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Autonomy and addiction

Abstract

Can someone with an addiction make autonomous decisions? There is a lot of disagreement about the nature of addiction and what things count as addictions. In order to decide whether someone with an addiction can make an autonomous choice, I first consider what constitutes an addiction, and then I characterize the psychology and behaviour of someone with an addiction. I sketch out which conditions justify calling choices 'non-autonomous' and how the choices of someone with an addiction could be considered 'autonomous' choices.

INTRODUCTION

Can someone with an addiction make autonomous decisions?

People who use drugs, especially mind altering drugs are generally viewed as the paradigm of the non-autonomous person and the image is probably clearest when we think of a heroin user who is addicted and seems unable to resist the desire for the drug.[1] In order to assess whether a person addicted to drugs can make an autonomous decision, it is important to consider what constitutes an addiction. There is a lot of disagreement about the nature of addiction and also about what things count as addictions. I look mainly at heroin and I argue that although heroin can interfere with autonomy there are circumstances in which heroin addicts can and do make autonomous decisions. It is important to note that I am not arguing that they *should* be able to make autonomous decisions or that they *should* be able to stop taking drugs.

The question of autonomy is relevant if we want to know whether someone can autonomously refuse treatment for their addiction, whether someone can autonomously *continue* to take a drug such as heroin, or whether an addicted drug user can autonomously volunteer to be a research subject, particularly when payment is involved.[2]

I begin in the next section by describing what makes a decision autonomous. In the following sections I look at the nature of addiction, the psychology and behaviour of someone with an addiction, and the relationship between autonomy and addiction.

AUTONOMY

In order for a decision to be called autonomous, a person needs to be able to understand and appreciate the circumstances of the decision. Autonomy is primarily about having the right kind of thinking. A person who chooses autonomously reflects critically and makes decisions backed by reasons. This involves higher order reflection. When questioned, they are able to critically reflect about whether their decision fits in with the kind of life that they want to lead and they are able to defend their choices in terms of their own values. This is not necessarily the same thing as following a life plan. It could involve briefly held values. Nevertheless, autonomous decisions *reflect* a 'fundamental commitment' about how a person wants to live. A person making an autonomous choice is aware of influences on their deliberation and their reflection undergoes scrutiny. Autonomy on this account is assessed according to the way a person reasons and it involves rationality. Finally, autonomous choices do not have to be 'good' or palatable choices.

Obstacles to autonomous choice are things that prevent critical reflection. A person cannot choose autonomously if they have severe cognitive impairment, if they are brainwashed, coerced, deluded and disturbed, if they lack understanding or if they are choosing from fear or

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[1] Dan Brock, 'The Use of Drugs for Pleasure: Some Philosophical Issues', Thomas H. Murray, Willard Gaylin, and Ruth Macklin (eds) *Feeling Good and Doing Better: Ethics and Nontherapeutic Drug Use*, Humana Press, New Jersey, 1984, [pp.83-106], pp.103-4

[2] Craig Fry & Robyn Dwyer, 'For love or money? An exploratory study of why injecting drug users participate in research', *Addiction*, 2001, 96, [pp.1319-1325], p.1319

severe depression. Depression rules out autonomy if it is severe enough to prevent critical reflection but less severe depression is compatible with autonomy. Finally, a certain amount of rationality is necessary for autonomy and for consent to have meaning.[3]

The notion of autonomy I am using is a *descriptive psychological* theory.[4] It tells us how to identify autonomous from non-autonomous decisions and it gives us a clear picture of what it takes to make an autonomous decision. It is derived from Gerald Dworkin's theory involving higher and lower order desires; having desires about desires.[5] My view however, is *task related* rather than a global concept. This will be covered in the discussion that follows.

WHAT CONSTITUTES AN ADDICTION?

We may wonder if substances cause addiction, whether exposure to a substance causes it, or whether a susceptibility to addiction is a trait of some people - something internal to the person. We need to look at what causes or explains addiction because what we find may impact on our assessment of autonomy.

