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# LESSONS FROM AKRASIA IN SUBSTANCE MISUSE:

## A CLINICOPHILOSOPHICAL DISCUSSION

### **Abstract:**

This article explores the philosophical concept of akrasia, also known as weakness of will, and demonstrates its relevance to clinical practice. In particular, it helps unpack an implicit notion of control over one's actions that might impede recovery in instances of substance misuse. Reflecting on three fictional case vignettes, we show how philosophical work on akrasia helps avoid this potentially harmful notion of control by supporting a holistic engagement with people, for whom substance misuse is an issue. We argue that such engagement enhances their prospects of recovery by focusing on agency over time as opposed to individual lapses.

**Declaration of Interest:** None.

### **1. Introduction**

Substance misuse is an important public health issue as well as a major clinical challenge (Nuffield Council of Biomedical Ethics 2007). Arguably, these aspects are intimately related. In public discourse, substance misuse is routinely associated with increased burden to national health and social services, loss of productivity and the commission of more or less violent criminal offences. These uniformly negative connotations reinforce some stigmatising attitudes toward substance misuse that might not only discourage people from seeking professional help in a timely fashion, but also stand in the way of successful recovery. In turn, the relatively high relapse rates (Levy 2013) exacerbate the negative impact of substance misuse on to public health widely construed. Philosophical work on the nature and scope of akrasia (Arpaly 2000; Davidson 2001; Radoilska 2013) offers a promising way of breaking out of this impasse by providing the conceptual resources required to challenge an implicit notion of control over one's actions that seems to be at root of the problem. While the article focuses on variant models of akrasia, the potential role of other relevant factors that could complement a holistic approach to a viable recovery plan is also acknowledged.

### **2. Substance misuse: Three fictional case vignettes**

#### **Case vignette 1**

### **Mr Miller: “Biological causation”**

Mr Robert Miller is a 65 year old retired Chief Executive. His mother died at the age of 82 years from “old age”. His father died at the age of 58 years from carcinoma of the oesophagus having been a heavy drinker throughout his adult life. Mr Miller was an only child and described a happy and stable childhood despite his father’s drinking. He excelled at school, enjoyed good peer relationships and obtained a first class honours degree at University. He married in his late 20s, had two children in his 30s, and in his mid-40s became the Chief Executive of a national company. He was described by his family as a good husband and father, with a reputation for honesty, integrity and fairness. Throughout his working life he drank alcohol most days, attributing this to the stress of his job and frequent socialising. In his early 60s he developed a tremor of his hands in the morning which he thought was anxiety. His wife and children became increasingly concerned about his drinking, especially as he was known on occasions to drink and drive. Under considerable family pressure he saw his GP and was referred for CBT to treat anxiety, stress and depression. He attended these sessions regularly but did not find them helpful and his drinking pattern did not change. Following a blood test to check thyroid function his GP detected markedly deranged liver function tests and referred him to a Consultant Psychiatrist who diagnosed moderate alcohol dependence. Mr Miller declined the offer of medication, believing that he was strong willed enough to reduce his drinking on his own, but he did accept two counselling sessions with a substance misuse liaison worker. When he was 64 years old he arrived home one evening after drinking and fell out of his car in a very intoxicated state. An ambulance was called and Mr Miller was taken to the A&E department. He was “terrified” that he would be reported to the Police for driving under the influence of alcohol, but this did not occur. The shock and embarrassment of this episode led him to accept treatment advice from his Consultant Psychiatrist, who arranged for a home detoxification followed by treatment with acamprosate 666mgs t.d.s., and disulfiram 200mgs daily which his wife promised to supervise “religiously”. For 6 months prior to his retirement Mr Miller complied with treatment. His wife, however, gave up supervising disulfiram after 3 months as she had started to “trust” her husband again. His mood was buoyant, his work performance strong and he looked physically fit, having lost weight. Against the advice of his Consultant Psychiatrist Mr Miller stopped taking medication one month prior to retirement so that he could “enjoy” his farewell party. He was convinced that he there would be no problems with alcohol after retirement in view of his clinical progress

and the future stress-free lifestyle he anticipated. He drank at his retirement party, relapsed back into uncontrolled heavy drinking and spent his early retirement days feeling depressed, deeply ashamed and bored. His very caring family were desperate for him to stop drinking and asked his Psychiatrist if he could be “sectioned”. After some persuasion Mr Miller had another home detoxification and restarted treatment with acamprosate and supervised disulfiram. He drank on top of his medication and started to talk about “checking out”, by which he meant committing suicide.

