

READING AGAINST THE GRAIN OF VULNERABILITY IN ADDICTION: PHILOSOPHICAL REFLECTIONS ON AGENCY AND VULNERABILITY

ABSTRACT

Addicted individuals are arguably a vulnerable population in health care and in society. Typically, this claim is based on views that consider drug use as the source of vulnerability, either as a cause for pathologies in the brain or as a target for societal regulation that results in harm for the users. In this article, I question the common conceptions that, first, the vulnerability in addiction actually traces back to drug use and, second, vulnerability in addiction necessarily undermines the addicted individual's agency to a problematic degree. Insofar as drug use is considered to be the main source of vulnerability in addiction, the view of addicted individuals as vulnerable may be misplaced. I suggest that in certain contexts drug use can be regarded as a resource for one's agency. However, questioning the polarization between autonomy (i.e., 'full-blown' agency) and vulnerability may undermine the view that addicted individuals are a vulnerable population that requires special measures.

Keywords: addiction, vulnerability, agency, autonomy, control

INTRODUCTION

As is typical in philosophical enquiries, this analysis sets off exploring the conceptual commitments of the concept of vulnerability that is here, roughly, understood to refer to an increased likelihood of being subjected to harm and moral wrongs (see Hurst 2008). Vulnerability of addicted individuals is something that is generally agreed upon (see e.g. NIDA 2018, GCDP 2017). They are arguably a vulnerable population in health care, and in

society in general. However, the claim may be based on various views. For instance, the US National Institute of Drug Abuse (NIDA 2018) states that brain sciences generate evidence of the vulnerability of addicted individuals referring to pathologies of the brain, typically induced by drug use, whereas the Global Commission on Drug Policy (GCDP 2017) stresses that the vulnerability caused by drug policies is often more severe and harmful than the pathologies of the brain. Both identify drug use as the locus of the vulnerability, but

the cause for the vulnerability lies in different sources, namely in the effects of a psychoactive substance in the brain functioning, and the illegal status of the drug and social policies, respectively.¹

Both of these vulnerabilities are understood to be the kind that may typically undermine an individual's capability for autonomous agency, i.e. making meaningful decisions regarding one's life and carrying them out without controlling influences such as coercion. Pathological vulnerability suggests that the addicted individuals crave drugs and the use is characterized as compulsive. In this framework, addicted individuals are driven to use drugs even in light of severe foreseen consequences. The threat is in some sense internal, as the drug changes the brain and consequently takes control of the drug user's agency. Yet, addicted individuals seem competent to make decisions regarding that use: how to obtain drugs, and when and where to consume them, for instance.

In a similar autonomy undermining vein, the structures of society may undermine addicted individuals' agency, that is, they may take away the chance of living (or deciding to live) a meaningful life. Substance use and substance use disorders, i.e. addictions, are prevalent in homeless populations (e.g., NCH 2017). For instance a society may bring about regulations in which homeless addicted individuals are compelled to use additional drugs due to the circumstances. It may be that the rules and regulations of a city prohibit loitering in the name of safety and in promotion of anti-vagrancy regulations (cf. Langegger and Kloester 2017).² Indeed, it seems correct to assume that this kind of prohibition prevents or at least hinders shady business taking place out in the public. However, it has other implications. This regulation is likely to deprive homeless people of the chance to rest in public,

even when the article 24 of the United Nations' Universal Declaration of Human Rights (1948) proclaims the right to rest belongs to every human being. In the case that homeless people decide to stay in the city, they are left with very few options to seek means to address this challenge: one of them is obtaining illegal drugs such as methamphetamine that help them keep alert and be on the move. It seems that those individuals are coerced into decisions that they would not in other circumstances make; their agency is shaped by a controlling influence.

With these illustrations, the two views problematize the addicted individual's agency in two very different ways. Yet, they both agree that to the extent that the individuals are not able to make meaningful decisions concerning their own lives, they fall short of 'full-fledged' agency or, in other words, autonomy. The addicted brain imposes internal 'coercion' to agency whilst social policies (and for instance stigma) amount to external controlling influences for the agent. This suggests that vulnerability in addiction as fleshed out in these views indeed seems to be contrasted with autonomy.³ Nevertheless, what I suggest in this article is that vulnerability in addiction *qua* (problematic) drug use is not automatically something that generates potential harm and injustice, undermining the individual's agency, but can also have aspects that can be considered as resources.