When we say someone is an addict or is addicted we are generally referring to chemical or substance based addictions such as addiction to alcohol, opiates, cocaine, amphetamines, nicotine and caffeine.[6] It is unlikely however, that the answer to what makes these substances addictive is to be found in the substances themselves. Chemically, structurally and pharmacologically, they have no common features. Some are stimulants and some are sedatives.[7] Family and adoption studies suggest the tendency to abuse drugs is not substance specific but a heritable tendency 'toward substance abuse in general'.[8]

Sometimes when we talk of addictions we are also referring to activities and behaviours e.g. being addicted to gambling, to eating or to exercise. It seems that the criteria by which psychologists and psychiatrists formally define substance dependence can also apply to a variety of activities. People who watch a lot of television meet the criteria when they 'strongly sense that they ought not to watch as much as they do and yet find themselves strangely unable to reduce their viewing.'[9]

The distinction between a substance based addiction and one that is a behavioural trait is not a clear distinction. Being addicted to substances can also be explained in behavioural terms or in terms of activities such as drug seeking. And, some behaviours which are described as addictions can also be explained in terms of chemicals or biology. Gamblers get the same rush of dopamine when they win money as cocaine addicts get when they have a fix. And, some people claim that social conditioning may have a role in becoming addicted to drugs. One study using macaque monkeys grouped so that they formed social hierarchies, found that these social clusters 'appeared to trigger a change in brain chemistry.' With free access to injectable cocaine which raises dopamine levels in the brain, the subordinate monkeys injected themselves more and with higher amounts of heroine than the dominant monkeys. While cautious about drawing

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[3] Autonomy requires more than rationally pursuing goals; it also requires that people not be deluded about the nature of their goals and the consequences of their actions.

[4] Autonomy is spelt out in terms of the psychology of an agent. See Merle Spriggs, *Autonomy and patients' decisions*, PhD thesis, Monash University, 2001

[5] Gerald Dworkin, *The theory and practice of autonomy*, Cambridge University Press, Cambridge, 1988.

[6] Jon Elster and Ole-Jorgen Skog (eds), *Getting hooked: Rationality and addiction*, Cambridge University Press, Cambridge, 1999, p.5

[7] Eliot L. Gardner and James David 'The nuerobiology of chemical addiction', in Elster and Skog 1999, op. cit., [pp.93-136], pp.98-100.

[8] William R. Clark and Michael Grunstein, *Are we hardwired?* Oxford University Press, Oxford, 2000, p.200

[9] Robert Kubey and Mihaly Csikszentmihalyi, 'Television addiction is no mere metaphor', *Scientific American*, 2 February 2002. Referring to Robert D. McIlwraith, '"I'm addicted to television": The personality, imagination, and TV watching patters of elf-identified TV addicts', *Journal of Broadcasting and Electronic Media*, Vol. 42, No.3, [pp.371-386], this article also notes that some researchers would not call television addictive because although 'displacement of other activities by television may be socially significant', it falls short of 'the clinical requirement of significant impairment'.

parallels with human behavior, the researchers claim the study may explain why some people 'can be exposed to hard drugs yet not become enslaved to them.' It was suggested that the monkeys were 'self-medicating to compensate for below-par dopamine function' and that 'low social standing may be a predictor of whether a person will succumb to hard drugs.'[10] Peer pressure is also implicated in addiction. Some people argue that peer pressure and substance availability are consistently evident factors in pushing susceptible persons towards substance abuse and addiction.[11]

With regard to opiate addiction, epidemiologic data suggest that those who experience the greatest exposure have the highest rates of addiction. In his history of opiate addiction in America, David Courtwright notes that 'the outstanding feature of 19th Century opium and morphine addiction was that the majority of addicts were women', typically middle-aged white women of the middle or upper classes. This came about because, prior to 1900, doctors liberally dispensed opium and morphine to their patients. Physicians had a high rate of addiction too. Physician was the leading occupation of male addicts.[12] In light of this, Courtwright claims that there is little in the historical record to contradict the 'blunt' but 'essential insight' of William S. Burrough that: 'By and large those who have access to junk became addicts … There is no pre-addict personality anymore than there is a pre-malarial personality…'[13]