## **Case vignette 2**

### **Amy Parker: “Social causation”**

Amy Parker is a 21 year old mother of one child. She never knew her biological father. Her mother had multiple boyfriends who often brought alcohol and drugs into the home. As a young girl she was given alcohol and was sexually abused by a number of her mother’s temporary partners. Her educational performance was poor and she socialised with a group of students on the fringe of school life. At the age of 11 years she started smoking cigarettes and as a 13 year old she self-harmed by scratching the inside of her thighs with scissors, but this behaviour never came to the attention of her teachers or GP. By the age of 15 years she had used a wide range of “party” drugs. Social Services were temporarily involved when Amy was found living on the streets having stopped going to school. At the age of 17 years she smoked heroin and within 3 months was injecting into her arms and hands. Amy also used street diazepam, cheap alcohol and occasionally shared a pipe of crack cocaine. When she was 18 years old she developed a left sided DVT after injecting into her groin and was found to be hepatitis C positive. She became pregnant at the age of 19 years and this led to a remarkable change in her behaviour. Amy began to attend a Community Substance Misuse Team (CSMT) where she was started on a methadone prescription. Her medication was supervised on a daily basis at a local supermarket pharmacy and the dose was gradually increased to 120 mls methadone mixture 1mg/ml. This, together with the support of a substance misuse worker, appeared to help her stop using heroin and diazepam. A number of consecutive urine and swab tests were negative for illicit drugs. In view of being hepatitis C positive Amy was offered appointments at her local hospital antenatal department which she attended regularly. Towards the end of the second trimester she returned to live with her mother. Amy said that she was determined to give her baby the “best possible chance”, and was “desperate” to be a good mother and to care for her child well. Throughout her

pregnancy Amy received close support from a Community Midwife, Social Services and the CSMT. By the third trimester she was considered to have made excellent progress. In view of this, and continuing regular negative tests for illicit drugs, the pick-up regime of methadone was reduced to twice weekly. A small-for-dates baby boy was born in good health (apart from a squint) at 38 weeks gestation by spontaneous vaginal delivery. Amy experienced a short period of baby blues and did not take to breast feeding. Even with close support she found the routine of caring for her baby demanding and exasperating. Within two months of the birth Amy was no longer picking up her methadone on a regular basis and she began to make excuses for failing to attend her key worker appointments at the CSMT. When she did attend she said she was exhausted. A drug screen taken at 12 weeks post-delivery tested positive for heroin, cocaine and diazepam. Conflict with her mother accelerated when Amy started going out in the evenings leaving the baby in her mother's care. Her mother told the CSMT that Amy was "seeing" drug users and dealers she had relationships with in the past. Despite strenuous efforts and serious warnings from the CSMT, a Health Visitor and Social Workers from the Child Protection Team, Amy returned to her old pattern of injecting drug use and unstable relationships. Despite Amy's promises of improvement and pleas for clemency her son was eventually removed from her care and put up for adoption.

### **Case vignette 3**

#### **Peter Phillips: "Psychological causation"**

Peter Phillips is a 27 year old, ex-Army Corporal with no family history of psychiatric disorder. He was an average student, sporty, popular and outgoing. After leaving school he joined the British Army and excelled during basic training. He loved Army life, enjoying the hard work, discipline and camaraderie. At weekends he would drink heavily with his friends but this did not seem to impact on his work performance. His military Unit was closely knit, especially after their first tour of duty in Afghanistan. Whilst leading a night patrol during a second tour in Afghanistan, the soldier behind him stepped on a landmine. Peter was spattered with blood and shrapnel fragments but able to continue. The patrol came under heavy fire and the men ran for cover. Peter found himself in an irrigation channel with two friends. Whilst they attempted to provide covering fire Peter showed great bravery (later formally recognised), running back to the wounded soldier and dragging him 20 metres into