In order to make sense of my suggestion, I will first flesh out the key concepts and their relations and provide a characterization of addiction. I proceed by reflecting on the alleged polarization of autonomy and vulnerability in addiction and suggest further that vulnerability can also be something else than merely autonomy undermining (for a review of these views that polarize the two concepts, see, for instance ten Have 2016). After this, I will briefly consider the suggestion's implications

for the view that addicted individuals are a population requiring special measures for instance in health care. Why else would they require special measures if the drug use does not overthrow their agency and make them, for instance, justifiable objects of interventions?

The interest in this concerns the normativity of the notion of ‘vulnerability’. Accepting that different notions of vulnerability carry different normative force has implications for the normativity of vulnerability in addiction. Typically, it seems, this vulnerability is seen as something that requires measures; If possible, we need to prevent and mitigate this vulnerability, or at least monitor it in order to be ready to take action, if necessary. However, if this is not possible, we need to take action either by protecting the vulnerable or in other ways taking measures that the vulnerable will not be subjected to unnecessary harm. It could be asked, then, whether vulnerability necessarily amounts to an indicator of normative action, and if it does not, does it lose its plausibility in health care, for instance? Should it be abandoned all together and replaced with other concepts? This is a worry that has received attention in the conceptual literature on vulnerability (see e.g. Luna 2009; Rogers, Mackenzie and Dodds 2012) and needs to be addressed also in this context. Indeed, it is not plausible to argue for a view that would deprive or decrease individuals’ possibilities of accessing health care, for instance. However, I argue that the force of normativity should be considered not only in terms of its source but also in relation to the circumstances. This further enables us to identify the situations in which normative action is called for.

My investigation falls within empirically informed philosophical bioethics, with a particular focus is on understanding human agency in addiction. This means that the theoretical discussion is further strengthened

by references to empirical research on the topics discussed. This gives the discussion a concrete foundation and allows it to engage with research on addiction across disciplinary borders. As the two exemplary views on vulnerability in addiction illustrate, there is tension between vulnerability and autonomy. The polarization of the two concepts in this manner raises my philosophical interest in the topic: what kind of agency does addiction allow, and are vulnerability and autonomy in this agency incompatible with each other? With the means of applied philosophy, I will scrutinize the concepts of vulnerability and autonomy. I do this in the light of an example of addicted individuals in research on treatment and will consequently provide a more nuanced understanding of their agency.

THE KEY CONCEPTS AND THEIR RELATIONS

Addicted individual’s agency underlies and motivates many modern discussions about addiction (e.g. Heather and Segall 2016; Fraser, Moore and Keane 2014; Levy 2013; Poland and Graham 2011). In order to capture the nuances of this particular agency, we need more basic understanding of issues involved. In light of my aim to philosophically analyze and reflect on vulnerability, I follow the methods and style of the Anglo-American philosophical tradition, broadly construed (see Schlosser 2015), but this seems to resonate with the ideas of agency in anthropology as well (e.g. Honkasalo 2009; Ketokivi and Meskus 2015). In discussing human agency, I mean a person’s competence and abilities to engage with the world. Even newborn babies are agents to some degree in this sense, as they interact with the world. Moreover, agency is not limited to intentional physical movements, but extends to

all kinds of acts ranging from mental acts, such as calculation or individuals' abilities to make plans, to carrying them out, and interacting with the world. However, this is a pretheoretical conception of agency and does not require a theoretical framework to be conceivable.