People who use drugs for medical reasons tend not to be classed as addicts. *Cancer Pain Release,* a publication of the World Health Organization, has published a summary of studies providing evidence that the medical use of opioids rarely leads to addiction. These surveys involve diverse patient populations including patients who self-administer opioids following bone marrow transplantation.[14] Some of these studies find that psychological dependence seems to be rare also.[15] Some of the authors in the WHO publication suggest that addiction is a psychological state rather than a 'physical dependence' but it is not psychological *dependence* that is being suggested – instead it is described as a 'dysfunctional psychological and behavioural syndrome.'[16]

'Hierarchies of appetitiveness' can be established between different classes of addicting drugs e.g. crack cocaine is extremely appetitive; morphine moderately so; and benzodiazepines marginally appetitive.[17] Judged by a lack of physical withdrawal symptoms however, cocaine does not create the same level of physical dependence. This suggests that addiction may be more closely tied to a psychological state [18] and the position taken by the World Health Organization (WHO) seems to support this. According to the WHO 'a cancer patient who is

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[10] Anjana Ahuja 'Abject lesson from simian coke addicts' *The Australian*, January 29 2002, p.15

[11] Clark and Grunstein op. cit., p.218

[12] David T. Courtwright, *Dark paradise: A history of opiate addiction in America*, Harvard University Press, Cambridge, 2001, pp.1&6

[13] ibid.

[14] 'Research in cancer pain and palliative care: Pain, opioid use and the incidence of addiction', *Cancer pain release*, Vol.11, No. 3, 1998. Accessed January 2002 at http://www.medsch.wisc.edu/WHOcancerpain/eng/11_3/research.html
Chapman CR, Hill HF. 'Prolonged morphine self-administration and addiction liability: Evaluation of two theories in a bone marrow transplant unit. *Cancer* 1989, Vol.63, [pp.1636-1644]

[15] *Cancer pain release*, op. cit., see especially Porter, J, Jick H. 'Addiction rare in patients treated with narcotics' *New England Journal of Medicine* 1980, Vol.302, p.123

[16] Sophie M. Colleau and David E. Joranson, 'Tolerance, physical dependence and addiction: Definitions, clinical relevance and misconceptions' *Cancer pain release*, Vol.11, No. 3, 1998. Accessed January 2002 at http://www.medsch.wisc.edu/WHOcancerpain/eng/11_3/tpda.html
Portenoy R. K. 'Opioid tolerance and responsiveness: Research findings and clinical observations' in Gebhart G. F, Hammond D. L, Jensen T. S (eds), *Proceedings of the 7th world congress on pain*, Seattle, IASP Press, 1994, [pp.595-619]

[17] Gardner and David, op. cit., p.103

[18] Clark and Grunstein, op. cit., p.208

physically dependent (as manifested by withdrawal) is not considered dependent (i.e., addicted).'[19]

It seems that environmental, psychological, chemical or biological factors alone do not cause or explain addiction. Instead it seems to be a mixture of these factors but a psychological and behavioural state is obviously involved.

Harmful and harmless addictions

Addiction seems to be a matter of degree and some addictions are harmful while others are not. Addiction is generally viewed as a bad thing and there is a tendency to label things we don't approve of as addictions. In the public mind the image of an addict is typically based on the image of a down-and-out, street criminal or prostitute. Also, what we think about addiction' and those who are addicted can be based on our perception of who is addicted.[20] The common view of addiction causes people dying of cancer to suffer because of the fear of becoming addicted.[21]

In some cases, the circumstances which surround an addiction seem to be what determine whether an addiction is harmful or not. Caffeine is addictive but we don't generally view caffeine addiction as harmful. Many people allow themselves to become or remain addicted to caffeine. They may even think it enhances the pleasure of drinking coffee. Maintaining the addiction is not a problem but if supply dried up forcing the addict to go without or if the addict chooses to give up drinking coffee, withdrawal is merely 'uncomfortable'. It is 'not disastrous' for the addict.[22]

The circumstances of heroin addiction, on the other hand, seem quite different. It is more difficult to withdraw from heroin. It is illegal and expensive, there are risks involved in obtaining the drug, supply is not assured and the quality of the drug is not guaranteed.[23] There is also a danger of contracting AIDs. Although it has been argued that 'many of the evils of addiction' are 'the 'product of the illegality of drugs and not of their pharmacology'[24] the consequences of addiction to heroine can be harmful in other ways. The literature on opiate use prior to drug laws supports this view.[25]

The remainder of my discussion focuses on harmful addictions such as alcohol and heroin – mainly heroin.

