Weakness of Will, Addiction and Self-control: using Relapse Prevention Methods in Philosophical Counselling

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Introduction

The possibility of weakness of will has posed thorny philosophical problems through the ages, and is still hotly debated today. It can, however, represent an equally difficult challenge for the philosophical counsellor. It is a fairly common scenario for people to give serious consideration to an issue in their life, come to the conclusion that decision x is, all things considered, best for them, and yet find themselves, when the time comes, doing y instead. This could of course be due to a faulty decision-making process, and to overlooking some factors that should in fact have been given more importance. Equally, however, it may be that the decision reached is the right one, and that one needs to find ways of counteracting whatever it may be that prevents one from carrying out the chosen option.

Traditionally, weakness of will has been seen as a problem of rationality and addiction as a phenomenon entirely outside the sphere of rationality. More recent psychological theories, however, draw a more complex picture of addictive behaviour, which brings in the notion of self-control; at the same time, philosophical theorists on weakness of will have found it problematic to account for the phenomenon solely in terms of practical reasoning, and have begun to posit the existence of other factors that may influence action. I shall review the literatures on weakness of will and on addiction in order to show how the two seem to dovetail. I shall then outline some relapse prevention methods that could be useful in dealing with weakness of will in a philosophical counselling setting.

Weakness of will

Background

The problem of weakness of will as discussed in Western philosophy first arose in relation to the Socratic doctrine that ‘no one does wrong willingly’. This is usually taken to mean that doing something wrong results from ignorance of the good and that it is impossible to know the good and at the same time pursue evil things. This is grounded in the doctrine that all deliberate action aims at the good, and that a judgement about what is best is a judgement about how to achieve the good. If people pursued the wrong course of action it would show that they didn’t really know the good in the first place. The problem is that this does not seem to fit the fact that human beings sometimes (or even often) do wrong while declaring that they know what the right thing to do is. Plato is held to have accepted Socrates’ position early on, and later have come to allow that knowledge of the good may be made ineffective by the workings of passion.

Plato’s explanation seems to solve the problem by positing that the agent is somehow overcome by an alien force. While this explanation may apply in some cases, it leaves out the seemingly plausible cases in which action against one’s knowledge of the good is intentional. Aristotle introduced the term akrasia, usually translated as ‘weakness of will’, but also ‘lack of self-control’. Like Plato, Aristotle seemed to allow desire to override reason. However, he also introduced some novel distinctions. Akrasia involves acting on a desire (in cases where most people would refrain) and contrary to one’s true moral judgement, whereas the opposite is true of enkrateia (self-control). Akrasia is divided into two types: impetuosity (which involves acting to satisfy a desire without thinking) and weakness (in which the agent does reason but does not abide by the result). Furthermore, akrasia may be due to different types of desires. There is much controversy about what Aristotle’s theory really was, and in particular whether he allowed the possibility of intentionally acting akratically. Both akrasia and enkrateia are seen by Aristotle primarily as character traits.

In Greek philosophy, the debate focused primarily on moral concerns. A problem similar to the one that had arisen in Greek philosophy was faced by R. M. Hare (1963), who believed that the very function of moral
judgements was to guide conduct, and that accepting that we ought to do something committed us to doing it (hence the name sometimes given to Hare’s theory, prescriptivism). Again, this did not fit the facts, and Hare also resorted to blaming moral weakness on some kind of overwhelming desire that made the moral judgement powerless. The only other possibility envisaged by Hare to account for moral weakness was that of some kind of insincerity, which could go from self-deception to hypocrisy. The problem is created by positing a close connection between thinking a course of action good, wanting to pursue it, and pursuing it. It would seem that any philosophy that held a version of this theory would find it impossible to solve the problem in any way other than the ones that were actually resorted to. Neither the Greeks nor Hare could account for intentional action against one’s moral judgement. However, our experience seems to tell us that this possibility exists. This was the focus of Davidson’s work.

**Davidson and beyond**

The original problem revolved around acting contrary to what one knows is right, which, given the conceptual frameworks, could be solved only by positing some kind of ignorance, or psychological compulsion, or insincerity. In Davidson’s (1970/1980) formulation, the problem of weakness of will became that of intentionally, and while aware of alternative courses of action, acting against one’s better judgement. Clearly, in order to generate this puzzle, the agent needs to be sincere in his or her better judgement and still hold it at the time of action. Davidson shifted the focus of enquiry from moral judgements to better judgements of any kind, from moral weakness to rationality, but he accepted a version of the close connection between forming a better judgement as to what course of action should be pursued, wanting to pursue it and pursuing it (judgement, motivation and action).

