilfully resist temptation, we can plan in advance to avoid temptation, or we can exercise self-control by adopting a certain identity: our valued self, or our ideal future self. When I see myself as a certain person some behavioural options become salient while others recede.

I have not argued that the existing theories are wrong. In fact, these theories explain a variety of ways in which self-control can fail in addiction. Rather, I have claimed that they are incomplete. Specifically, they are incomplete with regard to the normative side of human agency, and this oversight means they fail to capture a whole range of factors that influence self-control in addiction. A hierarchical account of self-control

reveals where the hiatuses are in the current models on addiction and self-control. While there is an extensive literature on how intentional and instrumental self-control are impaired in addiction, impairments in normative self-control receive very little attention. It is likely, however, that the loss of normative self-control in the context of addiction precedes or reinforces impairments on the intentional or instrumental level.

Normative agency lost and regained: findings from a longitudinal, qualitative study

To gain insight into the circumstances in which normative agency is developed or impaired, I designed a longitudinal, qualitative study involving opioid and alcohol dependent people. I followed 69 participants over a period of 3.5 years, asking them what hampered their self-control and the goals they set for themselves.

The empirical study I conducted revealed some significant ways in which normative self-control can be impaired in addiction. The first is the significance of a person's body for their agency. When I asked respondents where they saw themselves in one year's time, or if they had any plans for the future, they often replied that they had no plans since they were not sure whether they would wake up tomorrow. Many of the respondents saw so many of their friends or family members die due to substance related illnesses and accidents, they had little trust in their physical future. To pursue our long term plans, we need a body we can trust, and most respondents did not trust that their body would carry them into the future. The sense of impending death that can accompany addiction was one way in which the body influences the agency of substance dependent people.

As we have seen, another way in which the body influences the agency of substance dependent people is by draining them of energy. Substance use deregulates habits of eating and sleeping, as well as hormonal homeostasis. Respondents often described feeling low for quite a long time after they stopped their substance use. It takes time for their bodies to reset, it takes energy to resist craving, and effort to rebuild healthy or functional daily habits. Substance users must often devote most of their

energy to getting through the day, energy that cannot be devoted to more long-term plans. A healthy body enables us to live the life we value, while an impaired body makes it harder for us to pursue our plans. It is well known that substance dependency is associated with a wide range of health problems and increased morbidity. However, these losses of health in addiction are often viewed as the logical consequence of substance use – consequences that the people who use substances must resign themselves to. Little attention is paid to how these health problems influence the self-control of substance dependent people.

The third way in which the body influences the agency of substance dependent people is by changing their physical appearance. The real or imagined responses to an addicted person's physical appearance influence their self-concept. Respondents felt they lost control over defining their identity, they felt reduced to an 'addict' identity.

The empirical study also illuminated the way in which a person's normative agency can be undermined by a hostile environment. It is often assumed that substance dependent people do not have an image of the good life or of the person they value being. On this view, they just live in the moment, and do not possess a global perspective on their lives. Although this is one way in which normative agency can be impaired, I have argued that another option is more common. Substance dependent people do possess an image of the life they value living and the person they value being. They believe, however, that this life is not available to them, or that they are not worthy of it. In other words, substance users stop believing in their self-efficacy; rather than lacking normative goals, they give up on them and become resigned to their addiction. Although resignation is often presented as a rational choice – the best option people have left – I argue that it nonetheless belies a loss of self-control. The resigned addicted person seems to be in control of their actions; importantly, however, their actions no longer reflect their normative goals.

Environmental theories of addiction argue that if a person's living conditions improve, such that they are presented with suitable alternatives to their substance use, they will cease using substances. However, when addicted persons are severely resigned, they will fail to respond to improved circumstances. Respondents frequently narrated their own self-sabotage. Not only are our capacities for self-control important, but also our belief in those capacities, our belief in self-efficacy and a feeling

of trust that we have some influence on how our life will turn out. I argued that many people with addictions lack this belief in self-efficacy. Although my study showed the severe ways in which the normative agency of addicted people can be impaired, the findings also revealed how support for normative agency can play a role in recovery. Respondents described how a restored sense of self-efficacy was often a turning point in their recovery. This sense of self-efficacy could be restored in an awakening moment, but also needed to be crystallised in core projects succeeding.

To conclude, addiction involves a complex failure of intentional, instrumental and normative self-control. Further, the kind of impairment in self-control that an agent experiences in the early stages of addiction differs from those they confront in the later stages. There is often an asymmetry between the level on which self-control is initially lost, and the level on which it is regained. The hierarchal account of self-control shows that self-control is not only an internal mental capacity, it is also determined by our body, our social context, and our self-concept.

Experts on their own lives: strength and limitations of the study

Addiction trajectories often stretch out over years, so a follow up of 3.5 years is relatively brief. Nevertheless, not many longitudinal qualitative studies have been done among substance dependent people, so the study gives valuable insights in how issues of agency, self-control and identity in relation to addiction necessarily unfold over time. The findings show the existential and biographical circumstances in which addicted people have to shape and exercise their agency.

Since I recruited in public health facilities – a detoxification centre and a maintenance treatment facility – many respondents came from low socio-economic backgrounds and were treatment seeking. This means that the people I interviewed have higher comorbidity, more severe dependency, and more severe additional problems, compared to people who do not seek treatment or are from higher-socio economic backgrounds. So the findings particularly apply to this group of addicted people.

The respondents' interpretations of their experiences, followed by the researcher's interpretation of those accounts, form a distinct epistemic framework. Some doubt the value of this framework: both the respondents' interpretation of their experiences, as the researcher's interpretation can be flawed. However, the focus of the research was addicted people's self-understanding, life-stories, and normative goals, rather than objective measures on how much they used or constructing historically correct biographies. To limit the bias of the researcher, I modelled the interview techniques on the work of Carl Rogers, in the sense that it is fundamentally respondent-centred, non-judgmental, and – within the limitations of a semi-structured interview – it is nondirective. Participant validation was done during the (follow-up) interviews. During the process of interviewing and interpreting the data, respondents were treated as experts on their own lives.

Implications of the findings

The precise relevance of my conclusions will differ across domains of inquiry. For scientists working on addiction and self-control, the hierarchical account of self-control will provide them with a tool they can use to relate their own account to others. It will also make them aware of the wider range of issues that can threaten self-control – issues relating to how a person's self-concept and psychology is affected by substance use. For philosophers working on normative agency (and addiction), this thesis extends the current normative theories with empirical insights on how the impairment of normative agency looks like in addiction. In general my findings outline the importance of listening to the voices of substance users, of evaluating loss of control within someone's existential situation and normative framework. This has implications for research. Hopefully more researchers will connect their findings with qualitative, normative orientated first-person accounts of addiction. A promising approach to future research on addiction and self-control would be to focus on treatment: how can normative agency be repaired in treatment? Effect studies on narrative treatment are needed to confirm the promising results from the cases studies and to determine for which group of addicted people this treatment might work best.

For practitioners working with people struggling with addiction, the results presented in this thesis have several implications. In general, the hierarchical account of self-control can be a helpful tool to help clinicians understand and analyse their client's loss of self-control, and to understand how the levels of self-control interact. The results presented in this thesis highlight the numerous ways in which normative self-control can be impaired in addiction, and how important it is to restore it. Practitioners should evaluate whether the current dominant treatments are enough to bootstrap their client's normative agency, or whether a more rigorous approach like narrative treatment is needed. The results can also help practitioners to become aware of the importance of a person's body and self-concept for their capacity for self-control. Furthermore, my conclusions support the importance of harm-reduction approaches in minimising the harm that substance use can inflict on a person's body. Importantly, my results also highlight that addicted persons are at risk of losing belief in their self-efficacy, and this has serious consequences for their agency and recovery. The category of the resigned addict which I described will help to understand this form of loss of self-control in addiction. I showed how persistent poverty and mental illnesses like depression can make people resign from their normative goals.

The results also stress the importance of helping addicted persons to connect with their image of their ideal future self, to let go of their feelings of guilt and shame, and to work towards feelings of self-worth. These changes can happen through treatment, or by supporting substance dependent people in material ways (through housing and work projects), or in physical ways (developing constructive daily habits, medical support), but also by showing trust in their agency and self-efficacy – by assuring them, in particular, that it is possible for them to live the life they value living and be the person they value being.

Final recommendations

I close with a list of recommendations that draw upon the findings of this project. It is my hope that these will improve the understanding of people who struggle with addiction, inspire new research, improve the care and support they receive, and inspire new policies.

Assessing loss of self-control in addiction

- To assess to what extent someone with an addiction has lost self-control, it is helpful to distinguish between different hierarchical levels of self-control, and to understand how these levels interact. For example, loss of instrumental control can also erode normative control, resulting in people resigning from their normative goals.
- The main question in assessing loss of self-control in addiction is not whether addicted people have intentional or instrumental self-control but whether they have normative self-control: are they able to live the life they valuing living, and be the person they aspire being?
- For this, it is important to explore what addicted persons aspire, hope, dream, which core projects are important to them, and what they need to believe it is in their power to fulfil these.
- Professionals and researchers should acknowledge the autobiographical, existential context in which addicted people have to exercise their agency. Addiction not only changes the brains of addicted people, but can also change their bodies, their social relationships, their belief in self-efficacy, and their self-understanding.

Recommendations for treatment

- Loss of self-control in addiction is in most cases not caused by one factor, but by a set of factors that interact with the different levels of self-control. Recovery should also target the three levels of self-control.
- Most of the currently used treatments already successfully address one or more levels of self-control. However, a hierarchical account of self-control will help to assess whether in the end, the normative self-control of users is sufficiently restored.
- For people who resigned from their normative framework, are low on identity materials, and have a low belief in self-efficacy, narrative therapy can have additional benefits in restoring normative agency. Giving the promising results of narrative therapy in case studies, more effect studies should be done.
- The fulfilling of core-projects helps to anchor identity, and results in an increase in normative self-control. Practical, social, and health issues often hinder the fulfilment of these core-projects. For example: criminal records, stigma, loss of driver's license, having hepati-

tis C. Supporting clients in fulfilling their core-projects by tackling the practical issues that get in the way, is an important way to restore people's normative agency.

- Rebuilding constructive daily habits can contribute to more energy being available for long term plans.
- Harm reduction strategies are extremely important, and should be used more widely, since they minimise the negative effects of substance use on the body. Harm reduction programs can result in people having more trust in their bodies, their bodily future, having a better physical endurance, and feeling more in control of defining their own identity.
- Additionally it is important to eliminate stigma from health professionals towards people with addictions, so that people with addictions can receive better physical care. Good quality health care, performed by non-judgmental health professionals, contributes immensely to the normative agency of those struggling with addiction by minimising somatic damage and damage to the self.

Recommendations for the development of policies

- Decriminalisation of substance use will result in people having more options to employ their normative agency when recovering from addiction. For example, the decriminalisation of the purchase and possession of substances for personal use. A step further would be to give people the chance to remove small offenses from their criminal record if they comply with a treatment program. Such a move would be comparable to leaving the offences of minors off their criminal record.
- A non-punitive attitude towards addiction is important. When people already struggle with feelings of low self-worth, shaming and blaming will only aggravate their negative self-image and will lead to self-sabotage and resignation from their normative goals. The attitude of responsibility without blame is very promising because it bootstraps people's existing agency without aggravating feelings of shame and guilt. This approach affords addicted persons a safe environment to practice strategies, learn from their mistakes, and develop their agency.

How to support someone struggling with addiction

- See the dot point above: an attitude of responsibility without blame of those around them can help addicted people to bootstraps their existing agency without aggravating self-destructive feelings of shame and guilt.
- Respondents describe how important it was for them to believe, or have someone tell them, that the life they valued living is available to them, that there is hope, even after repeated failure. Helping addicted people connect to their image of their valued life and identity, and showing trust in their self-efficacy can play an important role in their recovery.