the ditch. Attempts were made to provide first aid, with tourniquets being applied to both leg stumps, but despite their best efforts the soldier died. Following this Peter said that his nerves were “shredded”. He felt constantly in danger, irritable, aggressive and guilty. After the tour in Afghanistan was over the Unit was sent to Cyprus for R&R. Peter got drunk every day, was argumentative and started getting into fights. Back in the UK he lost interest in Army life and continued to drink heavily. He made the decision to apply for premature voluntary retirement. His Unit Medical Officer referred him to a CPN at the military Department of Community Mental Health. The CPN thought that Peter had Post Traumatic Stress Disorder (PTSD) so provided an abbreviated form of trauma-focussed CBT and suggested to the Unit Medical Officer that a prescription of mirtazapine, 30mgs at night, might help. The treatment proved beneficial. Peter subsequently left the Army but found it difficult to obtain work. He continued to suffer intermittent nightmares of the incident in Afghanistan and drank half a bottle of vodka most nights as he was “frightened to go to sleep”. He was unable to maintain a stable relationship with a girlfriend and due to continuing unemployment he came under financial pressure. His previous symptoms of PTSD returned “with a vengeance”. His drinking spiralled out of control, he wet the bed regularly and suffered a bad bout of pancreatitis after which his GP told him to “completely and permanently abstain from alcohol”. However, Peter considered that using alcohol was the only way he could get to sleep and suppress the vivid memories, sense of danger, jumpiness and anxiety he experienced. Peter was arrested after attacking a stranger in a pub who criticised the Army and he ended up on a Probation Order. His Probation Officer arranged for referral to Psychological Services but, after waiting 4 months for an assessment, Peter was told that nothing could be done for him until he stopped drinking. Following referral to a Community Substance Misuse Team he received an in-patient detoxification during which he was re-referred to Psychological Services. Peter continuing to have nightmares of Afghanistan, feelings of anger and aggression, and panic attacks. He kept away from all reminders of military life and avoided watching TV news programmes. Within two weeks of leaving the detoxification unit he started to drink a bottle of vodka a day. He was again turned away from Psychological Services because of his alcohol consumption. Peter has managed to get a job as a Car Park attendant but is still drinking very heavily and suffering from PTSD. He says he “hates the taste” of alcohol and wants to stop drinking, but he fears he might kill himself as he cannot cope with his nightmares, loneliness and sense of guilt.

### **3. Voluntary action as intention implementation and its implications for substance misuse**

The model of action as implementation of prior intention (Gollwitzer 1999; O'Connor and Sandis 2012) offers a plausible way of explaining voluntary, viz. intentional actions as opposed to coerced ones. Following this line of thought, voluntary actions could be fully accounted for by an agent acknowledging:

‘I did  $\phi$  because I wanted to  $\phi$ ’ in so far as this means

‘I did  $\phi$  because I like/ care about  $\phi$ -ing’ or

‘I did  $\phi$  because, by  $\phi$ -ing, I get [closer to] x, y, z that I like/care about’.

In contrast, coerced actions are not accurately explained by pointing to the fact that the agent consented to perform them. Even a first-person account, such as ‘I did  $\phi$  because I wanted to  $\phi$ ’ remains insufficient. In instances of coercion, this statement stands for:

‘I did  $\phi$  because I was made to [want to]  $\phi$ ’ or

Unless I  $\phi$ -ed, x, y, z that I like/care about, would have been lost or damaged. So, I did  $\phi$ ’ (cf. Radoilska 2013b).

The distinction between these two categories of actions, voluntary and coerced, is central to our thinking about intentional agency in terms of authorship and ownership of actions. In particular, it helps to pin down the idea of an agent as the ultimate source of actions, which are free, intentional, and uncompelled. At the same time, however, the basic structure of action that the distinction builds upon might not be as helpful once we go beyond the one-step everyday actions, such as making a cup of tea or catching a train that contribute to the intuitive appeal of this model. This is because the notion of action as implementation of prior intention hangs on two underlying presuppositions that do not justice to the variety of forms that intentional agency might take. According to the first presupposition, voluntary actions flow from an explicit decision or choice made by the agent. According to the second, in the absence of coercion, the application of direct conscious effort is sufficient to translate such a decision into action.