In discussions of addiction, agency is typically called into question, and this discussion concerns a certain aspect of human agency, namely whether the agent is in full control of his or her action. This can in some respect be understood as intentionality. This kind of action and agency can be considered autonomous. To be clear, autonomous action is one type of action. It is full-fledged in the sense that the individual acts on the basis of his or her meaningful decisions, not coerced by any external or intrinsic controlling influence (see e.g. Beauchamp and Childress 2001). This of course means that not all actions fall under the scope of autonomy, nor does autonomy imply action *per se*. At the same time, this agency always takes place in the world. The structures of the society and other people affect it. Bruce Jennings (2016: 13) describes this kind of contextualized or relational autonomy (and agency insofar as it refers to individuals' possibilities of being and acting in the world) as one of 'complex communities of reciprocity, cooperation, and normative order'. The autonomy in question thus is not an ideal that cannot be reached in the real life, but a minimum threshold that enables autonomous agency and action in everyday life (Beauchamp 2005). This is an important point, as I am concerned with meaningful agency in everyday life rather than high ideals that people should strive for. Moreover, agency does not take place in a vacuum but the structures and other people in the society may even enable it (e.g. Mackenzie and Stoljar 2000).

The key concept of this paper, nonetheless, is that of vulnerability. Even with its rich

and inconsistent history, the concept carries promise: it may help us to understand addicted individuals' agency beyond the traditional control—no control dichotomy (cf. Charland 2002; Hyman 2007; Foddy and Savulescu 2007). There are many ways to make sense of the concept of vulnerability, and the point here is not to provide an exhaustive review of its uses (see Honkasalo in this issue). However, it is good to distinguish between different ways in which the concept has been used in academic literature. Catriona Mackenzie and her colleagues (2014) as well Henk ten Have (2016) identify one of the uses as that made in reference to the human condition. This kind of approach discusses the ontological finitude and fragility of human beings (e.g. Butler 2009; Nussbaum 2006). Another approach is to see it as inherently social (e.g. Goodin 1986; see also Straehle 2017). This kind of susceptibility does not reduce vulnerability to ontology but rather in this sense refers to harm to and violations of an individual's interests. This kind of vulnerability picks out individuals and groups that are in danger of being harmed. The latter view already harnesses a stronger notion of normativity: Infliction of harm is something that should be avoided.

Mackenzie and her colleagues (2014) suggest a taxonomy of the concept of vulnerability that distinguishes the sources of vulnerability as inherent, situational and pathogenic, and further adds a dimension that enables the analysis to acknowledge whether the vulnerability in question is dispositional (like the human finitude) or occasional. This kind of mapping gives a nuanced reading of the possible vulnerabilities individuals may face. With this kind of sensitivity it is worthwhile to look at the vulnerability in addiction, especially when we want to find out issues related to normativity. In some sense, at its core this paper reflects on

how vulnerability can play into the ideas of agency (and autonomy) in the context of addiction, especially when many views seem to locate the vulnerability involved in addiction to drug use (e.g. Charland 2002; Heyman 2009; Leshner 1997; Dill and Holton 2014). For instance, insofar as drug use is the source of vulnerability, that vulnerability is present in addiction.

WHAT IS ADDICTION?

Before the more detailed analysis of the relation between vulnerability and autonomy, it is useful to spend a little time on what I mean by addicted individuals and addiction.⁴ Addicted individuals come in all forms and shapes, thus 'population' may be a misleading reference. The individuals that constitute the population may fail to have even a single common character or feature, apart from being labelled addicted. Moreover, the meaning of being addicted is far from self-evident: Consider, for instance, that MOT Oxford English Thesaurus gives synonyms to 'addicted' starting with the most common understanding, that is, 'dependent on'. This would mean that being addicted is a state of dependence of some sort (cf. Dodds 2014). The individual depends on something, in this case perhaps drugs and their use. This may give us insight, but not enough. Individuals are dependent on all kinds of things: sleep, nutrition, other people, even the air. The dependence requires elaboration in order to be understood as a state of being addicted. The thesaurus continues with phrases 'devoted to', 'dedicated to', 'fond of', 'partial to', 'enthusiastic about', 'enamoured of', 'in love with', 'infatuated with', 'obsessed with', 'fanatical about'.⁵ The stress in the kind of (affective) relation seems to vary in terms of, for instance, degrees of freedom and the general tone of the phrases.