APPENDIX ETHICS CLEARANCE



St Vincent's Hospital

22 February 2011

A/Professor Jeanette Kennett
Professor in Moral Philosophy
Department of Philosophy
Macquarie University
NSW 2192

Dear A/Professor Kennett

SVH File Number: 11/123

Project Title: Addition, moral identity and moral agency: integrating theoretical and empirical approached. (HREC Ref: HREC/11/SVH/96)

Thank you for submitting the above project for ethical and scientific review. The project was first considered by the St Vincent's Hospital HREC at its meeting held on 11 August 2011. This HREC has been accredited by NSW Department of Health as a lead HREC under the model for single ethical and scientific review.

This lead HREC is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research* and the *CPMP/CH Note for Guidance on Good Clinical Practice*. No HREC members with a conflict of interest were present for review of this project.

I am pleased to advise that the Committee at an Executive meeting on 21 September 2011 has granted ethical and scientific approval of the above **single centre** project.

You are reminded that this letter constitutes *ETHICAL* and *SCIENTIFIC* approval only. You must not commence this research project at a site until a completed Site Specific Assessment Form and associated documentation have been submitted to the site Research Governance Officer and Authorised. A copy of this letter must be forwarded to all site investigators for submission to the relevant Research Governance Officer.

The project is approved to be conducted at St Vincent's Hospital.

If a new site(s) is to be added please inform the HREC in writing and submit a Site Specific Assessment Form (SSA) to the Research Governance Officer at the new site.

The following documentation has been reviewed and approved by the HREC:

- Protocol Version 2.1 dated 1 September 2011
- Participant Information Sheet and Consent Form Version 2.1 dated 29 August 2011

The National Ethics Application Form (NEAF) document reviewed by the HREC was NEAF AU/1/411A012.

Please note the following conditions of approval:

- The Co-ordinating Investigator will provide an annual progress report beginning in **September 2012**, to the HREC as well as a final study report at the completion of the project in the specified format.
- The Co-ordinating Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including unforeseen events that might affect continued ethical acceptability of the project and any complaints made by study participants regarding the conduct of the study.

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Continuing the Mission of the
Sisters of Charity

- Proposed changes to the research protocol, conduct of the research, or length of HREC approval will be provided to the HREC for review, in the specified format.
- The HREC will be notified, giving reasons, if the project is discontinued before the expected date of completion.
- HREC approval is valid for 5 years from the date of approval.
- Projects that are undertaken by Investigators holding an academic appointment (including conjoint appointments) or by students as part of a University course are also required to notify the relevant University HREC.

Please note it is the responsibility of the sponsor or the co-ordinating investigator of the project to register this study on a publicly available online registry (eg Australian Clinical Trial Registry www.actr.org.au).

Should you have any queries about your project please contact the Research Office, Tel: 8382-2075, email research@stvincents.com.au. The HREC Terms of Reference, Standard Operating Procedures, *National Statement on Ethical Conduct in Human Research* (2007) and the *CPMP/ICH Note for Guidance on Good Clinical Practice* and standard forms are available on the Research Office website: www.stvincents.com.au/researchoffice or internal at <http://exwwwsvh.stvincents.com.au/researchoffice>

Please quote **SVH File Number 11/123** in all correspondence.

The HREC wishes you every success in your research.

Yours sincerely



Sarah Charlton
HREC Executive Officer
Research Office
L6 deLacy Building

CC: Anke Snoek
Filename D/2011/16414

Macquarie University Student Email and Calendar Mail - Ethics applic... <https://mail.google.com/mail/u/0/?ui=2&ik=012b5c53ba&view=pt&q...>



MACQUARIE
University

ANKE SNOEK <anke.snoek@students.mq.edu.au>

Ethics application ref; 5201200001 - External Approval Noted

1 message

Ethics Secretariat <ethics.secretariat@mq.edu.au>
To: Prof Jeanette Kennett <jeanette.kennett@mq.edu.au>
Cc: Ms Anke Snoek <anke.snoek@students.mq.edu.au>

Mon, Jan 9, 2012 at 2:56 PM

Dear Prof Kennett

Re: "Addition, moral identity and moral agency: qualitative study"

The above application was considered by the Executive of the Human Research Ethics Committee. In accordance with section 5.5 of the National Statement on Ethical Conduct in Human Research (2007) the Executive noted the final approval from St Vincent's Hospital Human Research Ethics Committee and your right to proceed under their authority.

Please do not hesitate to contact the Ethics Secretariat at the address below, if you require a hard copy letter of the above notification.

Please retain a copy of this email as this is your official notification of external approval being noted.

Please do not hesitate to contact the Ethics Secretariat if you have any questions or concerns.

Yours sincerely

Dr Karolyn White
Director of Research Ethics
Chair, Human Research Ethics Committee

APPENDIX METHODOLOGY



1. Introduction

In this appendix I will describe in greater detail the methodology of the empirical part of the study. I will describe the recruitment, the characteristics of the respondent sample, the semi-structured interview guide and the structured surveys that were used, the data analysis and handling, and the strengths and limitations of the study.

2. Broader design

The qualitative study on which this thesis is based is part of a larger study named *Addiction, moral identity and moral agency: Integrating theoretical and empirical approaches*. The larger study consisted of different components: pilot, multidisciplinary literature review, as well as quantitative and qualitative data collection in both Sydney and Melbourne. The results presented in this thesis are mainly based on the results of the qualitative study in Sydney.

The Sydney data collection consisted of an extended qualitative data collection and a brief quantitative data collection (which will be described below). The Melbourne data collection focused on an extended quantitative data collection and a brief qualitative data collection. The final component of the study involved a control group: a small sample of alcohol and drug workers, who were interviewed about their ability to reach their goals and live according to their values.

The table below gives an overview of the different components of the larger study.

| | |
|--|---|
| Pilot | N=6 opioid dependent people |
| Literature study | Multidisciplinary literature review |
| Longitudinal study Sydney | Extended <i>qualitative</i> interview, brief quantitative data collected Baseline: N=69 Follow up 1: N = 28 Follow up 2: N= 28 Follow up 3: N=20 |
| Longitudinal study Melbourne | Extended <i>quantitative</i> interviews (n=180), a sample of those got a brief qualitative interview as well (n=43). The group that did a qualitative interview got a follow up interview Follow up 1: 6 |
| Control group (Alcohol and Drug workers) | Baseline: N= 16 Follow up: N=7 |

I was in charge of the data collection and analysis in Sydney, as well as the analysis of the qualitative data from the Melbourne study. However, for the purposes of this thesis, I decided to focus mainly on the Sydney data because the Melbourne study had only one partial follow-up and did not collect the time-line data. Since the Melbourne study focussed on quantitative data collection, the chief investigator decided to leave out the time line interview, since this was quite time consuming. However, without the time line interview much was lost about the autobiographical context I was primarily interested in. Leaving out the time line also meant that the data was narratively less interesting. Also, no field notes were collected in the Melbourne study. Due to logistic reasons (the chief investigator in Melbourne changing universities), the Melbourne study only conducted one partial follow-up. Due to these limitations of the Melbourne data, I decided to mainly focus on the Sydney qualitative data, although as part of my role in the larger study I analysed the Melbourne data as well, so there are also references to the Melbourne data in the thesis.

The respondents in the Sydney qualitative study all got a number (R1-R69), the follow up interviews were labelled a-d. So R53B refers to the second interview with respondent 53. The pilot respondents were labelled P1-P6. The respondents from the Melbourne study were assigned a label based on the location where they were interviewed - for example, MWE-14, FCA-3 etc. In the case studies, the respondents were given a pseudonym to protect their privacy.

Next I will describe in more detail the longitudinal qualitative study in Sydney on which this thesis is mainly based.

3. Recruitment and data collection

The study was funded by the Australian Research Council (DP 1094144) and approved by the Ethics Committee of St. Vincent's Hospital (11/123) and Macquarie University (5201200001). Primary ethics approval was gained by the Ethics Committee of St. Vincent's Hospital, since recruitment took place there. Subsequently, external approval was obtained from the ethics committee of Macquarie University.

3.1. Selection criteria and sampling strategy

Potential participants were age 18 years or older, fluent in English, and not heavily intoxicated at the moment of interviewing. The assessment of candidate participants in light of these criteria was conducted by the interviewer. Since the recruitment took place at a treatment facility, there were no participants under 18 years old, and none who were heavily intoxicated at the moment of interviewing. For the follow up, participants who were heavily intoxicated mostly failed to show up for the appointment. Only one respondent appeared heavily intoxicated to the interview, and we were unable to complete the interview because he kept falling asleep.

Since it was unclear how willing people would be to participate, the sampling strategy at first was convenience sampling. This sampling strategy is often used to recruit participants from hard to reach groups. However, halfway through the data recruitment, we noticed that men were more likely to volunteer than women, so in order to get more diversity in our sample, our sampling became more purposive, and women were approached explicitly.

3.2. First round of interviews

Recruitment and interviewing took place in a public detoxification treatment facility and an opioid substitute treatment facility. After being briefed by the staff about what method of recruitment would least disturb the staff and clients of the treatment facilities, I spent a few

weeks at the facilities approaching people face-to-face to ask them if they would be interested in participating in the research. Most of those who were approached agreed, and were interviewed immediately in a private room. Some asked to be interviewed later, and an appointment was made for a later interview. Staff also circulated flyers, and as a result some people approached me directly. Overall, recruitment proceeded well due to the high levels of interest in participation. In general, people in detox were more willing to be interviewed than those in maintenance treatment; people in maintenance treatment often only came to pick up their methadone and then had to leave for other appointments, while people in detox had to spend a few days inside with not much to do. After every interview, field notes were made.

Once people showed interest in the interview, I gave them an option to read the consent form, or to let me talk it through with them. Most people asked me to talk them through it. I emphasised that it was a longitudinal study and that at the end of the interview I would need their contact details and contact details of two loved ones in order to be able to follow them up. Everyone agreed with this. I talked them through their rights. I explained to them that their privacy and that of their contact persons was guaranteed, that they had the right to end the interview at any moment. I let them know that it was important to me that they felt comfortable during the interview: that they were free to skip questions they were not comfortable with, and I encouraged them to request a break if they needed. Respondents then were asked if they had any questions, and if they were willing to sign the consent form. Only one person dropped out after this briefing, because he found it threatening.

Respondents were reimbursed \$30 for their time and expertise, in accordance with accepted procedures for recruitment and interview of marginalised populations (Australian Injecting & Illicit Drug Users League (AIVL), 2002; Fry, Hall, Ritter, & Jenkinson, 2006). There are several ethical concerns regarding payment of substance abusers. One concern relates to the economic vulnerability of many individuals with alcohol and drug problems, which may make the payment coercive. Another concern relates to the fact that the money might be used to buy illegal drugs and that researchers have an ethical responsibility to prevent or minimise the misuse of payment (Anderson & DuBois, 2007).

A review on evidence-based research ethics (Anderson & DuBois, 2007) explored the empirical evidence for these concerns and concluded that there are several benefits of using payment incentives (for both the research and the participants), and they found no evidence of harm for the participants. There was no evidence that payment is coercive, undermines voluntariness, or increases drug use in the short term or relapse (Festinger et al., 2005; Ritter, Fry, & Swan, 2003).