Applied to substance misuse, this conception of voluntary action would support two possible alternatives. On the first, substance misuse is voluntary and therefore either chosen by the agent or resulting from his or her unwillingness to make the effort required to control

problematic consumption. On the second alternative, substance misuse is involuntary. The agent is deemed unable to exert control over this aspect of his or her behaviour.

Adopting the first alternative leads to a criminal model of substance misuse (Morse 2000). On this model, substance misuse boils down to a kind of transgression or dereliction of duty that is best tackled by the implementation of strong disincentives or penalties, whose role is to provide a reliable deterrent. Elements consistent with the criminal model of substance misuse can be observed in the treatment of ‘Amy Parker’ and ‘Peter Philips’, two of the fictional case vignettes we propose for discussion in this article: Amy is faced with the deterrent of having her child put for adoption unless she manages to ‘stay clean’ (**Case Vignette 2**), while Peter can only access much needed Psychological Services if he abstains from alcohol (**Case Vignette 3**).

Adopting the second alternative leads to a medical model of substance misuse. On this model, substance misuse points to aetiology that may include biological, social or psychological causes beyond personal choice and control. The proposed case vignettes can be read as illustrations of the aforementioned kinds of causation: e.g., ‘Mr Miller’ – biological, Amy – social, and Peter – psychological. In other words, substance misuse is taken to indicate certain passivity on the part of the user to the extent that, like any illness, it is something that happens to them instead of being done by them (Frankfurt 1971). The underlying intuition is made particularly salient in Mrs Miller’s request that her husband be sectioned since he is unable to control his alcohol consumption (**Case Vignette 1**). Treatment is called for to compensate for an agent’s apparently insufficient control over a particular aspect of his or her behaviour.

The coexistence of these alternative models leads to an apparent dilemma in societal as well as clinical responses to substance misuse: to treat, endorsing the medical model, or to deter and penalise, endorsing the criminal one. Both responses however imply that, in so far as substance misuse is an illness rather than a personal choice, no responsibility attaches to it. Furthermore, whenever responsibility for substance misuse comes to the fore, it is captured as much as possible in value-neutral terms. The underlying ambition, to avoid stigmatising further people for whom substance misuse is an issue, is understandable. Nevertheless, the resulting strategy is counterproductive as it suggests that responsibility for substance misuse can be assessed from the third-personal perspective of an impartial and expert observer. In so doing, it inadvertently underwrites the objectifying attitudes toward vulnerable agents that it



means to avoid. Box 1 summarises the key issues and problem areas arising from understanding akrasia on the model of voluntary action as implementation of prior intention.

#### **4. Philosophical work on akrasia**

Philosophical discussions of akrasia challenge the basic model of voluntary action as intention implementation. In this respect, they can be of direct relevance to clinical practice: by revising this model, it becomes possible to develop a better strategy for addressing substance misuse, beyond the limitations of the medical and criminal alternatives. To identify possible lessons from akrasia, this section first offers a concise overview of two classical conceptions, Plato's and Aristotle's. It then recaps central tenets of Donald Davidson's conception of weakness of will, which has been instrumental in shaping contemporary thinking on this issue.

##### **Plato and Aristotle on akrasia**

Plato's and Aristotle's theories of akrasia are of major philosophical interest in their own right; furthermore, their influence can be readily felt in the current debates on this topic. Protagoras and Nicomachean Ethics, Book VII are the two main texts presenting their respective positions – the first rejecting, the second defending the possibility of akrasia. An additional source is the Republic, Book IV in which Plato draws a more nuanced picture.

Importantly, both Plato and Aristotle discuss akrasia as an irreducibly ethical issue. For instance, Plato's rejection of akrasia is grounded in the so-called Socratic intellectualism: the idea that no one does wrong knowingly. On this view, what looks like an akratic behaviour, such as jeopardising long-term projects for the sake of instant gratification is recast as being mistaken about what really matters. In other words, akrasia amounts to a kind of ignorance or cognitive failure rather than a failure of self-control. This cognitive failure is explicitly defined in ethical terms: an akratic person is ignorant about ethical matters and this ignorance constitutes a distinct character flaw. Box 2 summarises Plato's view of akrasia in the context of substance misuse.