The concept of addiction has complex history with social, cultural, and political agendas giving shape to its meaning (e.g. Acker 1999). If we want to narrow down the number of meanings, maybe we can take a defined field in which the use is managed and moderated in some standardized ways. This, of course, does not mean that the meaning would be detached from its social and political contexts (see Fraser, Moore and Keane 2014). In health care, addiction and being addicted have a narrower scope: addiction is a recognized disorder. For instance, it is recognized by the two dominant diagnostic manuals in the field, namely American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and World Health Organization's *International Statistical Classification of Diseases and Related Health Problems* (ICD). Consequently, there are available means for addressing the issue accordingly. However, even if we want to hold on to the clinical understanding of addiction, the population of addicted individuals covers users of a wide range of different substances and even behavior, for example gambling. It may be one thing to discuss (the vulnerability of) individuals addicted to tobacco, a legal and more or less socially acceptable substance with psychoactive effects that do not drive the typical user out of control. It may be entirely another thing to discuss (the vulnerability of) methamphetamine-addicted individuals whose substance is either controlled by prescriptions or it is illegal, as in most countries. Do these users share a common feature that allows labelling them a population?

Moreover, it is telling that DSM-5 and ICD-10 both provide a list of symptoms of which a certain amount need to be identified in the patient with enough severity in order to qualify for a diagnosis. The more criteria are

satisfied, the more severe the disorder. (APA 2013: 484.) Different psychoactive substances have different kinds of effects and thus are likely to bring about certain symptoms. Nonetheless, even within the diagnosed population of people with substance use disorders, with for instance alcohol, addicted individuals may be suffering from symptoms that they do not share with each other. To illustrate this, take a lorry driver or a construction site worker suffering from alcohol use disorder and compare them with some other individuals. The lorry driver or the construction site worker may be more likely to find themselves in situations in which use of alcohol is physically hazardous (DSM-5, criterion 8) than a low-income student or a pensioner simply because of their social and professional circumstances. Another case would be to compare individuals who use opioids. The physical hazards of using prescribed opioids in comparison to opioids obtained in the streets are likely to differ also in relation to the chemical composition of the drug, for instance, the substance bought in the street may have additional, harmful, ingredients or it may contain more of the effective substance than expected, thus increasing the risk of overdose.

So far I have been critical of the ways in which addicted individuals could be grouped together: The criteria cover such different aspects of life—for instance self-control, social relations and duties—and the pharmacological aspects of substances vary from substance to substance (see also Fraser, Moore, and Keane 2014). How could these constitute an entity that we can consider as a population and then deem the population vulnerable? In my view it is possible. The critical assessment of the variety of criteria was not conducted in order to suggest that they cannot be labelled a population in a meaningful sense, but rather to highlight that the population is far from homogenous. What

I suggest is that the feature that constitutes the population is not, maybe contrary to the expectation, (problematic, frequent, and heavy) drug use, but impairment of self-control in the issues that relate to drug use. This may include criteria such as using more than intended, but also failing to balance the use with any kind of social obligations, be they at school, work or home, and in interpersonal relations. At the same time, this way of grouping the population may include individuals who are not actually using drugs in the current moment. This is an important aspect to take into a consideration as addiction is a continuum, rather than a phenomenon with a clear and distinct beginning and end.⁶

What is important to notice is that impairment of self-control is a normative notion. It relies on what one ought to (have) do(ne), but it leaves open the nature of impairment.⁷ Of course, the criteria for addiction (or rather ‘substance use disorder’ in DSM-5, for instance) also includes purely “naturalistic features” without this kind of normativity. Purely pharmacological criteria in addiction include tolerance and withdrawal. These typically constitute dependence grounded in an individual’s physiology. However, they should not be equated with addiction, as psychoactive substances used in medications also typically satisfy these criteria (APA 2013: 42). The pharmacological criteria seem insufficient in capturing most problems associated with addiction. They do not allow making a distinction between a heavy user and an addicted user, for instance. A chronic pain patient may be a heavy user of opioids in terms of the amount of substance the individual consumes, but it is far from evident that we would want to identify this kind of an individual as addicted and suffering from problems of self-control. Their self-control may be functioning

and intact even if they were to suffer from withdrawal when they abstain.

All in all, addiction is far from an objectively observable disorder with measurable symptoms; rather it always seems to involve evaluation that rests on notions of harm, (loss of) control, and excess. These aspects always involve consideration of what amounts to acceptable thresholds; how much harm is acceptable, what counts as too much, and what does it mean to be out of control.