The benefit for the research is that payment is effective in recruiting hard to reach substance users, especially if there is a follow-up, which was the case in our study (Festinger et al., 2005; Reynolds, Fisher, Cagle, & Johnson, 2000; Scott & White, 2005). The benefit for the participants is that it is a respectful way to interact since they are free to spend the money according to their own view instead of being limited to vouchers (Australian Injecting & Illicit Drug Users League (AIVL), 2002; Festinger et al., 2005; P. Miller, Carter, & Hall, 2010). A review of Fry and colleagues (2006) on the ethics of paying drug users who participate in research comes to the same conclusion and states: 'In the case of addictions research, denial of reward or fair recognition for research contributions based on negative assumptions about drug user motivations for research participation, their entitlement to such payments, and their use of research payments would seem to be inconsistent with the principles of respect for autonomy, distributive justice and beneficence.' Being financially reimbursed for their time and effort made participation in research more rewarding for the respondents (Scott & White, 2005). Research of Fry and Dwyer showed that participants did not simply participate in research for the monetary gain, but a strong motivation was the hope of helping others struggling with addiction (Fry & Dwyer, 2001).

However, the maintenance treatment facility feared that paying the respondents cash would cause unrest because the amount of money was relatively high, and I could only interview a limited amount of people every day. This unrest would jeopardise the safety of staff and clients, so for the recruitment at this facility we were limited to vouchers. However, we chose a voucher that could be spent at a wide range of shops.

3.3. Follow up interviews

After one year, two years, and three years respondents were contacted for a follow-up interview. At the first interview I asked them what their

preferred way to be contacted was: by mail, by phone, or by email. For each participant, I first tried their preferred contact method, and if this failed, I then proceeded to use their other contact details.

Most people provided family members as contact persons, some gave the names of friends or health care professionals. I would explain to the respondent's nominated contact that I was looking for their brother/son/friend because he participated in a study and gave their number as a contact. However, I would not give details about the study to protect the respondent's privacy.

Once contacted, most people vividly remembered the interviews and were willing to participate in the follow-up. The follow-up interviews mostly took place at the hospital connected to the recruitment facilities, but also in public places, at participant's homes, or by phone for those respondents who moved out of the area. Participants were reimbursed \$50 dollars for the follow-up interviews; the payment was higher than the initial interviews because participants often had travel costs.

Tracking participants down proved challenging. At both the second and third interview, 28 of the 69 respondents were successfully reached. At the fourth round, however, only 20 remained. A total of 18 people completed all 4 interviews, and 33 participated in at least two.

The main reason for interview drop-outs (90%) was that people were untraceable. Both their own contact number, as well as that of loved ones, was repeatedly not answered or out of order. In addition to this, two of our participants died. In two instances participants were unable to do one or more of the follow ups because they were incarcerated. One person served a short term jail sentence and was able to do only the third follow-up, while the other person served a long term jail sentence, and I was unable to follow him up. Another participant moved overseas, and although I obtained a new number, she did not answer her phone. One person had severe memory problems: I was able to reach her, but she could not remember participating in the study, and she was unwilling to do the follow-up. Another person could also not remember participating in the research or giving me his number, and became very paranoid and aggressive when I contacted him. Although I repeatedly tried to explain him that he gave consent for the follow up, he became increasingly aggressive, so I decided not to pursue the matter further for safety reasons. In the case of one participant I was able to contact his daughter, but

she did not see the relevance of her father participating in the research since he was very ill. Another participant was hospitalised and unavailable for a follow-up interview. One person repeatedly failed to attend the planned interview, so I was unable to follow him up.

3.4. Saturation and cut-off point

Saturation was reached when no new codes emerged during the coding of the interviews. During the first round of interviews, this happened after I interviewed the 30th participant. However, we decided to recruit past the saturation, since we expected a high drop-out. So we recruited at least double the number. During the coding of the last round of interview, saturation was reached again.

3.5. Difficulties with recruitment

Although the recruitment of the first round of interviews went very well, the recruitment for the follow-up interviews was harder than expected. Since many of the respondents had no stable accommodation and stressful financial situations, many lost their phones. Some would change their phone numbers regularly because they would want to lose contact with acquaintances from the substance using scene, including their dealer.

Although we asked respondents to provide us with the phone numbers of people who were close to them and who might be able to give us their new number, the contact persons they provided were often suspicious about being contacted and unwilling to cooperate. They quite often lost contact with the substance dependent person themselves as well.

Some respondents were incarcerated, some were severely relapsed and said that they were in no good shape for an interview, or they repeatedly failed to show up at the interview appointment. Two participants have died that we know of. But the main reason why we were not able to perform follow-ups was because respondents were untraceable.

To reduce the drop-out rate, we contacted the maintenance treatment facility and asked them if some of the respondents we could not trace were still in their care. The maintenance treatment then distributed a letter to those clients to ask them if they were interested in a follow-up interview, and if so, they could book a time and date for the interview.

We also asked permission from the ethics committee of St. Vincent's Hospital to access the 'registry of birth, death and marriages' to establish vital status prior to contacting family members. The reason for this was that one family member of a deceased respondent got very upset when I contacted her to ask the whereabouts of her brother. Since this registry has a 30 year embargo on death certificates, this register could not be accessed by our researchers, but had to be searched by an employee of the services. This limitation of access meant that the employee of the services needed to be given a list of the full names and birth years of the respondents, and this could potentially mean a breach of confidentiality. However, the employee was not given any information concerning the nature of the research. The ethics committee gave permission.

3.6. Characteristics of the respondent sample

Respondents were between 23 and 64 years of age, most respondents being between 30-50.

| | <30 | <30-40 | 40-50 | 50-60 | 60-70 | Total | Total % |
|----------------|-----|--------|-------|-------|-------|-------|---------|
| Male | 3 | 18 | 13 | 10 | 5 | 49 | 71% |
| Female | 3 | 9 | 5 | 2 | 1 | 20 | 29% |
| <i>Total</i> | 6 | 27 | 18 | 12 | 6 | 69 | 100% |
| <i>Total %</i> | 9% | 39% | 26% | 17% | 9% | 100% | |

TABLE 1. Age range of respondents

Of the sample, 70% were male (49) and 30% were female. This ratio reflects the gender ratio in the substance using population in general. Findings from an Australian national household survey estimated the men-women ratio of problematic alcohol use 2:1 (Swift et al., 1996). American population data found similar male to female ratios of alcohol dependence (1.9:1) as well as of any illicit drug dependence (1.5:1) (Greenfield et al., 2007).

Most of the respondents have an Australian nationality (50), four respondents were indigenous. Other nationalities were: Greece, New Zealand, Iraq, Vietnam.

Below we can see the main substance people were dependent on. Although many people were poly-users, this table only reflect the substance they struggle with. Some people were dependent on two substances, that is why the total does not add up to 69.

| Substance | Male | Female | Total |
|---------------------|------|--------|-------|
| Alcohol | 25 | 7 | 32 |
| Opioids | 22 | 13 | 35 |
| <i>Maintenance</i> | 17 | 9 | 26 |
| <i>Heroin</i> | 5 | 3 | 8 |
| <i>Pain killers</i> | 1 | 2 | 3 |
| Amphetamine | 6 | 1 | 7 |
| <i>Speed</i> | 2 | 0 | 2 |
| <i>Ice</i> | 4 | 1 | 5 |

TABLE 2. *The main substance respondents are dependent on*

Below are the characteristics of the people who attended at least one follow-up. The drop-out seems to be highest amongst the eldest group >60, probably because they are less familiar with mobile phones, or because they do not have such a strong social network anymore.

| | <30 | <30-40 | 40-50 | 50-60 | 60-70 | Total | Total % |
|----------------|-----|--------|-------|-------|-------|-------|---------|
| Male | 2 | 9 | 7 | 5 | 0 | 23 | 70% |
| Female | 2 | 6 | 2 | 0 | 0 | 10 | 30% |
| <i>Total</i> | 4 | 15 | 9 | 5 | 0 | 33 | 100% |
| <i>Total %</i> | 12% | 45% | 27% | 15% | 0% | 100% | |

TABLE 3. *Age range of respondents who did at least one follow-up*

The table below represents the substance use of the follow-up group. All the substances were represented in the follow-up. The amphetamine group seems to be relatively overrepresented compared with the initial sample.

| Substance | Male | Female | Total |
|---------------------|------|--------|-------|
| Alcohol | 11 | 3 | 14 |
| Opioids | 12 | 6 | 18 |
| <i>Maintenance</i> | 10 | 5 | 15 |
| <i>Heroin</i> | 2 | 0 | 2 |
| <i>Pain killers</i> | 1 | 2 | 3 |
| Amphetamine | 6 | 1 | 7 |
| <i>Speed</i> | 1 | 0 | 1 |
| <i>Ice</i> | 5 | 1 | 6 |

TABLE 4. *The main substance follow-up sample respondents are dependent on*

To conclude, it seems like there was no bias with regard to age/gender/substances, although there seems to be a slightly higher dropout in follow-up amongst the eldest group. However, if we look at recovery status, it is hard to tell whether we had a bias. The people we were able to follow up represent a variety of recovery statuses: no recovery (4), rocky recovery (8), vulnerable recovery (7), resigned (3), controlled use (5), stable recovery (5). The *no recovery* group consists of people who tried to control their substance use, but succeeded for no longer than a few days or weeks. *Rocky recovery* refers to those people who showed a pattern of being abstinent or who controlled their use for a few months, but then had lost control again for an extended period. *Vulnerable recovery* refers to those who managed to stay abstinent for longer periods, but reported a constant struggle. *Resigned* refers to those respondents who appeared to give up the attempt to control their use. *Controlled use* refers to those who were satisfied with the amount they consumed, although their use might still be high. Finally, *stable recovery* refers to people who managed to stay abstinent for a long period, and who reported no ongoing struggle (Snoek, Levy, & Kennett, 2016). However, since we did not have data about the people we were not able to follow up, it is hard to tell if there was a bias in recovery status. Although a hypothesis is that we lost the most marginal group who had no recovery and were homeless.

4. Interview guide

4.1. *Rationale behind the interviews*

The aim of the research project was to come to a better understanding of how self-control is lost in addiction. We noticed a gap in the current literature with regard to normative agency. We saw in chapter 1 that to get a better understanding of normative agency, we need to know the existential and autobiographical context in which this agency is exercised. This context will help us understand how people form their certain beliefs about themselves and how their narrative self-concept shapes over time. We also needed a longitudinal approach to see whether people succeeded in their core-projects and diachronic plans, which constitute normative agency. To gain more insight into how normative agency is impaired, a qualitative approach was most suitable, since this captures the lived experience of people, and the narrative they tell about themselves (Wertz et al., 2011).

I used a combination of open interviewing and semi-structured interviews to collect the data. I started the qualitative part of each interview with an open question. In the initial interview this open question was: ‘Can you talk me through your substance use history, and other important things that happened in your life, using this timeline’. In the follow up interviews the first question was: ‘How have you been since the last time we spoke? What kind of things happened to you?’. We mostly spent 20 minutes to half an hour on this opening question, so that respondents could bring up topics that were important to them. In this section, questions were limited to clarifications. Regularly the interviewer paraphrased the responses of the respondent to make sure the interviewer understood the interviewee correctly, and to give the interviewee the opportunity to refine or expand their answers. This method of interviewing ensures that rich data are collected (Rogers, 1945). After the open question, I proceeded to the semi-structured interview questions.

The method of interviewing is modelled on the work of Carl Rogers, in the sense that it is fundamentally non-judgmental, respondent-centred and – within the limitations of a semi-structured interview – is nondirective. This way of interviewing enables the respondent to express the

themes that are important to them, while keeping the biases of the researcher to the minimum (Rogers, 1945).

Since the qualitative study was part of a larger study with a large quantitative component, it was decided that qualitative data were augmented with data collected using structured questionnaires (VAS-craving scale, Schwartz short value survey, AUDIT, and SDS).

4.2. First round of interview

The first round of interviews started with Visual Analogue Scale from 0-10 on which people were asked to rate their craving. These data gave us insight into whether current craving influenced the answers people gave. Respondents were then asked what substance they were craving at the moment. We chose this scale because it is validated and brief (Mezinskis, Honos-Webb, Kropp, & Somoza, 2001; Wewers, Rachfal, & Ahijevych, 1990).