Aristotle moves away from the Socratic intellectualism by introducing the notion of an apparent conflict of values. In essence, an akratic person mistakenly perceives good and pleasant courses of action as mutually exclusive. The former are deemed as difficult and unrewarding albeit valued, the latter, as immediately gratifying yet ultimately worthless. And so, akratic action is a response to the appeal of pleasure that is disvalued, in the face of

valuable but challenging alternatives. On this picture, confused cognition and faltering self-control are intertwined: disvalued courses of action seem pleasant to an akratic person only as a result of akrasia. Once indulged, they, inevitably, turn out to be disappointing. Similarly, valuable courses of action forgone as difficult and unrewarding only appear so through the lens of akrasia. Awareness of lost opportunities contributes to the underlying frustration of the akratic experience, which offers but dissatisfying pleasure.

As illustrated in Box 3, in terms of ethical assessment, Aristotle's model of akrasia points to a kind of weakness rather than wrongness. This becomes apparent, if we consider the four main features of this model, which can be summarised as follows:

- firstly, akrasia is a character disposition between virtue and vice. It cannot be assimilated to either;
- secondly, akrasia is closely related to another character disposition, enkrateia or strength of will. They both share the confused conception of good being incompatible with pleasure;
- thirdly, failing self-control is only an indication rather than a defining feature of akrasia; and
- fourthly, unlike vice, akrasia can be overcome over time. This is achieved via a two-stage process, which starts with an akratic agent moving toward an enkratic pattern of action, whereby akratic pleasures are avoided but nevertheless missed, and ends with the now enkratic agent coming to appreciate valuable activities as inherently rewarding and enjoyable. This corrected evaluative perspective effaces the appearance of conflict between pleasure and goodness that motivates akrasia.

### **Davidson on weakness of will**

Donald Davidson's seminar paper 'How is weakness of the will possible?' (2001) brought the topic into prominence in contemporary philosophy. Since its original publication in 1970, it has served as a standard, in relation to which later conceptions of akrasia are often defined. According to Davidson, akrasia or weakness of will is acting – knowingly and willingly – against one's better judgment. He argues against the then dominant view, according to which akrasia is merely apparent and not a real issue since it is impossible to sincerely make an evaluative judgment, such as 'Drink is bad for me' without at the same time being motivated to abstain from drinking (cf. Hare 1952). Davidson addresses this challenge by showing that although we cannot go against unconditional evaluative judgements of ours we can go against

all-things-considered judgments, such as ‘Overall, drink is bad for me’ by thinking along the lines ‘yet, this drink will relax me’. The capacity of bracketing out our own all-things-considered judgements in this way makes akrasia possible. Box 4 indicates how Davidson’s view could be applied to instances of substance misuse.

In later works, Davidson (e.g. 2004) pursues further this line of thought to reach the conclusion that akrasia is a form of irrationality resembling self-deception. This is because akrasia derives from holding a contradictory, hence irrational, judgment, such as ‘Drink is bad and at the same time good for me’ concealed from the conscious mind. Instead, the contradiction takes the form of two mutually exclusive judgments: ‘Drink is bad for me’ and ‘Drink is good for me’ that are kept separate by an underlying mechanism of mind-partitioning. As a result, the irrationality of akrasia hardly ever comes to the fore at the point of akratic action.

The Davidsonian account of akrasia has four main features:

- firstly, akrasia is different from other failures of rationality, such as ambivalence, procrastination or indecisiveness;
- secondly, it points to a failure to exercise rational self-control when this is clearly within one’s remit;
- thirdly, this failure is defined in prudential as opposed to moral terms – acting against one’s own better judgement; and
- fourthly, akrasia is exemplified in individual actions as opposed to patterns of behaviour over time.

Alternative conceptions of akrasia, such as Bratman (1979) and Holton (1999) challenge the fourth feature and argue that akrasia is a failure of maintaining stable intentions over time. Nevertheless, they share the key aspects of the conceptual framework set out by Davidson that are of particular relevance to clinical practice: akrasia is seen as a prudential, not a moral failure of self-control. There are three further theoretical paradigms, from which the issue of akrasia could be explored: 1) theories of volition in neuroscience, psychology and the social sciences emphasising readiness potential (Mele 2012; Walter 2012) 2) philosophical discussions of free will engaging with issues, such as determinism, indeterminism and compatibilism (Bishop 20012; Nahmias 2012), and 3) interdisciplinary work on motivation and resilience (McGregor et al. 2009). For the purposes of the present discussion, it is important to note that in spite of significant differences at methodological and conceptual

level, all three paradigms share the feature of considering self-control from a prudential as opposed to moral perspective.