WHAT DOES IT MEAN TO BE ADDICTED?

The psychology and behaviour of someone who is addicted

Someone who is addicted has strong desires but not all strong desires are addictions. Graham Oddie explains that there is a difference between addictive desires and strong desires such as wanting to floss teeth at bedtime or wanting to have a gin and tonic. According to Oddie, we see the difference if we contrast an alcoholic's desire for a gin and tonic with the strong desire of a non-alcoholic for a gin and tonic. The difference is that although the desires 'might be equally strong' it is difficult for the addict to 'dislodge' his desire without it being fulfilled. If his child required medical attention and if having the drink caused a delay that endangered the child,

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[19] WHO and the terminology of addiction,*Cancer pain release*, Vol.11, No. 3, 1998. Accessed January 2002 at http://www.medsch.wisc.edu/WHOcancerpain/eng/11_3/terminology.html
World Health Organization Expert Committee on Drug Dependence, *Twenty eighth report*, Series 836, Geneva, Switzerland, WHO, 1993; Joranson D. E., *Fear of addiction is an impediment to cancer pain relief: A proposal to the WHO Programme on Substance Abuse*, University of Wisconsin Pain Research Group/WHO Collaborating Center, Madison, Wisconsin, 1992. (Monograph)

[20] Courtwright op. cit., pp.1 & 88.

[21] Mark A. R. Kleiman, *Against Excess: Drug policy for results*, Basic Books, New York, 1992, p.34.

[22] Graham Oddie, 'Addiction and the value of freedom', *Bioethics*, Vol. 7, No.5, 1993,[pp.373-401], pp.385-6

[23] ibid., p.386

[24] Douglas N. Husak, *Drugs and Rights*, Cambridge University Press, Cambridge, 1992, p.120

[25] Kleiman op. cit., pp.362-3, i.e. that heroin users take more from society than they give.

the alcoholic is 'less likely to be able to act on overriding factors.' The strength of the non-alcoholics desire 'can be moderated' by other considerations.[26]

Addiction seems to have a characteristic sequence in development, usually beginning with 'moderate or controlled use' then a stage characterized by loss of control which is 'often accompanied by a desire to quit.'[27] According to Elster and Skog in their book *Getting Hooked,* some authors who try to define addiction emphasize objective criteria, notably (i) tolerance, (ii) withdrawal, and (iii) objective harm, while others rely on more subjective criteria such as (iv) craving, (v) a desire to quit, and (vi) an inability to quit. But most authors give some weight to all of these criteria. [28] I have discussed some of these criteria already and I will look at the remainder in terms of the psychology and behaviour of an addict.

Tolerance

Over time, heroin users have 'a need to use increasingly larger and larger amounts' of the drug 'to achieve the intended effect'[29] This may be caused by an increased rate of metabolism or neurochemical changes in the brain that cause a kind of *deficit* so that the heroin user needs the drug to feel 'normal' again.[30] This may explain why users who seem to have escaped the grip of the drug start again, and again.[31]

Withdrawal

The phenomenon of withdrawal is 'often considered one of the most important features of addiction'[32] The body's reaction to withdrawal from addictive drugs is seen as an indication of physical dependence.[33] Unpleasant, even painful symptoms occur when drug taking stops but taking more drugs eliminates the symptoms. Physical dependence and the desire to avoid withdrawal symptoms helps maintain some drug habits but this does not explain why we sometimes say an addict 'can't quit' or has 'no choice'.