In the first interview respondents were asked to fill in a timeline after completing the craving scale, starting with when they were born up until now. In this timeline important life events were filled in, as well as their substance use history: when was their first use, when did their use become problematic, were there periods where they had their substance use under control again, when did they relapse?

Using a visual tool during a qualitative interview can improve the quality and completeness of the data collected (Adriansen, 2012; Berends, 2011; Kolar, Ahmad, Chan, & Erickson, 2015). Although there are some timelines already developed for the substance use field (Anglin, McGlothlin, McGlothlin, & Wilson, 1977; Sobell & Sobell, 1992), these are mostly developed for the treatment field, and are very structured. These instruments are also very strongly focused on getting an objective self-report about quantity of use. What we were interested in, however, was a more narrative approach not solely focussing on substance dependency. We wanted the timeline to reflect what people themselves saw as important life events, rather than asking them if and when certain life events occurred. The time line helped respondents to regain their memory, and helped during the interview to refer to different periods in the respondent's life. After the timeline, I asked respondents to reflect on their values, identity and hopes in life. Using the timeline, we distinguished a period before they became substance dependent, when they were substance depen-

dent, periods of recovery, and the current moment. I asked respondents if their values, sense of self and plans for the future differed during these different periods, and what they thought the cause was of these differences or continuity.

After these questions on their values and identity, a series of questions followed on their sense of control. Did people feel in control of their actions, their substance use, their lives? Did they think addiction is a disease, a choice, or something else? Do they have an example of something they did that they regret, and how did they handle this situation? What strategies do they have to stay in control over their substance use and their lives?

Next, I asked respondents about their plans for the future, in particularly their next year. What were their plans, and how did they think they would get where they wanted to be? Where did they see themselves in one year's time?

After the semi-structured interview some quantitative data were collected: a value survey, and a dependency screener. First, people were asked to fill in the short Schwartz value survey. The short Schwartz value survey presents people with 10 universal values which they have to rank in a hierarchy representing how important those values are at that moment in their lives (Lindeman & Verkasalo, 2005; Schwartz & Mark, 1992). This survey gave us an opportunity to triangulate people's answers on values; to complement the material on their values that was collected during the qualitative interview. Lastly, they were asked to fill in a screener to measure their substance dependency. Opioid dependent people filled in the Severity of Dependence Scale (SDS), and people struggling with alcohol filled in the Alcohol Use Disorder Identification Test (AUDIT). The dependency screeners provided us with an objective measure to see if people met the criteria for dependency, and whether the gravity of dependency changed during the follow ups. These surveys were chosen because of their validity and brevity (Reinert & Allen, 2002; Gossop et al., 1995; Gossop, Best, Marsden, & Strang, 1997). The quantitative data were used to triangulate the qualitative data (Östlund, Kidd, Wengström, & Rowa-Dewar, 2010).

4.3. Follow up interviews

The follow up interviews mainly had the same structure as the initial interview: a semi-structured in-depth interview followed by the same quantitative surveys. However, the craving scale was put at the end of the interview, before the other quantitative surveys. While at the initial interview starting with the craving scale provided a good opening to get insight in the current substance use problems of the respondent, and to build up rapport, the follow up interview started in a more conversational style, tuning in on the pre-existing rapport. At the beginning of the interview I recapitulated the stage in their lives respondents were the last time we spoke. Respondents were asked how they have been since that time: what kind of things happened in their lives in general, how was their substance use in the last year?

After speaking at length about how the past year had been for them, I recapitulated the respondent's goals from the previous year, and their plans to reach those goals. I asked respondent what got in the way of their plans, and if they were happy with their lives at the moment. I repeated their answer to last year's question 'where do you see yourself in one year's time', and we reflected on the answer. Then we discussed their plans for the coming year. Finally, we discussed some general questions about their values, control, and identity.

After the interview I checked with respondents if they were feeling alright, or if some of the issues we discussed upset them. If respondents were upset, I recapitulated the positive things they said in the interview about their own strengths.

In an iterative process the interview guide was refined after every round of data collection. No major changes were made in the semi-structured interview guide, although some questions were rephrased to make them clearer. Two questions were added after the first round of interviews: 'do you see yourself as strong-willed, weak-willed, or somewhere in between?', and 'What do you think your addiction taught you?'

5. Data handling and analysis

5.1. Data handling

All interviews were transcribed ad verbatim by a transcription agency specialised in transcribing qualitative interviews. Poor diction was indicated with: [unclear]. After the transcription, the respondents were anonymised, and all identifiers (names, places) were removed from the interviews. The key to re-identify the respondents (necessary for the follow-up) was stored in a locked cabinet, separate from the interviews themselves. After anonymising the data, the interviews were also accessible to the rest of the team (the Melbourne researchers and the theoretical researchers in Sydney), as per the HREC approval.

5.2. Rationale behind the analysis

The analysis is based on the principles of grounded theory, or more precise, constructivist grounded theory (Charmaz, 2011). Analysis mostly happened bottom up from the data, rather than using the data to confirm a hypothesis. Although traditionally grounded theory requires approaching the data *tabula rasa* with regard to theory, a more recent stand in grounded theory rather requires us to approach the data with ‘theoretical agnosticism’, and subject our earlier ideas to rigorous scrutiny – or, as Charmaz states, the literature has to earn its way in (Charmaz, 2011; K. Henwood & Pidgeon, 2003).

So how do the literature and the data relate? Before the method was designed, a literature review was done to outline the current theories on addiction and self-control. This led to the theories presented in Chapter 2, and already provided the seminal insights for Chapter 1: views on self-control and agency. The data showed how the current theories on addiction and self-control are too thin, and can only account for a certain aspect or a certain phase of addiction, so the philosophical views on addiction and self-control, which are described in Chapter 1, were further developed. The findings in the data also led to new literature searches on the body and addiction, disability bioethics, stigma, identity, self-efficacy, and so on. Thus most of the literature that is discussed in Chapter 4-7 was collected after the first round of data collection.

5.3. Data analysis

The interview transcripts were uploaded to Nvivo, a software program for the analysis of qualitative data. The data was analysed on four levels. The first level of analysis consisted of a rigorous round of open coding. Relevant sections were coded line by line (Charmaz, 2011). Nodes could refer to concepts in the literature, but mostly were created bottom up, emerging from the data rather than applying a theoretical framework from the literature. As the interviews proceeded over the years, the coding became more fine grained and comparative. Axial codes were developed to outline the relationships between the nodes. This way of analysis was helpful for a thematic analysis: identifying which themes the respondents brought up, and the similarities and differences in how they viewed these themes.

The result of this level of analysis was an insight into the main themes respondents brought up, and the diversity of the themes respondent brought up. I started with a more general question about how addicted people experienced their self-control. The aim of this thesis was to focus on those impairments of self-control in addiction that are poorly understood or ignored in the current literature. During the interviews and the analysis, two of those impairments stood out: the role of the body in agency, and the role of adverse external circumstances and how they influence people's beliefs in their self-efficacy. These themes stood out in several ways. Firstly, these nodes stood out because of the frequency with which they were mentioned by the respondents. Secondly, these nodes stood out because they overarched many other key concepts like diachronic expectations, experiences of stigma and identity, loss of belief in self-efficacy, and experiences of control over one's life. Thirdly, these nodes stood out because of the absence of these themes in the literature. Chapter 5 on the body relies most heavily on the results of this level of analysis, although the case studies in chapter 3, 6, and 7 are also complemented with data from this level of analysis.

The second level of analysis focussed on a more individual level: case studies. Here, a more narrative approach was employed (Wertz et al., 2011). During this analysis I studied all the data related to one person: my field notes, the consecutive interviews, the results from the structured surveys. I analysed how their story developed, how their narratives changed. Results of this level of analysis especially provided inside in

how agency developed over time. Three case studies were selected to be discussed in detail in this thesis, because they were most representative. The case studies are discussed in chapter 3, 6, and 7.

The third level of analysis was based on qualitative comparative analysis (Jansen, 2014). In this level of analysis respondents were grouped according to a typology construction based on whether they were successful in recovery or not. This gave a possibility to compare different groups of people. This way of analysis made it easier to determine what successful people did differently than people that were less successful in their recovery. The results of this analysis are described in chapter 7.

The fourth level of analysis happened during the follow-up interviews. Mostly participant validation is done through focus groups after the transcripts or the analyses are done, but in this research much of the interpretation of the data was done during the interviews, in collaboration with the respondents. Respondents were repeatedly invited to interpret their own life story and reflect on current theories on addiction and agency. This approach to interviewing left participants in control of their own story, and invited them to be experts on their own life. This approach also limits the bias in interpretation of the researcher. It was inspired by the method of integrated ethics (Abma, Baur, Molewijk, & Widdershoven, 2010; A. C. Molewijk, Stiggelbout, Otten, Dupuis, & Kievit, 2003; B. Molewijk, Stiggelbout, Otten, Dupuis, & Kievit, 2004; Widdershoven, Abma, & Molewijk, 2009)

The data was coded primarily by me. A sample of the data was cross-coded by a researcher from Melbourne.

6. Strengths and limitations of the empirical study

The study has several limitations. The first limitation is that we were only able to follow people over a 3,5 year period. 3,5 years is quite a short period to describe the process of addiction or recovery. We hope to get funding to do more follow-up interviews in the future. However, since there are not many longitudinal qualitative studies that stretch over several years, the study does provide exclusive and detailed data on how the lives of addicted people develop over time. Although there are some retrospective studies on how normative agency is exercised (Biernacki,

1986), there are no prospective studies. So this is an important strength of the current study.

The second limitation is that we recruited in public treatment services. This means that our sample consists of people who sought treatment for their addiction. People who seek treatment for their addiction are considered to have higher comorbidity and more severe dependency, compared to people who do not seek treatment (Heyman, 2009). The fact that we recruited from public treatment services means that the people we recruited are from quite low socioeconomic backgrounds. People from low socioeconomic backgrounds (SES) tend to have more persistent additional problems. However, since these groups (in-treatment and from low SES-backgrounds) are also considered to have the worst treatment prognosis, and maybe also are quantitatively the biggest group, it might be reasonable that most research focuses on this group. However, focussing on this group might provide us with a quite pessimistic view on addiction, in contrast to, for example, studying spontaneous recovery. A result of this limitation is that the results presented in this thesis might not be generalizable to people from higher socio-economic backgrounds struggling with addiction, or to the non-clinical population of people struggling with addiction. However, this limitation is partly counteracted because during the follow up many people were no longer in treatment, so the data also reflects non-clinical views. Some people who recovered also experienced a change in their socio-economic status (i.e. they no longer belonged to a low socio-economic group), although this is a minority of the sample.

The third limitation of the study is the large drop-out rate, which could create a selection bias. Little is known about the people who dropped out and the reasons why we were unable to track them down. One hypothesis is that the reason why people were unreachable is because they were in a very bad shape; heavily addicted, homeless, in bad physical health, in jail. This would mean that the people we followed up were people who were reasonably well off in their recovery. However, since we had multiple follow ups, people would also retrospectively fill us in about the years we were unable to interview them. I also followed-up one person who was homeless by scanning the parks surrounding the hospital. But there is still a chance that we had a selection bias in the follow up and that we lost the most marginal group.

Another possible limitation of this study is that most of the people I interviewed were not under influence of substances when we asked them to reflect on their use. It is difficult to capture how attitudes to use change in the lead up to using, using and then long after. However, people did reflect retrospectively on how they thought when they had strong craving, they could describe what they thought when they were 'thinking like an addict'.