The problem then is as follows. Davidson believes that the phenomenon of weakness of will (or ‘incontinence’, as he prefers to say) exists, in the sense that it is possible for an agent to do y intentionally while at the same time believing that there is an alternative action x open to him and that, all things considered, it would be better to do x than to do y. At the same time, he also maintains two principles of rationality, which are that: 1) if an agent judges that it would be better to do x than to do y, then he wants to do x more than y, and 2) if an agent wants to do x more than y, he believes himself free to do either x or y, then he will intentionally do x if he does either x or y intentionally. (1) and (2) make the connection between judgement, motivation and action a prerequisite of rationality, and they clearly contradict the fact that there are incontinent actions (as defined above), since they do not, as they ought to, ensure that the agent does indeed do x.

Davidson’s solution is technical and complex but does not ultimately work. An important distinction that was made in response to his theory, however, is that between evaluation and motivation (Watson, 1977; Mele, 1987). (1) is true or false depending on what sense we attribute to ‘wants’: it is true if we take it to mean that if an agent judges x better than y he or she ranks x more highly, but it is false if we take it to mean that he or she is more motivated to do x. Although both may be described as ‘wanting more’, what the agent ranks more highly does not necessarily coincide with what he or she is more motivated to do. Mele writes that at this point reason-explanation comes to an end, and that the only way to deal with Davidson’s problem is to recognise that practical reasoning is not the sole determinant of motivation: reasons and judgements do have some motivational force, but we need to take other factors into consideration in order to explain at least some actions.

Mele’s account of action against one’s better judgement aims at preserving both the rationality and the irrationality of such action (it is done for reasons, but not the reasons considered best). In his view, ‘action against one’s better judgement is adequately explained in terms

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1 Davidson resolves the problem by introducing a ‘prima facie’ sentential operator that limits the desirability of the pro-attitude to certain respects (‘insofar as’) and turns the conclusion into an ‘all things considered’ judgement, which includes a weighing up of all the pros and cons known to the agent (‘a is better than b, all things considered’). An action, on the other hand, reflects an unconditional judgement of desirability, later identified with an intention (‘a is better than b’). The link between ‘all things considered’ judgements and unconditional ones is causal, but there is also a logical link (as rational agents we should perform the action we consider best). Incontinent action, on the other hand, is action in accordance with an unconditional judgement that has been caused by a ‘prima facie’ judgement rather than by an ‘all things considered’ one. Davidson is unable, however, to explain why, in such cases, prima facie considerations are able to override the normal transition from ‘all things considered’ judgements to unconditional judgements/action.
of: 1) the perceived proximity of the rewards of the incontinent alternative; 2) the agent’s level of motivation to perform the continent alternative and his earlier level of motivation from the akратic alternative; 3) the agent’s failure to make an effective attempt at self-control; and 4) the agent’s attentional condition.’ (p. 92) This account builds on the distinction made earlier between evaluation and motivation, but seeks to further explain why the balance of motivation is as it is: to explain this is to explain the incontinent action (or the continent action in cases of motivational conflict).

**Conclusion**

Some philosophers use ‘akrasia’, ‘weakness of will’, ‘incontinence’, ‘action against one’s better judgement’, seemingly interchangeably. Others make subtle distinctions, such as whether an intention was formed, whether a better judgement was formed, whether recklessness and compulsion are included, and so on. Whether there actually is one underlying phenomenon is unclear. What matters more, and what is really important for the philosophical counsellor, is that all these phenomena (which may include intentional action against one’s better judgement, but also ‘subjectively compulsive’ action, action against the better judgement one would have reached if one had not been self-deceived, and so on) seem to revolve around a lack of self-control.

Why is all this relevant for the philosophical counsellor? As we all know, weakness of will is a very common problem, which can prevent us from carrying out our resolutions and from effecting the changes that we have identified as necessary to our self-improvement. Unfortunately, *pace* Socrates, it does not seem to be the case that knowledge of the right thing to do is all we need. If evaluation does not entail motivation, then it is not enough for philosophy to help people to reach the right judgement. In order to make a real difference to people’s lives we need to be able to make a difference to motivation as well. It might be helpful therefore to examine the significant literature from the field of addiction that aims precisely at counteracting the motivation to act against our better judgement. I will first of all consider the concept of ‘addiction’.