## 5. Discussion

At first blush, there is a clash between classical and contemporary approaches to akrasia or weakness of will: the former opt for an ethical, the latter for a prudential appraisal. However, a closer look reveals that the underlying contrast is of degree or emphasis only. Classical approaches of akrasia avoid the stigmatising implications associated with a moralised attitude to failing self-control. In this respect, they are well-suited to address timely concerns about the ‘vindictiveness’ of responsibility talk in the context of substance misuse and substance dependence (Poland and Graham 2011). Arguably, the classical approaches fare better than recent attempts to sketch a secondary notion of responsibility, such as ‘responsibility without blame’ (Sinnott-Armstrong and Pickard 2013). The reason for this is twofold. Firstly, no stigmatising effect arises from discussing akrasia in ethical terms as long as the first-personal perspective of akratic agents is treated on a par with the third-personal perspective of experts, observers and other interested parties. This is because stigmatisation does not flow from ethical considerations about akrasia. Instead, it derives from the implicit imbalance of third- and first-personal standing that comes with insulating expert from ethical discourse. Secondly, by employing an explicit ethical vocabulary for understanding and appraising akrasia, the classical approaches counterbalance the objectifying trend of a third-personal narrative whereby a ‘patient’ is someone who is ‘acted upon’ and ‘passive’. In particular, by acknowledging substance misuse as something that a person does rather than something that happens to a person, an ethical outlook on akrasia strengthens the foundations of personal agency. In so doing, it provides the conceptual resources needed for engaging people with problematic substance use as full members of the moral community.

Broadening the prudential interpretation of akrasia to encompass explicit ethical considerations has the welcome upshot of deemphasising self-control in terms of direct conscious effort over individual actions. As clarified in Section 3, the model of voluntary action as implementation of prior intention does justice only to some basic one-step actions but cannot be helpfully generalised to account for agency over time.

In the context of substance misuse, this basic model happens to support an unhelpful focus on ‘relapses’ as indicative that ‘all is lost’, as poignantly illustrated by the fictional case

vignettes presented in Section 2. ‘Mr Miller’, ‘Amy Parker’ and ‘Peter Philips’, all are

Use of the	Agent	Cognition/Intention	Control/	Action	Observer’s
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expected and expect of themselves to somehow take control over substance use rather than revisit their projects and commitments as a whole. Yet, on reflection, the underlying compartmentalisation – problematic ‘out of control’ behaviour, on the one hand, and on the other, meaningful occupations, such as employment, family life and child care – is unsustainable. This is because both sides of life – problematic and meaningful – are perceived through the lens of the basic model of voluntary action, which in fact is inadequate for either. As shown by recent philosophical work (Radoilska 2013a), this model explains well only lesser, secondary actions at the periphery of intentional agency. The fact that these actions are relatively frequent in our everyday lives does not change their conceptual status, which is derivative. By setting aside the model of voluntary action as intention implementation, this new theory allows us to adopt a holistic approach to personal agency as actualisation of a person. On this theory, problematic aspects can be readjusted once they are recovered as expressions – be it peripheral – of a self. In other words, by putting back agency at the heart of action, philosophical work on akrasia can be usefully integrated into a viable recovery plan that turns patients into lead agents.

Additional factors that could complement the holistic approach include: 1) maintaining stable intentions over time (Bratman 2007), 2) improving participation and 3) nesting intention implementation within a behavioural modification network (Schweiger Gallo 2009), all of which can be achieved by putting in place structures of positive behavioural support (Gore et al. 2013).

## 6. Conclusion

This article identified and explored lessons from akrasia that could inform clinical practice in cases of substance misuse. In particular, we articulated the negative implications of an intuitively appealing yet misleading model of voluntary action as implementation of prior intention. We then expanded on an alternative model of action as actualisation and showed its advantages in supporting a holistic approach to personal agency in the context of substance misuse.