Some have been sceptical about the use of self-report in addiction studies (Dalrymple, 2006; Davies & Baker, 1987; Foddy & Savulescu, 2010; Pickard, 2015), claiming that addicted people present their addiction quite differently to their peers than to non-addicted researchers or psychiatrists. The view they present to non-addicted people is strongly influenced by the culturally dominant addiction-narrative that motivates people to present themselves as being violated by their own desires. The view they present to their peers, by contrast is the true version. Elsewhere (Kennett et al., 2013) we have outlined a number of problems with this view and argued that the discrepancies between the different stories represent an ambivalence in themselves, rather than one story being more true. We suggested that the stories they told their peers are also shaped by a narrative that is accepted amongst peers in the substance using sub-culture that many of them inhabit.

It is worth underlining that individuals' interpretations of their experiences, followed by the researcher's interpretations of those accounts, form a distinct epistemic framework. This is of course common to all qualitative, person-centred research, but it places certain epistemic and hermeneutic constraints on the knowledge obtained. In a nice experiment, Charmaz (2011) asked 5 qualitative researchers to interpret the same data. The researchers came up with quite different interpretations, but all these interpretations were validated by the research subject. Gialdino calls this a non-exclusive way on knowing (Gialdino, 2009). Davies and Baker (1987) argue that self-report will not give us any objective information on the nature of addiction. However, the aim of this study is to see how addiction influences self-concept, the narrative a person develops around their substance using, and how this narrative and self-concept influence behaviour. For this, qualitative research is the best method. I started this thesis stating that addictive behaviour is puzzling, also for the addicted persons themselves. Because they found their

own behaviour so puzzling, many have thought about their behaviour extensively, and much can be learned from their own reflections. So I would like to argue that the method of self-report is a strength of my study, rather than a weakness.

APPENDIX INTERVIEW GUIDE



1. Qualitative interview first year (baseline)

o. Can you tell me something about your substance use history (using this timeline)?

- What is your substance of preference? When did you start using it, when did you realise you were dependent on substances? What major life events influenced your substance use? Do you consider the drug use harmful or useful?

Time line: life events and substance use

- 0. Major life events that influenced your substance use
- 1. First time of drug use
- 2. First time of drug dependency
- 3. Treatment history

0 5 10 15 20 25 30 35 40 45 50 55 60 65
Age

(printed on A4 and presented to the respondent)

1. Thinking back to the time before you started your drug/alcohol use, can you tell me about what kind of things were important for you then?

- For example: values, goals, how you saw yourself, what kind of person you wanted to be.

2. What kind of things are most important to you now?

- If things have changed, why, and what role did you think your drug use played in this?

3. What are your goals for the future? In particular, for the next year?
 - Can you tell me a little bit more about how you are going to get to this point? What plans have you made to achieve this goal(s), what will you need to do?
4. In your day-to-day life, do you generally feel that you are in control of what you do or what happens?
 - What gets in the way and what works? What strategies do you have to stay in control? How is your drug/alcohol use related to this?
5. Can you tell me something about a moral dilemma you had with regard to your drug use and how you solved this?
 - Or can you tell me something that you regretted or that you were proud of?
6. What do you think of the claim that addiction is a disease that reduces the control someone has over his life?
7. Debriefing
 - These were my questions. Do you have something to add or something you want to say that we haven't discussed?
 - Are you interested in the results? If yes, how can we reach you?

2. Qualitative interview second, third, and fourth year

- FU.1. [recapitulation of where someone was at last year's interview] Can you tell me something about the main events that happened last year in your life?
- Did you have any relapses?
 - How difficult has it been for you to stay off alcohol/drugs?
 - What do you do to deal with craving?
 - Do you feel in control over your substance use?
 - Do you want to tell me anything about changes in your personal life/work/relationships?
- FU.2. What was one of the best things that happened last year?
- What was one of the worst things that happened last year?
 - Is there something you are proud of?

- What would you say is the best thing about your life?
- Is there something you did last year that you regretted?

FU.3. Do you feel in control over your life?

- Do you think the control over your life is increasing or decreasing?
- Do you have examples of that?

FU.4. What kind of things are important to you in your life at the moment?

- Last year you told me that the things that were important for you were ... (recapitulate the interview). Is that still the case? If not, why not?

FU.5. What do you think your addiction taught you?

- About yourself?
- About addiction?
- What have you learned from your addiction that you would like to pass on to other people to help them?
- What do you get out of your substance use?

FU.6. Some people say that addiction is a (brain) disease, others claim that it is a choice. They say habitual users just prefer using to staying clean. What do you think?

FU 7. Do you see yourself as the same person or a different person when you are using/drinking?

- Which person is more 'you'?
- What is the difference?

FU 8. Would you describe yourself as a strong-willed person, a weak-willed person, or just like other people?

FU.9. What are your goals for the future? In particular, for the next year?

- What will you do to achieve that/those goals? How will you go about it?

FU.10. Last year you told me about your plans for the future, and that this year you wanted to achieve or to be ... (recapitulate the interview). Did this work out for you?

- Why or why not?
- what extent did your substance use disrupt your plans?
- What got in the way?
- What strategies did you use? For example, to keep away from drugs/alcohol or places you used to go?
- Are you satisfied with where you are now?
- How many times in the last year, if any, have you made an attempt to stay clean?
- What do you think would help you reach your goals better?

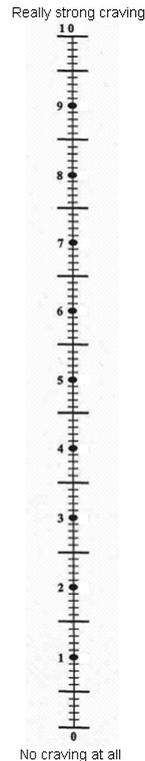
Debriefing

- These were my questions. Do you have something to add or something you want to say that we haven't discussed?
- Are you interested in the results? If yes, how can we reach you?

3. Visual Analogue Scale (VAS) craving

Please put a cross on the scale on the right to indicate how strong your craving is AT THIS MOMENT for the drugs you were most addicted to.

Place your mark somewhere between 0 (no craving at all) and 10 (really strong craving).



4. Severity of Dependence Scale (SDS) (for opioid dependent people)

SEVERITY OF DEPENDENCE SCALE (SDS)

The following questions are about your drug use prior to commencing treatment. For each of the five questions, please indicate the most appropriate response, as it applied to your drug use in the month prior to starting treatment.

[Note: Give Response Card to participant. When reading out the questions below, replace "(drug)" with the name of the principal opiate for which treatment is currently being received, e.g. heroin, opium, etc.]

| | Never/ almost never | Sometimes | Often | Always/ nearly always |
|---|------------------------|-----------|-------|-----------------------------|
| 1. Do you think your use of (drug) was out of control? | 0 | 1 | 2 | 3 |
| 2. Did the prospect of missing a fix (or dose) make you anxious or worried? | 0 | 1 | 2 | 3 |
| 3. Did you worry about your use of (drug)? | 0 | 1 | 2 | 3 |
| 4. Did you wish you could stop? | 0 | 1 | 2 | 3 |

| | Not difficult | Quite difficult | Very difficult | Impossible |
|--|---------------|--------------------|-------------------|------------|
| 5. How difficult did you find it to stop or go without (drug)? | 0 | 1 | 2 | 3 |

SDS TOTAL: _____

5. Alcohol Use Disorder Identification Test (AUDIT) (for alcohol dependent people)

Please circle one of the following options for each question

1. How often do you have a drink containing alcohol?

NEVER MONTHLY 2-4 TIMES 2-3 TIMES 4 OR MORE
OR LESS A MONTH A WEEK TIMES A WEEK

(If you answered NEVER please go on to the next page)

2. How many standard drinks containing alcohol do you have on a typical day when you are drinking (see diagram below for examples of a standard drink)?

1 OR 2 3 OR 4 5 OR 6 7 TO 9 10 OR MORE

3. How often do you have six or more drinks on one occasion?

NEVER LESS THAN MONTHLY WEEKLY DAILY OR
MONTHLY ALMOST DAILY

4. How often during the last six months have you found it difficult to get the thought of alcohol out of your mind?

NEVER LESS THAN MONTHLY WEEKLY DAILY OR
MONTHLY ALMOST DAILY

5. How often during the last six months have you found that you were not able to stop drinking once you had started?

NEVER LESS THAN MONTHLY WEEKLY DAILY OR
MONTHLY ALMOST DAILY

6. How often during the last six months have you been unable to remember what happened the night before because you had been drinking?

NEVER LESS THAN MONTHLY WEEKLY DAILY OR
MONTHLY ALMOST DAILY

7. How often during the last six months have you needed a first drink in the morning to get yourself going after a heavy drinking session?

NEVER LESS THAN MONTHLY WEEKLY DAILY OR
MONTHLY ALMOST DAILY

8. How often during the last six months have you had a feeling of guilt or remorse after drinking?

NEVER LESS THAN MONTHLY WEEKLY DAILY OR
MONTHLY ALMOST DAILY

9. Have you or someone else been injured as a result of your drinking?

NO YES, BUT NOT IN YES, DURING
THE LAST SIX MONTHS THE LAST SIX MONTHS

10. Has a relative or friend or a doctor or other health worker, been concerned about your drinking or suggested you cut down?

NO YES, BUT NOT IN YES, DURING
THE LAST SIX MONTHS THE LAST SIX MONTHS

STANDARD DRINKS

A standard drink contains 10 grams of alcohol. Beer, wine and spirits vary in the amount of alcohol they contain. One standard drink equals:



6. Short Schwartz Value Survey

VALUE SURVEY

What values are important to YOU as guiding principles in YOUR life, and what values are less important to you?

Before you begin, read the values in the list, choose the one that is most important to you and rate its importance. Next, choose the value that is most opposed to your values and rate it 0. If there is no such value, choose the value least important to you and rate it 1 or 2, according to its importance. Then rate the rest of the values in the list.

0 - means the value is opposed to my principles

1 - means the value is not at all important, it is not relevant as a guiding principle for you.

4 - means the value is important.

8 - means the value is very important.

The higher the number (1, 2, 3, 4, 5, 6, 7), the more important the value is as a guiding principle in YOUR life.

In the space before each value, write the number (0,1,2,3,4,5,6,7) that indicates the importance of that value for you, personally. Try to distinguish as much as possible between the values by using all the numbers. You will, of course, need to use numbers more than once.

AS A GUIDING PRINCIPLE IN MY LIFE, this value is:

| opposed to my values | | not important | | important | | very important | | supreme importance | |
|-------------------------|---|---------------|---|-----------|---|----------------|---|-----------------------|--|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |

VALUES LIST

- 1 Power (social power, authority, wealth),
- 2 Achievement (success, capability, ambition, influence on people and events)

- 3 Hedonism (gratification of desires, enjoyment in life, self-indulgence)
- 4 Stimulation (daring, a varied and challenging life, an exciting life)
- 5 Self-Direction (creativity, freedom, curiosity, independence, choosing one's own goals)
- 6 Universalism (broadmindedness, beauty of nature and arts, social justice, a world at peace, equality, wisdom, unity with nature, environmental protection)
- 7 Benevolence (helpfulness, honesty, forgiveness, loyalty, responsibility)
- 8 Tradition (respect for tradition, humbleness, accepting one's portion in life, devotion, modesty)
- 9 Conformity (obedience, honoring parents and elders, self-discipline, politeness)
- 10 Security (national security, family security, social order, cleanliness, reciprocation of favors).

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NEDERLANDSE SAMENVATTING



Hoe beïnvloedt verslaving self-control?