Withdrawal from heroin is frequently described as 'comparable to the symptoms of a one-week flu or a bad cold. At worst, these symptoms include some combination of vomiting, chills, diarrhea, nausea, irritation, insomnia, headache, and the like.'[34] It is easy to exaggerate the importance of physical dependence and withdrawal symptoms. What is more, it is 'almost always possible to avoid withdrawal symptoms by slowly decreasing the amount of the drug taken each day until the drug-free state is reached.' This may be a prolonged process but it can be 'accelerated by the adjunctive use of medications' and it is 'almost always possible to keep the addict comfortable'.[35]

Withdrawal symptoms however, are not sufficient to explain continued drug taking and there are other reasons why some people continue to take drugs. In some circumstances it may seem to be a rational choice. It is possible for a 'fully rational person' to find himself unable to stop taking the drug, while realizing that he would have been better off if he did not take it. It just means the addict does not want to suffer the temporary setback implied by quitting.'[36] Mark Kleiman presents a thought experiment that illustrates how 'not quitting' can be a rational decision. Given that withdrawal from heroin has been compared to a bad case of the flu, he asks:

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[26] Oddie, op. cit., pp.381-2
[27] Elster and Skog op. cit., p.3
[28] ibid., p.8
[29] Gardner and David op. cit., p.105
[30] Kleiman op. cit., p.361-2 & p.33; Elster and Skog op. cit., p.8
[31] Kleiman p.33
[32] Elster and Skog op. cit., pp.9-11. Little is known about withdrawal in relation to behavioural addictions.
[33] Clark and Grunstein op. cit., p.201
[34] Douglas N. Husak, 'Liberal neutrality, autonomy, and drug prohibitions', *Philosophy and Public Affairs,* Vol. 29, No.1, Winter 2000, [pp.43-80] p.73
[35] Gardner and David op. cit., p.109
[36] Ole-Jorgen Skog, 'Rationality, Irrationality, and Addiction – Notes on Becker and Murphy's Theory of Addiction' in Elster and Skog op. cit., [pp.173-207], pp. 181 & 201

> Imagine that you have the flu and that there is a bottle of pills sitting next to your bed that will both stop the symptoms for twelve hours and make you feel better than you felt before the flu, but at the price of postponing your recovery. To be cured, you have to refrain from taking a pill for two consecutive weeks. Could you resist the temptation for every minute of those two weeks?[37]
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> 'I'm not sure I could' he says.

When cessation of drug use almost certainly brings discomfort and continuation postpones the discomfort and may bring pleasure, not quitting can be seen as a rational decision.[38] When the addict takes the drug again he counteracts, to some extent, the negative effect of past drug taking on present welfare.[39] He spares himself the symptoms of withdrawal and he is able to forget or suppress the recognition that his life has become a misery.[40]

Kleiman's example highlights the effect of an addict's bias for the present or what is referred to as 'temporal myopia'[41] and the example shows that there are important insights to be gained if addiction is discussed in subjective rather than objective terms.

Craving

The following is a description of the subjective experience of addiction and the intense craving that goes with it:

> Between episodes of use of the substance, the addict commonly experiences a build up of tension, irritation, anxiety, boredom, depression, or other dysphoric states. As time passes since the last use, these dysphoric states typically become stronger, more persistent, more intense, and more demanding. In some cases, the build up is described as sheer desire, sheer wanting. As the wanting remains unsatisfied, increased dysphoric states or, in some cases, excitement, accompany the wanting. For illicit-drug addicts, anxiety or fear about obtaining the substance often adds to the dysphoria.
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> At some point, the addict metaphorically, and in some cases perhaps literally, can think of nothing else but the desire to use the substance. One informant described the desire like a "buzzing in my ears that prevents me from focusing." It is like an extreme version of being dehydrated or starved: The addict can ordinarily think of nothing else except getting and using the stuff … There is only one tune or story in the addict's head and nothing can drive it out. When the addict can't get the tune out of his head, it's very difficult to concentrate the mind on the good reasons not to use … Fundamental components of rationality – the capacities to think clearly and self-consciously to evaluate one's conduct – are compromised. The agent may not recognize the various options at all or may not be able coherently to weigh and assess those that are recognized.[42]

It seems that the subjective experience of the addict including the addict's intense craving is an important part of addiction. Craving has an important role in the relationship between autonomy and addiction.