**Addiction**

Nowadays we think of addiction as something that *happens to* (some) people, and thereby removes their ability to control their behaviour in relation to that substance/activity. This folk usage is a relatively recent one, dating back to the Temperance Movement in the United States. Before the end of the 18th century, however, it was thought that people drank because they wanted to rather than because they ‘had to’; people who were frequently intoxicated were called drunkards, and if the word ‘addicted’ was used at all it was in the sense of ‘habituated’ (to drunkenness) (Levine, 1978). The vocabulary of vice was more likely to be used with regard to drunken behaviour than that of compulsion.

**The disease model**

All this changed in the late 18th and 19th century, when a new perspective was developed mainly at the hands of two doctors, Benjamin Rush (considered the founder of the Temperance Movement) in the US and Thomas Trotter in Britain. The main points of the new perspective were:
1) the notion of alcohol as an addictive substance
2) the drunkard’s loss of control over drinking
3) the understanding of the condition as a disease
4) abstinence as the only cure

These, with the significant difference that alcohol was considered addictive only for some congenitally predisposed people, were to become the cornerstones of Alcoholics Anonymous many years later.

The AA model was developed after the end of Prohibition in the US (1933), at a time when alcohol problems were beginning to reappear while at the same time the nation was in no mood for a model of alcoholism that disallowed moderate consumption. The general AA model, developed by the physiologist Jellinek, is that one is born an alcoholic in virtue of some unspecified vulnerability to alcohol. This means that on consuming alcohol the alcoholic experiences craving (i.e. a compulsion to drink against their will) and loses all power to control intake. The disease is progressive and irreversible, and cannot be cured, although it may be arrested by lifelong abstinence. There is a difference between the alcoholic, who is afflicted by a disease, and the excessive drinker, who is not: the differentiating factor between these is the phenomenon of loss of control.

The disease model, which has had several reincarnations since the original formulation, has been criticised on several grounds. The distinction between ‘real’ alcoholics and mere excessive drinkers is dogmatic and not open to contrary evidence (an example of the ‘no true Scotsman move’ (Flew, 1975)). But the very
application of the notion of disease to goal-directed behaviour has been challenged as incoherent. According to Davies (1992), ‘there is a clear difference in the way the word [‘symptom’] is being used when (a) we describe something such as high temperature, shortage of breath, or a skin rash, as a symptom, and (b) we talk about going into a pub and buying a pint of beer as a symptom. Whatever we mean by the word ‘voluntary’ ... it is clear that going into a pub is voluntary in a sense that having a high temperature is not.’ (p. 48)

On the other hand, the development of the disease model was useful in that if people were ill rather than sinners, it would then become possible to provide services to help them.

The mechanism of craving is often resorted to in order to effect this re-classification of voluntary into non-voluntary behaviour. Davies points out that ‘in ordinary usage, craving is a response to some basic biological need, giving it an implied compulsive quality, and semantically distinguishing it from a simple want. ... The implication of craving is that the person in question does not simply want, but in some sense has to have, something.’ (p. 49) He goes on to question what grounds we have for postulating ‘an irresistible drive rather than a desire to have’ (p. 50). A number of studies (in Davies, 1992) suggest that even tolerance and withdrawal, whose existence is well attested, are not in fact determined solely by pharmacological factors, but also by contextual (psychological and social) ones. This challenges the idea, behind the disease model, that the pharmacology of drugs somehow turns people into addicts ‘against their will’.

**Psychological models**

The main alternative to the disease model is represented by the psychological approaches, which share the belief that addictive behaviours are influenced by a variety of physiological, psychological, social and cultural factors, and aim at explaining the processes through which these exercise their influence.