ON THE INCOMPATIBILITY OF AUTONOMY AND VULNERABILITY IN ADDICTION

In light of these insights to the nature of addiction, it is time to have again a more detailed look at the concepts of autonomy and vulnerability and their relation.⁸ Vulnerability stems from the Latin word *vulnus* meaning 'wound' and it seems understandable that it is typically understood as a notion that indicates fragility or weakness of some kind. This kind of understanding seems to pose a challenge to individual agency and autonomy even if it is not clear that, for instance, being frail would somehow automatically prevent or hinder the agent from making meaningful decisions and carrying them out. However, this autonomy and agency undermining view seems fitting when we consider, for instance, newborn babies: they are fragile in the sense that they need a caretaker and lack autonomy, when autonomy is, roughly, understood to be a capacity to act in accordance with what the agent sees best, that is, making meaningful decisions without controlling influences. Babies lack the required competence for the decisions due to their developmental state. This kind of vulnerability is universal in the sense that no human newborn possesses the kind of competence, so that it is something that

characterizes the state of being newborn. This is the kind of vulnerability that is sometimes referred to as ontological vulnerability, as it relates to the human condition that is shared by all human beings (see Mackenzie, Rogers, and Dodds 2014: 4). The agency of the newborn falls short of being at the level that enables them to satisfy their needs, for instance. Furthermore, there are other issues that can be regarded as vulnerabilities in the autonomy undermining sense even though they do not trace back to the human condition in the same way as being newborn does. For instance, illiteracy, being lost in a new city, having a condition that undermines one's ability to move, all imply that the agency of the individual is compromised in one way or another.

In the introduction of my article, I suggested that it is common in addiction literature to identify an individual's vulnerability with substance use, as it is argued to give rise to compulsive behaviour (e.g., Charland 2002; Leshner 1997). Simplistically put, the drug changes the brain functioning in ways in which it seems that the drug dominates the individual when it comes to issues concerning drugs and their use (Charland 2002; see also Koob and Volkow 2016). This vulnerability is located in the agent; it is part of the individual. It is inherent (Mackenzie, Rogers and Dodds 2014: 7). The brain is hijacked and it seems there is no room for autonomy, or even intentional agency. This, of course, is not the full story: addicted individuals do have agency. They are not mere automata or marionettes. They are able to make choices and complex plans, even for their drug use. For instance, individuals addicted to heroin have reported to willingly undergo withdrawal in order to lower their tolerance (Ainslie 2000: 82). This is not, however, to argue that there are no problems with their agency. It is simply to say that their agency seems more complex than

merely being dictated by strong desires to use drugs or being driven by fear of withdrawal. Agency is not a binary position where either you have agency or you do not. It may well be that even if people consider human agency to be one of degree, the conception still turns out to be too simplistic.

The other kind of vulnerability that I mentioned in the beginning is not reducible merely to the agent, but rather the addicted individual's agency is inherently embedded in the society. The Global Commission on Drug Policy highlights the point that regulation and policies on drugs and drug use can be a source of vulnerability for addicted individuals.⁹ Policies that aim for total ban on drugs are likely to cause serious harm to addicted individuals, as they seem to assume that it is a matter of a simple choice of stop using substances. In this picture, addicted individuals are ultimately vulnerable due to policies mandated by national and regional agents. The vulnerability is not an inherent property of the agent, rather it is situational. The circumstances bring about the individual's vulnerability (Mackenzie, Rogers, and Dodds 2014: 7). However, here again, it is a question of autonomy in the sense that addicted individuals may not be able to act in ways that they see best. They cannot make meaningful decisions regarding their lives, as they are easily stigmatized, treated as deviant members of the society, and even punished accordingly (see e.g., GCDP 2011). This kind of vulnerability is especially important to identify, as it may be a source of social injustice. For instance, drug use is taken as intrinsically undesirable activity and it is treated unattached to the reasons behind the drug use. If an individual is using (illegal) psychoactive substances for self-medication, surely the way to treat the individual is not by sanctioning them for the (mis)use in a way that the individual's well-being further decreases.