‘Weet je’, zei een van mijn respondenten, ‘ik haat het idee dat verslaafden geen controle hebben over hun gedrag. Maar waarom gebruik ik dan elke dag weer, ook al weet ik dat het me eigenlijk geen goed doet?’ Verslavingsgedrag heeft iets tegenstrijdigs. Het voornaamste verschil tussen gewoon middelengebruik en verslaving lijkt dat bij een verslaving mensen de controle over hun gebruik verliezen: ze gebruiken meer of vaker dan ze zouden willen. Echter dit controle verlies is niet van dezelfde aard als bijvoorbeeld tics, of een epileptische aanval. Verslavingsgedrag heeft vaak een element van planning en keuze. Mensen met een verslaving besteden veel tijd, geld en energie aan het plannen van gebruik en consumeren van middelen. Anderzijds lijkt het onwaarschijnlijk dat verslaving een keuze is, en dat mensen willens en wetens hun gezondheid, werk, en relaties op het spel zet voor drugs of drank. Hoe kunnen we deze spanning tussen vrijwillig en onvrijwillig elementen in verslavingsgedrag duiden? Hoe beïnvloedt verslaving self-control¹ nou precies?

De huidige modellen die verslavingsgedrag verklaren zitten vaak vast in deze dichotomie: verslaving is óf een ziekte, óf een keuze. Hierdoor kunnen de modellen vaak maar een deel van het verslavingsgedrag verklaren. Bijvoorbeeld, recente ontwikkelingen de neurowetenschappen hebben aangetoond hoe herhaaldelijk middelengebruik de hersenen verandert, en capaciteiten voor self-control erodeert. Echter, de neurowetenschappen kunnen niet verklaren waarom mensen soms, als ze een

¹ In de Engelse versie van mijn proefschrift gebruik ik het woord ‘self-control’, hier is niet echt een gangbare Nederlandse vertaling voor. Het Nederlandse begrip dat dit het beste benadert is autonomie. Dit heeft echter in het Engelse vakgebied een heel andere betekenis. Ik gebruik dus het Engelse woord self-control in deze Nederlandse samenvatting, ook omdat dit een mooie gelaagdheid heeft die het Nederlandse equivalent niet heeft.

bepaald inzicht in zichzelf krijgen, van de een op de andere dag succesvol stoppen met middelengebruik. Keuzemodellen laten zien waarom mensen gebruiken: omdat ze er door ontspannen of genot ervaren, of als zelfmedicatie voor heftig psychisch lijden en trauma. Keuzemodellen uit de gedragseconomie beargumenteren dat verslaving een probleem is van bijziendheid: middelengebruik is vaak een korte termijn strategie om de huidige dag het effectiefst te benutten, echter, op de langere termijn zijn mensen die overdadig middelen gebruiken vaak slechter af dan mensen die dat niet doen. Echter, deze theorieën kunnen niet goed verklaren waarom mensen het vaak toch lastig vinden om te stoppen als ze tot het inzicht komen dat de tol van hun middelengebruik te hoog is geworden, en de voordelen van het gebruik niet meer opwegen tegen de nadelen.

Deze dichotomie tussen verslaving als vrijwillig of als onvrijwillig gedrag, zorgt ervoor dat de theorieën elkaar vaak beconcurreren in plaats van dat ze kijken hoe ze zich tot elkaar verhouden en hoe ze elkaar aanvullen. Echter, als we luisteren naar de levensverhalen van mensen met een verslaving, dan wordt duidelijk dat, hoewel de huidige theorieën belangrijk inzichten bieden, ze toch falen om verlies van self-control bij verslaving adequaat te duiden. Dit komt omdat ze een beperkte opvatting hebben over wat self-control is. In discussies over self-control ligt vaak de nadruk op 'control', en niet op 'zelf'. Echter, als we kijken waarom we self-control uitoefenen, dan is dat niet zozeer om controle uit te oefenen, maar omdat we het belangrijk vinden om ons leven zo te sturen dat het in overeenstemming is met onze waarden, zodat we het leven kunnen leven dat voor ons belangrijk is, en de persoon kunnen worden die we willen zijn. Self-control heeft een sterk normatief element, en dat is in de huidige theorieën vaak onderbelicht. Hoewel ze inzicht verschaffen in een aantal manieren waarop self-control bedreigd kan worden, blijft er tegelijkertijd een hele waaier aan factoren buiten beschouwing. Deze factoren kwamen aan het licht tijdens de empirische studie, en leidden tot het ontwikkelen van een hiërarchisch model van self-control dat gebruikt kan worden om controle verlies bij verslaving te analyseren, en herstel te ondersteunen.

Nicole's verhaal: langdurige verslaving brengt een complex scala van controle verlies met zich mee

In het empirische deel van deze studie heb ik een groep van 69 mensen met een verslaving (Alcohol=32, Opiaten=35, Amfetamines=7 er is enige overlap vanwege polydruggebruikers) over een periode van 4 jaar gevolgd, en jaarlijks een kwalitatief interview afgenomen. Ik stelde hun vragen over hun levensverhaal, wat ze belangrijk vonden in het leven, welke plannen ze hadden voor de toekomst, en wat hen bemoeilijkte in het behalen van hun doelen. Elk jaar evalueerden we samen hoe hun jaar was verlopen. De methode van interviewen was geïnspireerd op Carl Rogers, en behandelt de respondent als een expert met betrekking tot zijn eigen leven.

Het levensverhaal van Nicole laat op een mooie manier de kracht en hiaten van de huidige modellen zien. Nicole had een fijne jeugd, ze beschrijft haar gezin als warm en liefdevol. In haar adolescentie beginnen de eerste barsten te komen, ze begint te experimenteren met alcohol en cannabis om gevoelens van depressie de baas te komen. Ze krijgt de diagnose van ADD (Attention Deficit Disorder), en krijgt Ritalin voorgeschreven. In deze fase is haar gebruik onder controle, een welkome zelfmedicatie. Het gaat echter mis als ze haar opleiding als verpleegkundige afgerond heeft en gaat werken. Op haar werk heeft ze toegang tot morfine en pethidine. Op haar 21ste wordt ze ontslagen omdat ze deze middelen op haar werk ontvreemd heeft. Haar wereld stort in, ze begint ice te gebruiken. Het eerste keerpunt komt op haar 22ste als ze erachter dat ze zwanger is. Ze stopt radicaal met elk middelengebruik, vindt een baan in de kinderopvang, en krijgt veel steun van haar ouders bij het opvoeden van haar kind. Ze beschrijft dit als een heel gelukkige periode in haar leven.

Tot nu toe kan Nicole's verhaal goed verklaard worden door theorieën uit de gedragseconomie. Volgens deze theorie is verslaving het gevolg van een spanning tussen korte en lange termijn keuzes. Vaak maken mensen in hun adolescentie korte termijn keuzes, waaronder middelengebruik, maar als ze ouder worden, en er meer op het spel komt te staan (een kind, een baan), schakelen ze automatisch over op langere termijn keuzes en stoppen ze met middelengebruik. Nicole zegt in een van de interviews: 'Ik wil niet terugvallen. Ik weet dat als ik terugval, dat

dan al mijn harde werken voor niets was (...) De clou is, dat je wat meer in de lange termijn gaat denken, en na gaat denken over de consequenties. (...) Ik word er niet jonger op, en als ik dat besef raak ik soms een beetje in paniek. (...) Om je de waarheid te vertellen, soms heb ik nog wel zin in ice te gebruiken, het verlangen is altijd daar (...) als ik dat heb, dan denk ik na over de consequenties en wat ik allemaal ga verliezen.

Een uitzondering op deze *maturing out* theorie zijn mensen die ook psychische problemen hebben, voor hen blijft middelengebruik vaak een belangrijke functie hebben als zelfmedicatie. Dit lijkt het geval met Nicole, de hervonden stabiliteit in haar leven blijkt niet van lange duur, op haar 27ste ontwikkelt ze een eetstoornis, valt terug in haar opiaten gebruik, en raakt haar baan kwijt. Haar ouders zetten haar het huis uit, haar zoon blijft bij hen. Nicole zegt dat ze in deze periode elke controle over haar leven kwijt is, haar icegebruik neemt alles over. Een jaar lang ziet ze haar zoon niet, ze heeft niet echt een stabiele verblijfplaats, en ze werkt als sekswerker hoewel ze dat vreselijk vindt.

Na een jaar begint dit leven zijn tol te eisen, Nicole stort fysiek in en wordt gediagnostiseerd met hepatitis C. Ze onderneemt een nieuwe poging om het roer in haar leven om te gooien. Ze gaat op een opiaat onderhoudsbehandeling, ze begint een studie radiologie, en de weekenden gaat ze langs bij haar ouders en haar zoon. Op dit punt in haar leven interview ik Nicole voor het eerst, en in de twee jaar die volgen zie ik hoe ze langzaam aan haar nieuwe leven bouwt. Het studeren valt haar zwaar, de overgang van haar oude leven na haar nieuwe leven vraagt nogal wat van haar aanpassingsvermogen. Maar ze is erg blij dat de relatie met haar ouders en zoon herstellende is. Ze hoopt dat als haar studie afgerond is dat ze genoeg verdient om een eigen huis te vinden en dat haar zoon dan bij haar kan wonen. Ze zou graag een partner willen vinden en trouwen. Als ik haar vraag naar haar plannen voor de toekomst, dan beschrijft ze die als 'huisje, boompje, beestje'.

Als ik Nicole het derde jaar interview is haar leven echter weer helemaal uit elkaar gevallen. Ze vertelt dat ze gezakt was voor het laatste practicum, en dat toen haar hele wereld instorten. Ze is weer dakloos, gestopt met haar studie, heeft geen contact met haar familie, en heeft het afgelopen jaar verschillende keren in het ziekenhuis gelegen met een overdosis. Ze heeft zenuwschade opgelopen tijdens de overdosis. Het grootste deel van de dag slaapt ze.

Hoe moeten we Nicole's nieuwe terugval duiden? Volgens het neurowetenschappelijke ziektemodel zorgt herhaaldelijk middelengebruik voor langdurige, of zelfs permanente veranderingen in de hersenen. Mensen blijven verslavingsgevoelig, zelfs nadat ze jaren abstinente zijn geweest. Door hun middelengebruik zijn ze geconditioneerd geraakt op bepaalde signalen uit hun omgeving die middelengebruik voorspellen (een bierdopje, 'bij koffie hoort een sigaret'). De aandacht wordt automatisch naar deze signalen toetrokken en het zien van de signalen roept een sterk verlangen op naar gebruik. Ook al heeft ze een onderhoudsbehandeling voor haar opiaat afhankelijkheid, hetgeen het verlangen onderdrukt, er is geen onderhoudsbehandeling voor haar ice gebruik, dus valt ze terug. Nicole beschrijft dit ook tijdens een van haar interviews: 'Mijn craving kan echt verschrikkelijk sterk zijn (...) Je wilt dan alleen maar drugs, en dan doe ik echt alles om te gebruiken.' En: 'Ik heb een aantal hele slechte beslissingen genomen in mijn leven. (...) Ik dacht toen als een verslaafde (...) Ik wist dat het de verkeerde beslissing was, maar ik kon mezelf niet stoppen'.

De neurowetenschappen laten een belangrijk licht schijnen op een aspect van Nicole's ervaring: haar sterke verlangen naar drugs, ook al ze al lange tijd abstinente is. Echter, als we nader kijken naar haar verhaal blijken ook een andere factoren een belangrijke rol te spelen in haar terugval.

Nicole beschrijft dat ze zich slecht thuis voelde op de universiteit. Ze vertelt hoe ze door haar jaren van drugsgebruik, dakloosheid en sekswerk onzeker is geraakt over haar identiteit. 'Ik ben altijd bang wat andere mensen over me denken. (...) Ik denk dat ze aan mij kunnen zien dat ik verslaafd ben geweest. (...) Ik was veel gewicht verloren, en daardoor zag ik eruit als een verslaafde.' Nicole heeft het gevoel dat ze geen controle heeft over de constructie van haar identiteit. Ze voelt zich erg onzeker, ze heeft het gevoel dat haar lichaam een deel van haar identiteit onthult dat ze liever verborgen houdt. Ze weet niet zo goed hoe ze zich moet gedragen op de universiteit, hoe je je gedraagt op straat is behoorlijk verschillend van hoe je geacht wordt je op de universiteit te gedragen.