Some of the most influential theories in this area have been classical and operant conditioning, and social learning theory. Classical conditioning is based on the mechanisms of *conditioned/unconditioned stimuli* and *responses*, which are used to explain how neutral stimuli can come to produce responses that were previously explained only by unconditioned stimuli. The central theme of operant conditioning is instead that behaviour is influenced by what follows it. The main concept is that of *reinforcement*, positive when a behaviour increases as a result of the presence of a pleasant consequence, and negative when it increases as a result of the absence of an unpleasant consequence. Drinking, for instance, can be positively reinforced by the feelings of relaxation or sociability induced by alcohol, as well as negatively reinforced by the occurrence of withdrawal symptoms. Punishment applies instead to cases where the likelihood of a behaviour decreases as a result of its consequences.

Social learning theory includes principles from classical and operant conditioning, but expands them to include cognitions. The main concept here is *self-efficacy*, or a person's evaluation of his or her competence to perform a particular task in a given situation. If self-efficacy is low, then the person will have feelings of anxiety and avoid performing the task or attempt it with little effort; the opposite will be the case if self-efficacy is high. In this framework, people drink or use drugs because their use is reinforcing in some way. As such use increases, a number of negative consequences will begin to accrue, but these are likely to be disregarded in favour of the still more immediate rewards. The balance will continue to shift, however, creating a conflict that (depending on the degree of self-efficacy) can be resolved by changing either the behaviour or the cognitions related to it.

One of the consequences of this view is that the ‘addict’ is no different from anybody else in terms of psychological mechanisms, and addictive behaviours are governed by the same principles as any other behaviour, therefore it is plausible to view non-substance addictions as on a par with substance ones. Orford (1985) writes of ‘a range of appetitive activities which can become excessive. These include eating, heterosexual activity, and gambling.’ (p. 319) The rewards of these activities can be as powerful and immediate as substance use: the pharmacological action of a substance is then seen as just one type of reinforcer. According to Peele (1985), people become addicted to powerful experiences that modify mood and sensation, whatever their source.

**Conclusion**

The term ‘addiction’ is a fuzzy one. According to Miller and Brown (1991), current convention has it that ‘addictive behaviours constitute a subset of a larger class of improvident behaviours motivated by short-term gratification at the expense of longer-term negative consequences or risk thereof.’ (p. 9) Clearly, however, not all such behaviours are considered ‘addictive’. They
conclude therefore that ‘in current semantic use, behaviours seem to qualify as addictive only when they meet two criteria, both of which are subjective: [1] they yield immediate gratification, and [2] they involve some degree of diminished volitional control.’ (p. 9) In terms of attribution of agency, it is interesting to note that in pre-Temperance era, intemperate behaviour is seen as freely chosen; the assumption of agency is removed with the disease model, and is not reinstated even with conditioning models; it is only with the introduction of social learning theory that agency is at least partially restored, and we arrive at an agent who, as well as being influenced by conditioning, is able to control and direct his or her behaviour.

Both the discussion of addiction and that of weakness of will have led to the introduction of an agent whose behaviour is determined partly by non-rational factors and partly by the ability to reason and control his or her choices and actions. This ability is crucial in tipping the balance of motivation in favour or against a particular action, and therefore a relative lack of it could be used to explain both addictive and weak-willed behaviours.

**Self-control as a possible solution to weakness of will and addiction**

Self-control is defined by Mele as ‘the ability to master motivation that is contrary to one’s better judgement.’ (p.54) When self-control is applied, therefore, evaluational considerations prevail as a result of the agent’s intervention in his or her motivational state, while in the case of impaired control the opposite happens. A self-controlled person is one who is ‘disposed to exhibit self-control in appropriate circumstances’ (p. 60), although this does not mean that such a person will exhibit self-control at all times and in all areas of his or her life. Mele regards this as a version of Aristotle’s distinction between akrasia and enkrateia.

As already pointed out, in Mele’s model a number of states are seen as contributing to the causation of action: these can be beliefs, desires and intentions, but also unconscious states (such as attention), environmental states (such as proximity), and the capacity and motivation for self-control (which can be further analysed). It is interesting to note that while in philosophy unconscious mechanisms were introduced to explain the causation of action in cases of motivational conflict, in psychology the opposite movement seems to have taken place, from an explanation of action only in terms of automatic unconscious processes such as conditioning, to the acceptance of an executive element such as self-control. Psychologists’ wariness about a construct such as self-control is expressed by Wilkinson (1991) who, while recognising its usefulness, warns that it ‘implies the postulation of an inferred variable which is the product of an unobservable mental act that leads to the non-occurrence of a behaviour.’ (p. 108) On the other hand, there does seem to be a difference between refraining from performing a behaviour as a result of an automatic process of punishment and actually intervening to change the course of one’s own motivation (Mischel, 1977; Alston, 1977).