However, it is important to acknowledge that people also define vulnerability in different ways, as discussed in this special issue 'How does vulnerability matter?'. The notion of vulnerability I have discussed here is not opposed to agency and autonomy, but rather aligns with them. In fact, in some contexts it may even enable (autonomous) agency. This notion can often refer to the general human condition, that is, the fact that we are all vulnerable *qua* human beings. Our resources as humans are limited and this point, instead of being a constraint, should be seen as the framework from which we stem from. The kind of finite beings as we are shapes the way we reason. It may mean that we are predisposed to certain fallacies. (See for instance Bagnoli 2017.) This does not mean that we are falling short of standards of human agency, as there is no such thing as a completely invulnerable human agent. Insofar as addicted individuals are human beings, they too share this kind of vulnerability that is constitutive of human agency.¹⁰ But this kind of vulnerability does not seem to be the right one for discussing vulnerability in addiction, the kind of vulnerability that would enable us to identify addicted individuals as members of a population. The vulnerability in addiction seems to be special and is relevant only for the individuals who are addicted.

If this kind of universal vulnerability can be thought of as a resource instead of a constraint, can we perhaps see some special vulnerabilities in this manner, too, or do we lose the concept's normative function, that is, indicating increased likelihood of being subjected to harms and moral wrongs? In case of addiction, I suggest we can and should. As I pointed out in the beginning, drug use is typically seen as the source of vulnerability in addiction. Drug use is more often seen very narrowly through its negative aspects and consequently individuals

who become addicted to drugs are seen in very simplistic terms. They are first and foremost drug users, not *agents* who use drugs and who also have other interests and motivations. Heroin, for instance, is typically seen as one of the most dangerous drugs: in most countries, it is illegal to sell, buy, possess, and use it, it causes dependence and overdose can happen easily (see e.g. United Nation's World Drug Report 2018; EMCDDA 2018). These issues are far from exhaustive and they form a list of only a few reasons why it is considered dangerous. It is understandable that heroin use is seen through these aspects. Sometimes it is pointed out that heroin has positive effects as well (see for instance Blum et al. 2013); it is a substance that has been used for treating pain, for instance. However, my argument does not rely on this aspect, even if it is well worth acknowledging. Instead, I want to bring another issue to the table: What is typically left aside is the fact that heroin use implies that in order us to talk about 'heroin use' the individuals typically have had to use heroin more than once and that the consumption is relatively frequent. This not only brings about the various, negative and positive, effects of heroin but also highlights self-knowledge involved in drug use.

In fact, there are instances in which first-person knowledge of addicted individuals' own drug use provides them with unique insight to prediction and confrontation of future challenges, and consequently also possibilities of prevention and modification. For instance, in heroin-assisted treatment, one of the first things that needs to be done in order to begin the treatment is the determination of the right dose for each individual entering the treatment programme. It has been reported that in the beginning of heroin-assisted treatment, the medical staff was adamant in determining low-level initial doses of prescribed diacetylmorphine, that is, heroin,

even when the patients raised concerns that the dose was not suitable for them. (Perneger et al. 2000.) Maybe the staff were wary of the addicted individuals trying to exploit the system, treating the treatment programme merely as a source of heroin supply or maybe there were other reasons. In any case this practice of starting with (too) low doses affected the length of the adjustment period by extending it, as the point of the adjustment is to find a suitable dose for the individual in question. However, when the treatment programme changed the policy, skipping the phasing-in period, the addicted individuals' first-hand knowledge of their drug consumption enabled them to have more effective treatment from the beginning (see Perneger et al. 2000). In this light, their (addicted) drug use has not only made them vulnerable to the extent that they seek help, but at the same time it provides the individuals with means to utilize that vulnerability in further action and life in general. Thus understanding drug use as vulnerability merely in terms that imply something constraining, I suggest we should even consider it as a resource in certain circumstances.