Nicole beschrijft dat ze het erg moeilijk vindt om in zichzelf te geloven, ze is altijd bang dat het goede leven eigenlijk niet voor haar is weggelegd, en toen ze faalde met het practicum gaf ze zich helemaal over aan dit negatieve beeld van zichzelf. En dat terwijl ze eigenlijk haar identi-

teit als verslaafde ook niet als haar ware zelf ziet ‘Ik wil niet beschouwd worden als een drugsverslaafde, ik wil dat mensen me zien als een goede moeder’.

Nicole’s verhaal beschrijft hoe controle verlies bij verslaving niet alleen gaat om het verlies van bepaalde capaciteiten, maar ook een verlies van het zelf kan zijn. Nicole’s verslaving veranderde haar lichaam, en daarmee was ze bang dat ook haar sociale identiteit veranderd was. Ze had het gevoel dat ze de controle verloren was over haar identiteit, en daarmee ook over welke doelen ze zichzelf kon stellen. Hoewel het falen van een practicum voor de meeste studenten makkelijk te overkomen is, was het voor Nicole een bevestiging van de angst dat het leven dat ze naar streefde niet voor haar was weggelegd. Of, zoals een andere respondent zei: ‘we willen allemaal deel uitmaken van iets positiefs, maar door een gebrek aan geloof in onzelf maken we keuzes die een negatieve impact op ons leven hebben’.

Een hiërarchisch model van self-control

De empirische data gaven belangrijke handvaten in hoe een overkoepelende theorie over self-control en verslaving eruit kan zien. Een model dat laat zien hoe de bestaande theorieën zich tot elkaar verhouden, en waar de hiaten zitten.

Laten we terugkeren naar de bestaande modellen die verlies van self-control bij verslaving proberen te verklaren. Een moeilijkheid is dat deze theorieën uit uiteenlopende disciplines komen (neurowetenschappen, gedragseconomie, psychologie, filosofie, sociologie, symbolisch interactionisme), en verschillende opvattingen en criteria hanteren van wanneer gedrag onder controle is van een individu. We moeten dus terug naar de vraag wat self-control precies is, en waarvoor het wordt uitgeoefend.

Hierbij kunnen inzichten uit de normatieve filosofie helpen. De normatieve filosofie (Kennett 2001, Horstkötter 2009) stelt een hiërarchisch model van self-control voor. Als we een hiërarchisch model van self-control gebruiken, verdwijnt veel van de verwarring en dichotomie rond de intentionele en compulsieve aspecten van verslavingsgedrag. Een hiërarchisch model van self-control laat zien hoe iemand intentioneel kan

handelen, maar toch kan falen in het uitoefenen van self-control. Een hiërarchisch model van self-control laat ook zien in welk type self-control de verschillende theorieën geïnteresseerd zijn.

Het hiërarchische model onderscheidt drie vormen van self-control: intentionele controle, instrumentele controle, en normatieve self-control. Intentionele self-control gaat over doen wat je je voorgenomen hebt: ik wil mijn moeder bellen, en laat me niet afleiden door inkomende berichtjes als ik mijn telefoon pak. Intentionele self-control kan bijvoorbeeld bedreigd worden door verleiding of door gewoonte gedrag. Je neemt je voor vanavond vroeg naar bed te gaan, maar gaat toch Netflix kijken, je neemt je voor te minderen met drinken, maar trekt toch automatisch een wijntje open bij een feestelijk diner. Dit is het traditionele beeld dat veel mensen hebben van self-control: een gevecht tegen verleidingen door middel van wilskracht. Het weerstaan van verleidingen wordt vaak als een deugd op zichzelf gezien.

Maar waarom weerstaan we verleidingen? Waarom oefenen we self-control uit? Dit doen we omdat we bepaalde doelen willen halen, doelen die voor ons belangrijk zijn, doelen die een uiting zijn van onze waarden. Self-control gaat niet alleen over onze intenties uitvoeren, maar vooral ook over het sturen van ons eigen gedrag in een bepaalde richting, over langere tijd, zodat we in staat zijn om onze doelen te halen. Deze vorm van self-control is instrumentele self-control. Intentionele en instrumentele self-control liggen in het verlengde van elkaar, maar hoeven niet op elkaar te volgen. Iemand kan intentionele self-control hebben, maar falen in zijn instrumentele self-control. Neem bijvoorbeeld iemand die zegt: 'vanavond is een leuke voetbalwedstrijd, en ik laat me helemaal gaan qua drinken'. Zo iemand lijkt in eerste instantie self-control te bezitten: hij heeft een intentie om te drinken, en voert deze uit. Echter, als we weten dat hij de volgende dag een belangrijk sollicitatiegesprek heeft voor een baan die hij heel graag wil, en waar hij al veel energie in gestoken heeft, en we weten dat als hij teveel drinkt de avond van tevoren hij zich waarschijnlijk verslaapt en het sollicitatiegesprek mist, dan kunnen we ons afvragen of hij wel zo self-controlled is. Een hiërarchisch model van self-control laat zien dat deze persoon wel intentionele self-control heeft, maar geen instrumentele. Instrumentele self-control kan uitgeoefend worden met wilskracht, maar ook met diachronische strategieën: bijvoorbeeld vragen of het sollicitatiegesprek

een dag eerder of later mag als je weet dat er een belangrijke voetbalwedstrijd is waarbij je waarschijnlijk gaat drinken, of door alleen alcoholvrij bier in huis te halen.

Bovenin de hiërarchie staat normatieve self-control. Normatieve self-control gaat over hoe we ons gedrag in overeenstemming brengen met de persoon die we willen zijn, en het leven dat we willen leven. Bijvoorbeeld: een roker haalt zijn kinderen uit school. Het regent. Op het moment dat hij bijna bij de school is merkt hij dat hij geen sigaretten meer heeft, hij draait om om eerst sigaretten te kopen, maar realiseert zich op dat moment: 'ik wil niet het type persoon zijn die zijn kinderen in de regen laat staan om sigaretten te kopen'. Vanaf dat moment stopt hij met roken.

Normatieve self-control wordt uitgeoefend door onszelf actief te zien als een bepaald type persoon. Als we ons zelfbeeld (her)definiëren worden ook bepaalde handelingen aannemelijker voor ons terwijl andere handelingen naar de achtergrond verdwijnen.

Normatieve self-control ligt in het verlengde van instrumentele self-control: projecten waar we ons aan wijden definiëren ons vaak als persoon, en hoe we onszelf als persoon zien bepaalt welke projecten we aan ons willen wijden. Maar instrumentele self-control hoeft niet noodzakelijkerwijs tot normatieve self-control te leiden. We kunnen bijvoorbeeld doelen nastreven die we niet normatief ondersteunen, bijvoorbeeld mensen die een carrière nastreven onder druk van hun ouders. Zij kunnen ontzettend succesvol zijn in het behalen van hun doelen, maar toch niet het leven leven dat ze willen leven. Normatieve self-control staat aan de top, want waar het uiteindelijk om gaat is of we in staat zijn het leven te leven volgens onze eigen waarden, en de persoon te worden die we willen zijn.

De huidige theorieën over verslaving en self-control richten zich vooral op intentionele en instrumentele self-control: op de capaciteiten die daarbij horen, en de bedreigingen van deze vormen van self-control. Echter, de normatieve kant van self-control, en de capaciteiten en bedreigingen die daarbij horen blijven vaak onderbelicht. Als we echter naar Nicole's verhaal kijken, dan zien we echter ook een complexe set van factoren die haar normatieve self-control ondermijnen: haar onzekerheid over haar identiteit, het gevoel dat haar lichaam getekend is door haar verslaving, de angst dat anderen dat deel van haar identiteit ziet dat ze

probeert af te schermen, en de invloed van de sociale context op haar waarden, keuzes en handelingen. Nicole's verhaal laat het belang van het zelf in self-control zien, en dit zelf is een belichaamd zelf, een sociaal zelf, en een narratief zelf. Als we deze factoren goed begrijpen, liggen hier ook belangrijke kansen voor herstel.

Een hiërarchisch model van self-control laat ook zien hoe de verschillende levels van self-control elkaar kunnen beïnvloeden, zowel positief als negatief. Self-control kan bottom-up worden uitgeoefend: als we handelen volgens onze intenties is het ook makkelijker om onze doelen te halen, en als we onze doelen halen, is het makkelijker om de persoon te worden die we willen zijn en het leven te leven volgens onze eigen waarden. Of, top down: als we onze normatieve doelen ineens scherp voor ogen zien, zoals de roker die zijn kinderen uit school haalt, is het makkelijker om te zien welke projecten daarbij horen en is het makkelijker om ons intentionele gedrag bij te sturen als we verleiding tegenkomen. Een hiërarchisch model van self-control laat ook zien dat er een bepaalde asymmetrie kan zitten in het level waarop self-control verloren wordt, en het level waarop het herwonnen wordt. Het hiërarchische model is niet alleen een goed hulpmiddel om te analyseren hoe mensen self-control verliezen in hun verslaving, maar ook welke mogelijkheden ze hebben om het te herstellen.

Het model is hiërarchisch, want hoewel alle drie de vormen belangrijk zijn voor succesvolle self-control, is om te beoordelen of iemand self-control heeft de normatieve self-control doorslaggevend. Waar het uiteindelijk om gaat is of mensen in staat zijn het leven te leven dat ze willen leven, en de persoon zijn die ze willen zijn, en niet of ze intentionele of instrumentele self-control hebben.

Leeswijzer

In hoofdstuk 1 beschrijf ik hoe de normatieve filosofie self-control met een geloofwaardig, hiërarchisch model komt om de spanning tussen intentionele en compulsieve elementen in verslavingsgedrag te verklaren. In hoofdstuk 2 analyseer ik de huidige theorieën over verslaving en self-control: de neurowetenschappen, het hersenziektemodel, keuzemo-

dellen uit de gedragseconomie, en morele en liberale keuzemodellen. Ik analyseer in welk vorm van self-control ze met name geïnteresseerd zijn. In hoofdstuk 3 beschrijf is de methodologie (In de bijlage wordt de methodologie ook nog uitgebreider besproken). Aan de hand van Nicole's casus laat ik zien wat het oplevert om self-control te analyseren binnen iemands narratieve en existentiële werkelijkheid.

In hoofdstuk 4 laat ik zien hoe identiteit, of zelfbeeld gedrag beïnvloedt, en bespreek ik empirische studies die laten zien hoe een veranderd zelfbeeld een rol kan spelen in herstel bij verslaving. Ik beargumenteer dat deze studies een veranderd zelfbeeld vaak presenteren als het gouden ei, een soort eureka moment waarna alles goed is. Echter, wat uit mijn empirische studie blijkt, is dat een veranderd zelfbeeld alleen vaak niet genoeg is. Nicole bijvoorbeeld beschrijft een veranderd zelfbeeld, echter, ze heeft het gevoel dat dit zelfbeeld bekritiseerd wordt door haar omgeving, en als de projecten falen die bij haar nieuwe zelfbeeld horen, geeft ze het op. Ons zelfbeeld wordt ook beïnvloedt door externe factoren die soms buiten onze invloedssfeer liggen: stigma, gebrek aan praktische mogelijkheden voor belangrijke projecten die onze identiteit ondersteunen, et cetera.