In empirical psychology, the role of volition was neglected until the 1980s, but it came back to the fore with a renewed interest in cognitive processes (Miller and Brown, 1991). Miller and Brown argue that, while it is well known that behaviour is influenced by ‘genetic determinants, traumatic events, social and environmental conditions, parenting styles, and principles of learning and cognition’, (p. 7) many of which can operate outside conscious awareness, human beings also seem to have the ability to control their own behaviour. They conclude that ‘a more balanced perspective views human cognition and behaviour as partially self-determined.’ (p. 7) This interaction of volitional processes with other determinants of behaviour can be understood in terms of self-regulation, or ‘engaging in specific controlling responses in order to alter the probability of one’s own subsequent behaviour, usually decreasing or displacing a previously higher-probability behaviour.’ (p. 7) Self-regulation should not be thought of as either present or absent, but as occurring on a continuum.

In the field of addictive behaviours, the new focus on self-control prompted new theorising as well as a revision of past views: Heather (1991), for instance, who had been one of the main critics of the disease model, writes that rejecting the entire concept of ‘loss of control’ because of its role in the discredited disease theory was ‘a classic example of “inappropriate bath-time infant ejection”’ (p. 154). Heather’s reasons for this recognition were that: 1) the subjective experience of the majority of the people who seek help with an alcohol problem should not be dismissed; 2) if people complain about the negative consequences of drinking over their lives but show an inability to change, their behaviour must be suffering from some form of impaired control, otherwise they would make changes; 3) it is hard to imagine that before the ‘discovery’ of addiction nobody had ever had
the experience of drinking more than they intended to, or of starting to drink when they had intended not to.

Addictive behaviours may therefore be seen as failures of self-regulation, without this entailing allegiance to question-begging disease theory formulations. It is worth noting that such a view of addictive behaviours overcomes the ‘sin versus disease’ dichotomy mentioned earlier: addictive behaviours are the result of impaired functioning rather than a clear choice, but such impairment is not understood as unidimensional and irreversible as in the disease model. Miller and Brown (1991) also suggest that addictive behaviours could be understood in terms of impaired self-regulatory processes as a framework for self-regulation they adopt the distinction between automatic processing, which requires little or no attention, and controlled processing, which is needed when learning new behaviours or modifying old ones. In this model, self-regulation is associated with controlled processing.

In normal self-regulation, information about one’s current state signals whether a familiar behavioural repertoire is working or whether there is a need to shift from automatic to controlled processing (this may happen outside conscious awareness). This process relies on self-monitoring and self-evaluation (the ability to recognise internal states and detect discrepancies between one’s current status and one’s goals). The detection of a discrepancy tends to initiate change, although if the discrepancy is too big, or the person lacks efficacy, an attempt at change may not be made or be abandoned, in which case defensive cognitive strategies may be adopted in order to reduce the perceived discrepancy. According to Miller and Brown (1991) ‘genetic, neuropsychological, physiological, and personality characteristics may predispose individuals to experience difficulties in regulating drug use and other behaviours offering short-term gratification.’ (p. 27) While it could be said that failures of self-regulation are a normal phenomenon, a number of studies confirm that ‘persons at high risk for addictive behaviours differ in specifiable and quantifiable ways from lower-risk populations.’ (p. 35)

A similar distinction between automatic and consciously controlled action is offered by Goldman (1994) as a solution to, among other things, the problem of weakness of will. There may be ‘two complementary processes that operate in the selection and control of action. The first process is invoked to explain the ability of some action sequences to run off automatically without conscious control or the use of attentional resources, and is used to select simple, well learned, or habitual skills. The second process allows for deliberate conscious control to initiate, guide, or modulate the course of action,’ and is required for tasks that: [1] involve planning or decision making, [2] require troubleshooting, [3] are ill-learned or contain novel action sequences, [4] are judged to be dangerous or technically difficult, or [5] require overcoming a strong habitual response or resisting temptation.’ (Goldman, 1994, pp. 118-9) Goldman suggests that ‘so-called akratic actions’ may be explained by the fact that the automatic selection mechanism can initiate actions independently of, and even in opposition to, the conscious attentional system.