IMPLICATIONS OF THE NORMATIVITY OF THE CONCEPT 'VULNERABILITY'

What does this mean? Typically, when people talk about vulnerable populations, they seem to suggest that extra measures should be taken in order to guarantee that the vulnerable are protected, helped, and it is ensured that their rights are not violated. The kind of label proves quickly too simplistic: vulnerabilities should always be evaluated in context. The labelling as such is not enough, as the sources and kinds of harms vary from context to context (see Luna 2009). Belonging to a vulnerable population

does not automatically require that measures of prevention, protection, and helping are applied to the individuals in that population, no matter what the circumstances are. If people are willing to admit that those kinds of measures are not always called for, they face a challenge of identifying which cases of vulnerable populations have normative force that require action from others.

Let us consider an entirely different example to illustrate this: The state of being lost seems to fall short of requiring any paternalistic measures on its own: insofar as the agent is capable of asking for advice without compromising one's ability to make meaningful decisions and acting on the basis of them, paternalistic interventions seem unnecessary and exaggerated. Being lost typically means that one is lacking information of one's whereabouts and the agent is unsure how to arrive in a known place. Nevertheless, this kind of temporary 'weakness' does not as such justify any interventions for the agent's actions. Nor does it undermine one's competence in ways in which would require extra measures from others to strengthen the competence in any way.¹¹

The source of vulnerability seems to matter. Lack of information may hinder one's abilities to act autonomously or, rather, in a meaningful way from one's perspective, but at the same time it does not coerce or undermine one's competence to do so. It could be that the reason why we tend to think of vulnerability and autonomy as opposites may stem from the idea that vulnerable people who, for some reason or other, cannot take care of themselves, are in need of measures that can be characterized as paternalistic. One explanation for this kind of vulnerability is to juxtapose dependence with vulnerability (for discussion of the relation of vulnerability and dependence see for instance Dodds 2014). However, not all kinds of

dependencies question one's competence and thus agency. Being lost in a city (without a map) may make me more vulnerable than I would be when I have a map in my pocket. What it does not do is to hinder my agential abilities to use measures to overcome the situation, for instance, to seek help in finding my way to the place I know and want to be. No one is required to make an intervention to save me on the cost of overriding my agency in some way. Other aspects in those circumstances, however, may make it the case that I would benefit from an intervention of some kind. This kind of picture is commonly acceptable. In health care ethics, for instance, paternalism is typically justified with the principle of beneficence (see for instance Beauchamp and Childress 2001).¹² Other people help and protect the ones who, for some reason, fall short of doing so by themselves.

So what about addicted individuals? Where is the harm that they seem to be more sensitive to than other people in the same circumstances? Where does their vulnerability stem from? It is tempting to pinpoint the vulnerability in drug use, as it is associated with all kinds of harms starting with negative health effects, and extending to social and societal problems. As I have sought to illustrate, however, it is a complex issue and depends on the case in question. It may be that vulnerability in addiction is often, if not always, related to drug use in some way or another. At the same time, it is, however, far from obvious that the vulnerability of addicted individuals would always undermine their autonomy, or rather, their agency. Consequently, paternalistic measures aimed at addicted individuals that rest on this kind of assumption are problematic. In fact, this kind of idea *per se* can make addicted individuals vulnerable. It can generate vulnerability as unjustified interventions cause harm to the individuals in question in terms of violations to their right to

self-determination, for instance. It is important to acknowledge that the vulnerability that rises from their circumstances, that is, aspects in their environment over which they may not have enough control, should not automatically derive its normative force from the principle of beneficence, rather than from respect for persons, for instance. Acknowledging the agency of addicted individuals and paying attention to the point that their vulnerability need not undermine their agency may provide a more nuanced view of the addicted individuals and their actions. Instead of protecting and/or preventing harm in a way in which their drug use is simplistically the source of autonomy undermining vulnerability, it can also be seen as a resource. In this way, having the experience of drug consumption, for instance, makes them experts regarding their own drug use. This expertise should be respected, as I illustrated in the example of entering a heroin-assisted treatment above.