We zagen eerder hoe belangrijk het is voor self-control dat mensen zich normatieve doelen stellen, alleen dan kunnen we het leven leven dat we willen leven en de persoon zijn die we willen zijn. Wat echter sterk opviel tijdens de interviews, is dat als ik mensen vroeg naar hun plannen voor de toekomst ze vaak antwoorden: 'ik maak geen plannen voor de toekomst, ik weet niet eens of ik morgen nog wel leef'. Respondenten beschreven dat ze zoveel van hun vrienden hadden zien sterven aan een overdosis, of aan andere aandoeningen gerelateerd aan hun verslaving, dat ze weinig vertrouwen hadden in hun fysieke toekomst. In hoofdstuk 5 kijk ik naar hoe verslaving het lichaam verandert, en hoe dit self-control beïnvloedt. Ik laat zien dat de ervaringen van de respondenten sterke overeenkomsten vertonen met de ervaringen van mensen die chronisch ziek zijn. Beide beschrijven een gebrek aan energie, een veranderend uiterlijk en de daarbij behorende sociale stigma en uitsluiting, en dat ze gedwongen worden de lange-termijn visie op hun leven los te laten en over te gaan op een korte termijn strategie: de dag doorkomen. Hoewel er veel medische literatuur is over hoe verslaving het lichaam aantast, worden deze conclusies bijna nooit doorgetrokken in wat het

betekent voor de autonomie van mensen met een verslaving. Het verlies van hun gezondheid, en een gezond uiterlijk wordt vaak gezien als de prijs die mensen met een verslaving moeten betalen voor hun gebruik, in plaats van dat het gezien wordt als een factor die het extra moeilijk voor ze maakt om te breken met hun verslaving. Deze bevindingen benadrukken het belang van harm reductie strategieën.

‘We zijn eigenlijk maar gewone mensen’, zei een van de respondent, ‘maar met heel gecompliceerde levens’. In hoofdstuk 6 laat ik zien hoe zware externe omstandigheden zoals hardnekkig armoede en stigma ervoor kunnen zorgen dat mensen hun normatieve doelen opgeven. Door herhaaldelijke tegenslagen raken mensen ervan overtuigd dat het leven dat ze ambiëren, de persoon die ze willen zijn, niet haalbaar is. Zij worden dan ‘resigned addicts’. Deze vorm van verlies van self-control wordt vaak slecht begrepen in de huidige literatuur. Resigned addicts worden nogal eens verward met willing addicts, mensen die gewoon het liefst drugs gebruiken. Omdat resigned addicts zich neergelegd hebben bij hun leven als verslaafden, beschrijven ze niet een strijd met hun middelengebruik, zoals unwilling addicts. Hierdoor is het makkelijk te denken dat ze kiezen voor hun verslaving, of gewoon geen beter leven weten. Ik beargumenteer echter dat ze wel degelijk een ander leven verlangen, maar het streven ernaar opgegeven hebben.

In hoofdstuk 8 beschrijf ik het herstel van Tom, dat zich over een aantal jaren hard werken uitspreidt. De eerste keer dat ik Tom interview heeft hij net, een aantal weken daarvoor ternauwernood een overdosis overleefd. Na zijn overdosis begint hij weer te gebruiken, maar heeft ineens, wat hij zelf noemt, een helder moment. Daarin beseft hij hoeveel pijn hij de mensen om zich heen doet met zijn verslaving, zijn vrouw, zijn moeder. Hij herinnert zich dat hij eigenlijk altijd een heel sociaal iemand was, een helper. Hij nam het op voor kinderen die gepest werden, nam zwerfhonden mee naar huis, en kinderen die nergens terecht konden. Tom beschrijft hoe belangrijk methadon voor hem in geweest om op adem te komen van zijn cravings zodat hij na kon denken wat hij met zijn leven wil. Hij beschrijft hoe hij langzaam, stap voor stap zijn hervonden identiteit als helper verankert in projecten, met vallen en op staan en veel sociale steun. Hij beschrijft hoe hij steeds meer in zichzelf begint te geloven, en dat hij hierdoor eindelijk de capaciteiten en strategieën begint te gebruiken die hij eigenlijk al jaren had.

Aanbevelingen voor de praktijk

Het analyseren van verlies van self-control in verslaving

- Een hiërarchisch model van self-control biedt belangrijke handvaten in het analyseren van controle verlies in verslaving. Het laat zien welke levels van self-control voor deze specifieke persoon aangetast zijn, maar ook hoe de verschillende levels elkaar kunnen beïnvloeden.
- De hoofdvraag moet altijd zijn: heeft deze persoon normatieve self-control? Lukt het hen om het leven te leven dat ze willen leven, en de persoon te zijn die ze willen zijn?
- Hiervoor is het belangrijk om te verkennen wat iemand hoopt, verlangt, en wat voor hem van waarde is. Maar ook: welke projecten horen hierbij, en geloven ze dat dit leven haalbaar is voor hen?
- Professionals en wetenschappers moeten oog hebben voor de autobiografische en existentiële context waarin mensen met een verslaving hun keuzes moeten maken en hun self-control moeten uitoefenen. Verslaving verandert niet alleen de hersenen van mensen, maar ook hun lichamen, hun sociale relaties, hun geloof in zichzelf en hun zelfbeeld.

Behandeling

- Verlies van self-control in verslaving wordt haast nooit veroorzaakt door slechts één factor, maar vaker door een set van interacterende factoren. Herstel en behandeling moet daarom gericht zijn op alle drie de levels van self-control.
- Het kan een valkuil zijn om te denken dat als intentionele of instrumentele self-control hersteld is, normatieve self-control zal volgen. Er moet ook specifiek geëvalueerd worden of normatieve self-control hersteld is na de behandeling.
- Voor mensen die het opgegeven hebben om zichzelf doelen te stellen, en die niet meer geloven in hun normatieve self-control kan narratieve therapie een uitkomst bieden. Narratieve therapie is met name veelbelovend voor mensen met weinig 'identity materials'. Echter, meer effectstudies naar narratieve therapie zijn nodig.
- Het werken aan, en slagen van kern-projecten, projecten die mensen nauw aan het hart liggen, kan helpen om een nieuwe identiteit te verankeren. Praktische, sociale, en gezondheidsproblemen frustreren

deze projecten vaak. Bijvoorbeeld: een strafblad, stigma, hepatitis C, het kwijtraken van een rijbewijs. Het is belangrijk om mensen in herstel te steunen in deze projecten door oog te hebben voor deze praktische tegenwerkingen.

- Langdurige verslaving kan mensen hun dagelijks ritme ernstig verstoren. Dingen die de meeste mensen op de automatische piloot doen, zoals tandenpoetsen, ontbijten, douchen, boodschappen doen, kunnen voor mensen met een verslaving erg veel energie kosten. Het herstellen van de dagelijkse routine kan ervoor zorgen dat er meer energie overblijft, zodat mensen over kunnen schakelen op een meer lange termijn visie op hun leven.
- Harm reductie strategieën zijn erg belangrijk, en moeten breed ingezet worden aangezien ze de fysieke schade die middelen toe kunnen brengen beperken. Dit is met name belangrijk omdat gezondheidschade ook het uiterlijk van mensen kan beïnvloeden, en dus ook hun sociale identiteit en zelfbeeld.
- In het verlengde hiervan is het belangrijk om een eventuele stigmatiserende houding van medisch personeel aan te pakken. Goede gezondheidszorg, versterkt door niet-oordelende professionals kan een immens verschil maken voor de normatieve self-control van mensen met een verslaving.

Beleid

- Decriminalisering van middelengebruik kan ervoor zorgen dat mensen die herstellende zijn van een verslaving minder praktische problemen ondervinden in hun herstel. Vergelijkbaar met hoe minderjarigen hun strafblad kwijtgescholden krijgen als ze 18 zijn, kan erover gedacht worden om kleine vergrijpen kwijt te schelden als mensen in herstel zijn.
- Een niet-straffende houding naar mensen met een verslaving toe is belangrijk. Veel mensen met een verslaving worstelen met een negatief zelfbeeld. Wat ze nodig hebben van hun omgeving is niet nog meer oordelen, maar een houding van ‘verantwoordelijkheid zonder schuld’, zoals ontwikkeld door Hanna Pickard. We kunnen mensen verantwoordelijk houden voor hun gedrag en tegelijk compassie hebben voor de factoren die het hen bemoeilijken om hun gedrag te reguleren. Op deze manier nemen we mensen serieus, houden we

ze verantwoordelijk voor de keuzes die ze maken, maar erkennen we tegelijk de factoren die hun keuzevrijheid beperken.

Hoe iemand te steunen met een verslaving

- Zie het punt hierboven: naasten van mensen met een verslaving kunnen een houding aannemen van ‘verantwoordelijkheid zonder schuld’. Deze houding neemt mensen met een verslaving serieus, en houdt ze verantwoordelijk voor hun gedrag, maar straft niet als zij falen.
- Respondenten beschreven hoe belangrijk het voor hen was dat iemand in hen geloofde, dat iemand zei dat er, ondanks hun herhaaldelijk falen, toch hoop is voor hen, dat het leven dat ze graag willen leven haalbaar is voor hen. Naasten van mensen met een verslaving kunnen hen helpen om weer te geloven in hun normatieve doelen, om deze doelen in te kleuren, en erin te geloven.

CURRICULUM VITAE



Anke Snoek was born in the Netherlands and grew up in Cameroun, where her father was an agricultural developmental worker. She obtained her bachelor's degree and master's degree at the University of Humanistic Studies in Utrecht. During her master's she specialised in qualitative empirical research, philosophy, and counselling. Her master's thesis was on biopolitics, and was titled: 'What remains for human beings? On Agamben's naked life of the Homo Sacer'.

After completing her master's degree, Anke worked for four years at IVO Addiction Research Institute in Rotterdam. While working there she conducted numerous empirical projects on comorbidity, research methodology, prevention, and the vulnerability of young people to addiction. This resulted in the publication of several Dutch national treatment guidelines. She also worked on Joep Dohmen's *Art of Life* project of, which examines what philosophers can teach us about living well.

Between 2010 and 2016 Anke worked on her PhD thesis at Macquarie University in Sydney. During her PhD studies she was a visiting scholar at the Oxford Uehiro Centre for Practical Ethics, and wrote several guest posts on addiction for their blog. She was a guest editor for *Neuroethics*' special issue on the work of Marc Lewis and his challenge to the brain disease model of addiction.

The main focal point of Anke's work is the agency of marginalised people. Her interest is in identifying the means by which their agency is impaired as well as the inventive strategies they use to employ what is left of their agency. She published several peer-reviewed articles and book chapters on these issues. She also wrote the book *Agamben's Joyful Kafka: Finding Freedom Beyond Subordination* which focusses on the strategies Agamben offers us, inspired by Kafka, on how we can relate to biopolitical power.

She is now working on a postdoc at the University of Maastricht to develop a normative framework on how to intervene in families where one or both parents have an alcohol use disorder.

Anke lives in the Netherlands together with her partner and three children.



Addiction is often seen as synonymous with losing self-control. In this thesis I examine the various ways in which self-control can be impaired in addiction, and how self-control can be restored. I propose a hierarchical account that shows how the current, seemingly conflicting, theories on addiction and self-control relate to each other. I will argue that the current theories provide very valuable information on many of the challenges substance users face when exercising intentional or instrumental self-control. However, the current theories are incomplete because they largely stay silent on how normative agency is impaired in addiction. We cannot judge whether someone has impaired self-control solely by looking at the capacities they possess. We need to look at their self-concept and narrative understanding as well because this determines whether they will use their capacities. This insight into the importance of normative self-control became apparent during the longitudinal qualitative interviews I had with people dependent on alcohol, opioids and amphetamines. The image on the front visualizes the situation many chronic substance dependent people face. They often find themselves in a very deprived situation, with very little means to change their lives. However, change is sometimes set in motion when they can believe that a better life is possible for them, and that they are worth this change for the better. It is important to help addicted persons to connect with their image of their ideal future self, and restore their self-worth. This can happen in material ways (through housing and work projects), but also by showing trust in their agency and self-efficacy – by assuring them, in particular, that it is possible for them to live the life they value living and be the person they value being.