Both weak-willed and addictive behaviours, therefore, may be the result of automatic rather than consciously controlled action selection. Failure to apply self-control may be seen as failure to take action to control one’s motivation, letting the automatic selection mechanism function unhindered. Of course the fact that both weak-willed and addictive behaviours may be understood in this way does not imply that there are no differences between the two. Weak-willed behaviour, for instance, may occur on a single instance or be a long-term disposition; addictive behaviour may only be attributed over time. Typically, people manifesting addictive behaviours do not show impaired control all the time, and may be expected to apply self-control some of the time. This variation will be due to a host of psychosocial and environmental factors, which influence the ability and motivation for self-regulation. We could perhaps conclude that addictive behaviours may be seen as a subset of a wider range of phenomena that are explainable in terms of impaired self-control and of automatic functioning, although they may be further defined by other factors.

It is perhaps worth mentioning that some philosophers (e.g., Kekes, 1988) have identified self-control as a key virtue, essential to responsibility and self-direction. Unfortunately what they have not done is tell us how to achieve it. I will now turn to cognitive-behavioural methods that have been used to enhance self-control in the field of addictive behaviours.

Relapse Prevention

If it is the case that there is a substantial overlap between weak-willed and addictive behaviours, it might be useful to consider whether relapse prevention methods could add a few tools to the philosophical counsellor’s toolbox. The expression ‘relapse prevention’ refers to a
range of strategies based on Marlatt and Gordon’s (1985) model, used to prevent relapse in the field of addictive behaviours. This is based on the assumption that the person has freely chosen to adopt a set of rules to change an addictive behaviour.

‘Relapse’ may be defined as ‘a return to previous levels of activity following an attempt to stop or reduce that activity’ (Wanigaratne et al., 1990, p. 9). Relapse prevention techniques aim at enhancing self-management and maintenance of habit change, and include cognitive and behavioural interventions. The main danger for people attempting to maintain change is exposure to high-risk situations, or situations that threaten perceived control and increase the probability of relapse. These are specific to an individual, but are often determined by positive and negative emotional states, interpersonal conflict, and social pressure. If, on encountering a HRS, an individual exhibits a coping response, this will increase self-efficacy and decrease the probability of relapse; the opposite is likely to happen if there is no coping response. If a lapse, or initial indulgence, occurs, it is the person’s cognitive processes that will determine whether this will lead to a full-blown relapse: the rule violation effect (RVE) predicts that the conflict and guilt following the lapse may lead to further indulgence as a way of relieving these negative feelings.

As well as learning to identify, anticipate and cope with HRSs, a person will need to learn to recognise and deal with the covert antecedents of relapse, which will lead them towards HRSs. These include: urges and cravings to indulge, rationalisations (attempts to justify the indulgence) and seemingly irrelevant decisions (SIDs) (that will insidiously get them into HRSs). Self-monitoring is the starting point of relapse prevention techniques. Self-monitoring entails keeping detailed records of an activity, feeling or thought (e.g., drinking diaries, craving diaries, anger diaries and so on). The rationale for this is that addictive behaviours are characterised by being carried out automatically and unthinkingly, with little or no awareness of cues, triggers and patterns of behaviour. Self-monitoring could have the effect of weakening the ‘autopilot’.

The next step is to develop and practise coping responses, which may be very specific (how to cope with a particular HRS) or quite general (changing one’s attitudes, lifestyle, learning rational decision-making techniques and so on). The decision balance sheet (writing down positive and negative consequences of the behaviour in question), for instance, is a very useful tool for dealing with HRSs and urges and cravings by reminding oneself of the negative consequences of the behaviour and thereby strengthening one’s resolve. Skills training may include relaxation techniques for dealing with anxiety or assertiveness training for dealing with social pressure. Cognitive strategies may involve challenging thoughts that lead to depression or altering typical patterns such as the RVE and SIDs. Other useful techniques include various forms of urge coping (more specifically described in the next section).