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[37] Kleiman op. cit., pp.32 & 396 fn. 23. Kleiman's case is adapted from Schelling's case of a torture victim in Thomas C. Schelling, 'The intimate contest for self-command', *Choice and consequence*, Harvard University Press, Cambridge, 1984, p.67

[38] Kleiman op. cit., p.32

[39] Skog op. cit., p.176-7

[40] ibid., p.185

[41] ibid., pp.35-37

[42] Stephen J. Morse 'Hooked on hype: Addiction and responsibility' *Law and Philosophy*, Vol. 19, No. 1, [pp.3-49], pp.38-40. Morse's 'modal tale' is 'produced from experience with and wide reading in anecdotal and research literature about people addicted to various substances.'

CAN SOMEONE WHO IS ADDICTED BE AUTONOMOUS?

Given the above description we can identify different stages that the heroin addict experiences. The initial decision to take a drug is different from *continuing* to take the drug. Starting to take heroin looks like a deliberate decision but I am looking at *continued* drug use. There is a stage characterised by craving, progressing to intense craving. Then after taking the drug there is a euphoric intoxicated 'high'. (Alternatively this may be a state where the addict feels 'normal'). Also after taking the drug, there is the state in which the person is satiated.

As noted earlier, autonomy depends to a large extent on being able to critically reflect, so it seems quite straight forward that autonomy is very much affected when the addict is in the intoxicated 'high' state, when his ability to critically reflect is not good. However, if taking heroin causes the brain to undergo neourochemical changes and causes some kind of deficiency, it is not so clear that his autonomy is affected. If tolerance to heroin means that taking the drug returns the addict to what seems to be a 'normal' state, perhaps he will be more able to critically reflect when he is under the influence of the drug than not. However, this does not mean that he will necessarily make autonomous decisions.

There is little doubt that the intense craving experienced by an addict interferes with autonomy. Craving crowds out other goals. Drug craving has been compared to drives such as hunger and thirst, moods and emotions such as anger and fear and somatic sensations such as pain. According to George Loewenstein, these so called 'visceral factors' (which relate to inward feeling rather than the intellect),[43] serve an important survival function by creating an aversive sensation if the need is not met and also 'by increasing the subjective desirability of satisfying the need.'[44] These factors help focus attention on particular goals and they 'tend to narrow an individual's perceptual and motivational focus' in various ways. 'Hunger narrows one's focus to food, fear to options for flight, and so on. At low levels, autonomy does not seem compromised by these things: 'It makes perfect sense to eat when hungry, drink when thirsty, and withdraw when experiencing pain or fear.'[45] Low level craving indicates the existence of a desire, and even though the desire may persist and grow stronger, critical reflection still seems possible. Intense hunger, thirst, fear and craving however, do interfere with autonomy. As we saw in the description of the subjective experience of addiction, these factors tend to overwhelm other considerations.

There is another stage the addict goes through after having the heroin and is satiated. He may be under the influence of the drug for some time but may experience some respite before the next bout of craving. For an alcoholic, this is the stage in which he 'smashes his whiskey bottle in disgust in the morning, swearing never to drink again', before he buys another in the afternoon.[46] This also seems to be the stage referred to in Kleiman's example – when it is possible that the addict is making a rational decision to postpone quitting. In the time between the intoxicated euphoria of the drug and the onset of another bout of craving, the potential to make autonomous decisions seems real. There is opportunity to critically reflect and to make decisions backed by reasons. But someone might want to argue that an awareness of influences on deliberation is lacking.

A further stage that a heroin addict may experience is a period of non-use. The reasons for this may be an attempt to quit or he may be in prison. During these times, when the addict is free of physical dependence and withdrawal symptoms, critical reflection seems possible even if craving doesn't go away altogether. There may also be more opportunity in these times to be aware of influences on deliberation.

We may wonder what is happening through these stages when the addict has periods in which he can critically reflect and periods when he cannot critically reflect. Is the addict shifting back and forth between autonomy and non-autonomy? Some people might want to argue that the

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[43] *The New Oxford Dictionary of English*, Clarendon Press, Oxford, 1998.