<b>will</b>			<b>Implementation</b>		<b>response</b>
Voluntary,	‘me’, fully responsible	I freely intend to do x	Conscious effort	I do x (what I intend)	
	e.g. Peter Phillips	I choose to drink (even though they won’t let me get psychotherapy for my PTSD);	<b>Transgression</b>	I drink	Penalise
	e.g. Amy Parker	I choose to use drugs (even though I don’t want to lose my baby)	<b>Dereliction of duty</b>	I take drugs	Penalise/criminalise
Voluntary but coerced	‘me’, not fully responsible	I do not want to do x but if I don’t do x there are disadvantages	<b>Conscious effort too weak</b>	I do x (but it’s not really what I want)	
	e.g. Robert Miller	I do not want to drink but I crave for alcohol	<b>I try hard but the desire to drink overcomes me</b>	I drink (but I don’t really want to drink)	Medicalise

**Box 1: Understanding ‘weakness of will’ (akrasia) in terms of an ‘action’ being the implementation of an intention (problem areas in red):**

**Box 2: Plato’s view of weakness of will applied to substance misuse (problem areas in red):**

<b>Agent</b>	<b>Cognition/Intention</b>	<b>Control/implementation</b>	<b>Action</b>
‘me’, ignorant of ethical values	<b>I freely intend to do x instead of y, because I don’t know that y is more important than x</b>	Conscious effort	I do x
e.g.	<b>I intentionally take drugs, but should have known better</b>	Conscious effort	I take drugs, because I don’t know what is best for me

**Box 3: Aristotle's view of weakness of will** (problem areas in red):

Agent	Cognition/Intention	Control/implementation	Action
e.g.	What is good and highly valued is not pleasant	Confused effort	I do what is good (which is unpleasant)
	and		or
	What is pleasant is not good and is not highly valued	Confused effort	I do what is pleasant (but of no good)
	I keep away from drugs and alcohol	Confused effort	I'm healthy and abstinent (which is hard, miserable and boring)
	I use drugs and alcohol	Confused effort	or I use drugs and alcohol (which I like, but I know I'm wasting my life)

**Box 4: Davidson's view of weakness of will** (problem areas in red):

Agent	Cognition/Intention	Control/implementation	Action
'me', with an irrational mind able to hold opposing ethical values	It is best if I do not do x because I know it is wrong or harmful,  but  right now in this particular instance I think it is worth doing x	Conscious effort	I do x  I know x is against my own better judgement  I could refrain from doing x if I wanted

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### **Learning Objectives**

1. Understand the implications of the intention implementation model of action for treating substance misuse.
2. Appreciate the relevance of philosophical work on akrasia for supporting recovery from substance misuse.
3. Weigh up the advantages of applying alternative models of intentional agency in clinical responses to substance misuse.

### **MCQs**

Select the single best option for each question stem

1. The intention implementation model of voluntary action:
  - a. endorses a holistic view of agency
  - b. cannot account for coerced actions
  - c. helps avoid judgmental attitudes toward patients with substance misuse
  - d. supports the first-personal perspective of patients as agents
  - e. emphasises a potentially unhelpful notion of control.
2. On Plato's conception, akrasia:
  - a. has no ethical significance
  - b. is caused by an overwhelming appetite for pleasure
  - c. cannot be cured
  - d. is a distinct cognitive failure
  - e. never actually takes place.
3. On Aristotle's conception, akrasia:

- a. is just another vice
  - b. is defined by lack of self-control
  - c. only offers disappointing pleasures
  - d. can be helped by the conscious exercise of willpower
  - e. derives from a genuine conflict of values.
4. On Davidson's conception, weakness of will:
- a. is acting knowingly and willingly against one's better judgment
  - b. is very similar to other failures of rationality, such as procrastination
  - c. amounts to changing one's mind too often
  - d. cannot be explained from a value-neutral perspective
  - e. is an everyday phenomenon.
5. The model of action as actualisation:
- a. insulates expert from ethical discourse
  - b. treats patients with substance misuse as fully responsible agents
  - c. supports the programme of 'responsibility without blame' in clinical responses to substance misuse
  - d. deemphasises self-control
  - e. promotes a compartmentalised approach to patient well-being.

Answers: 1e; 2d; 3c; 4a; 5b