Other more general interventions may include: stimulus control techniques (manipulating our environment to some extent in order to minimise exposure to stimuli that trigger urges and cravings); identifying and using substitute indulgences, which could provide immediate gratification at times of urges and cravings, but are not associated with the problematic behaviour (of course one needs to be aware of the possibility of these becoming negative addictions themselves); introducing positive addictions (activities that may or may not have immediate positive outcomes, but are beneficial to the individual in the long run); and so on. In case of a lapse, the main objective is to construe it as a mistake that one can learn from rather than as an irreversible failure, thus succumbing to conflict and guilt, which would be more likely to lead to a full-blown relapse.

All this requires hard work on the part of the individual wanting to change. It is the case that most relapse prevention techniques fall down on one point, i.e. when people do not use them. Since it is so difficult to change engrained habits, and so easy to slip back into automatic behaviours, people have to really want to do it in order to succeed. A clear determination to change the behaviour in question, therefore, seems to be a necessary prerequisite for making oneself use these techniques. This takes us back to the beginning of this paper and the need to arrive at sound, thought-through decisions before considering how one can ‘trick’ oneself into carrying them out. Another important point is that clearly relapse prevention techniques will not be practicable to use with weak-willed behaviour unless there is a habitual pattern of such behaviour, even though not necessarily over a single issue. Applying self-control techniques can then become a habit that we are able to apply to different situations.

**How to gain more self-control**

So how can habitual weak-willed behaviour be dealt with by using relapse prevention methods? Let us take
the example of someone who has ended a dysfunctional relationship but, out of loneliness or other distressing state of mind, finds her/himself repeatedly going back to it. Where would we start? First of all, we would need to go through a decision-making procedure to see whether we arrive at a clear resolution that, all things considered, ending the relationship is in fact the best course of action. If that is the case, and the decision is routinely not being adhered to, then we could start with assessment and self-monitoring exercises to ascertain in what circumstances either the weak-willed behaviour or an urge to perform it occur (e.g., time of day, location, company, mood and so on). On the basis of this, we could devise a plan for counteracting the behaviour. This would clearly need to be geared to the individual situation, but may include (George, 1989):

1) Completing a problem list (stating the negative consequences of the behaviour in question), or decision balance sheet (highlighting positive and negative short-term and long-term consequences). This is to remind oneself of the reasons why the decision to end the relationship was made in the first place, and of the fact that the probable negative consequences of going back to it outweigh the possible short-term gains. This should be put on a card and be easily accessible to be useful at times of temptation.

2) Preventing urges, to the extent that is possible, through stimulus control techniques aimed at minimising exposure to the relevant external cues. This could include, for example, removing items that belong to the ex-partner and avoiding certain places or situations that are associated with him or her, at least temporarily.

3) Finding some effective form of urge coping, which would enable the person to feel the need to renew the relationship without acting on it. These may include urge surfing (reminding oneself that urges are not linear and likely to show an indeterminate rise in discomfort, but instead tend to rise in intensity, reach a peak, and then subside), externalising the urge (seeing the urge as an approaching external entity that can be fended off), labelling the urge as soon as it enters into consciousness, breaking the continuity of the urge (doing something practical that disrupts the automatic habitual sequence).

4) Identifying and challenging one’s rationalisations (thoughts that appear to justify the weak-willed behaviour). These may include thoughts to the effect that the relationship really wasn’t that bad, or that things have changed now, or that one can’t cope without the other person, or that the other person can’t cope without them, and so on. Rationalisations may either be plainly self-deceived (the relationship really was that bad), in which case it would be helpful to consider the contrary evidence, or may seem reasonable (perhaps the other person really does appear not to be coping well) but on reflection would still not warrant the weak-willed behaviour (renewing the relationship is not likely to lead to one’s own or the other person’s wellbeing in the long run). One also needs to identify and challenge seemingly irrelevant decisions (mini-decisions that put the person in situations in which the weak-willed behaviour is more likely).

5) Putting together an emergency pack to read in the event of urges or lapses. This should include a number of things mentioned above, such as a problem list or decision matrix, a reminder of how to deal with urges, challenges to rationalisations, perhaps the number of a friend who knows the situation and has agreed to help, and so on.

Conclusion

I have suggested that the concept of addiction and that of weakness of will dovetail, and that both may be understood in terms of a lack of self-control. If that is the case, philosophical counselling may benefit from incorporating established relapse prevention methods in order to be able to address the evaluation/motivation split that characterises the problem of weakness of will. This would be essential for philosophical counselling to make a real difference to issues such as carrying out one’s resolutions and gaining more self-control.

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