[44] George Loewenstein, 'A visceral account of addiction', in Elster and Skog op. cit., [pp.235-264] p233; George Loewenstein, 'Willpower: A decision-theorist's perspective', *Law and Philosophy*, Vol.19, No. 1, 2000, [pp.51-76], p.52

[45] Loewenstein 1999 op. cit. p.238

[46] Kleiman op. cit., p.29

addict is not autonomous because autonomy is a global concept that 'evaluates a whole way of living one's life and can only be assessed over extended portions of a person's life.'[47]

I argue autonomy is a task related concept rather than a global concept, so even though there are times when someone with an addiction may not be able to make an autonomous decision about the drug he is addicted to, or about the things that get in the way of his getting the drug, there are other things that he may be able to make autonomous decisions about. It is possible also that refusing medical treatment for his addiction could be an autonomous decision.

Craving causes shortsightedness but that does not necessarily extend to things other than the addict's drug and things associated with that. It seems that hunger and craving narrow an individual's focus by creating a bias for the present and by leading to a shortsightedness about goods that alleviate the hunger or craving: 'A hungry person makes shortsighted tradeoffs between immediate and delayed food, even when expecting tomorrow's hunger to be as intense as today's'

> This present-orientation, however, applies only to goods that are associated with the [hunger or the craving] and only to tradeoffs between the present and some other point in time. A hungry person would probably make the same choices as a nonhungry person between immediate and delayed money … A hungry person might also make the same choices as a nonhungry person between food tomorrow versus food on the day after tomorrow.[48]

This is important in the comparison with addiction and craving - and the relationship with autonomy. It shows that the shortsightedness caused by craving is confined to the substance a person is addicted to and things associated with it.

Like the person who is hungry, someone craving heroin makes shortsighted tradeoffs between the present and the future. The addict craving heroin however, may not make the same choices as a non addicted person between immediate and delayed money because money might enable him to buy heroin. But, if money does not equal heroin , he might make the same choice as a non addicted person. Decisions about obtaining heroin to satisfy a future craving (as opposed to a current craving) may be the same as that of a nonaddicted person. In other words, the addict might want not to want the drug. An addicted drug user can autonomously consent to taking part in research for which he receives payment if he is informed about the research and payment in advance and consents while not under the influence of a current craving. The findings of a recent study support this view. The study suggests that injecting drug users who take part in research are 'rarely motivated by economic gain alone.'[49] Even if the drug user/research participant does end up buying heroin with the money, that decision does not affect the autonomy of the earlier decision to participate. The latter decision is made under a different episode of craving.

Finally, it could be argued that someone addicted to heroin cannot be autonomous because even if they can critically reflect and make decisions backed by reasons, they are unaware of influences on their deliberation. Addicts tend not to appreciate their own susceptibility to drug craving.

It seems however, that there are ways around this problem. Under certain conditions, the addict can appreciate his susceptibility to drug craving. According to Loewenstein, human memory does not seem suited to storing information about visceral sensations. It is well suited to remembering other things such as 'visual images, words, and semantic meaning' but recall of things like hunger, craving or pain is 'qualitatively different'. Women's memory of the pain of childbirth is an example. [50]

Loewenstein goes on to argue that existing treatments of demonstrated effectiveness such as Alcoholics Anonymous 'maintain a vivid memory of the motivational force and misery of craving for those who have quit to prevent relapse.' This occurs by exposing those who have quit or those trying to quit 'to the agonies of people who are still addicted' and those still 'engaged in

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[47] Dworkin op. cit., p.15-16
[48] Loewenstein 1999 op. cit., p.239
[49] Fry & Dwyer op.cit., p.1319
[50] Loewenstein 1999 op. cit., p.241

an acute battle against craving'. It seems that an awareness of influences on deliberation is possible, if the memory of the experience of craving is kept alive.

CONCLUSION

We have considered the nature of addiction and the psychology and behaviour of someone with an addiction and we have seen that although there are times when the autonomy of someone with an addiction is obviously compromised, addiction does not preclude a person from making autonomous decisions. Even though someone addicted to a drug like heroin may seem like the typical example of the non-autonomous person, under some circumstances their choices can be autonomous - particularly in things not associated with the addiction.

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