There may well be various notions of vulnerability in play in a case and this seems to make the situation complex. One obvious objection to my view can be presented by pointing out how addicted individuals are compelled to continue drug use (e.g. Charland 2002). It can be argued that their agency is not in their hands and thus even though they seem to be competent agents they act in ways that cause them (and others) harm. How then do we know what to do and on what basis? Here I suggest that we remember that 'being autonomous' or 'being vulnerable' seem to be relational notions and should be considered as such (see Honkasalo in the introduction of this special issue). Compulsion of a drug can not be merely reduced to the drug as such, but the compulsion should be understood to concern the drug in a context; they are the circumstantial aspects that constitute the substance to be appealing

in potentially irresistible ways. For instance, the case I discussed earlier, namely (research about) heroin-assisted treatment, illustrates this complexity. There has been a considerable discussion in bioethics on whether heroin addicted individuals are able to voluntarily consent to (research about) treatment in which they are prescribed heroin as a part of the treatment regime (for instance Charland 2002; Foddy and Savulescu 2006; Levy 2006; Walker 2008; Henden 2013; Uusitalo and Broers 2015).¹³ At first blush it seems challenging to start obtaining informed voluntary consent. If addiction is a problem of self-control regarding the use of psychoactive substance, then how could the research participants be able to consent voluntarily to research in which they are given the very same substance with which they experience problems?

Addicted individuals' vulnerability has, in that discussion, been conceived in terms of the compulsive nature of addiction, that is, addictive desires (Charland 2002), but also in terms of the social and psychological circumstances (Henden 2013). Arguments like these rest on notions of vulnerability that require action from the medical researchers and personnel in a different way than views focusing on the (in)vulnerability of addicted individuals. The latter arguments rest on the idea that addicted individuals are not lacking in required decision-making abilities or circumstances, but that they are acting on the basis of their preferences like any other rational agents (e.g. Foddy and Savulescu 2006). This difference can probably be explained by looking at the sources of vulnerability. The first arguments trace the source of vulnerability to aspects that threaten addicted individuals' agency and autonomy whilst the latter arguments do not.¹⁴ This discussion resembles and resonates with the infamous debate about addiction: whether it is

a disease or a (disordered) choice that still seems to be going on (see for instance Heather et al. 2017).¹⁵

It is important to note that even if I see some aspects of drug use as resources for the particular individual, I do not deny that they may be vulnerable in normative ways that obligate others and the society to react to those vulnerabilities, too. The heroin-assisted treatment that I have referred to is a telling example of this. The treatment is targeted to the worst-off drug users, that is, those who have a history of repeated failures in other treatment programmes, most notably substance substitution programmes with methadone as well as abstinence-based treatment programmes (e.g., Ferri, Davoli and Perucci 2006). This is to say that heroin addiction can be so severe that despite (repeated) attempts to seek help, the individuals still struggle to gain control over their drug use, and are likely to fail easily. Still, this struggle not only illustrates their problems with control over the drug use, but rather it also illustrates that these individuals have other strong motivations, too; they keep returning to seek help even when they know that the previous attempts were unsuccessful (Uusitalo and Broers 2015). These individuals are not merely driven by the drug, but also by motivation towards well-being. In this light, the vulnerability that these individuals face cannot merely be reduced to the drug, as it is clear that in the treatment they are prescribed diacetylmorphine, that is, heroin, and yet they continue to recover and gain control over their lives.

If addicted individuals are vulnerable in ways that mobilize them to seek help, for instance from health care services, those vulnerabilities need to be taken seriously. They have normative force. It is, however, important to pay close attention to the sources of

vulnerability. Too general an analysis of ‘drug use’ as the source is simply too vague for effective counter-measures, as I hoped to have illustrated here. Also, it is important to notice that many of the vulnerabilities that people have seem to be socially constituted. This raises the question that if these vulnerabilities actually are a structural part of the society in question, would it be better to reconsider the structure instead of attending to the undesirable consequences?

CONCLUDING REMARKS

Vulnerability covers various notions, not all of which threaten agency (and autonomy). It is therefore important to identify the source of that vulnerability and evaluate its normative force: not all notions carry similar force. Vulnerability in addiction can not, then, be reduced to mere drug use and is not necessarily undermining of autonomy or agency, as I have tried to show with the example of (research on) heroin-assisted treatment. Addicted individuals may well be vulnerable due to their drug use, but it means different things in different contexts and, consequently, this vulnerability does not always imply that it necessarily undermines autonomy or agency.

There is a danger of confusion, as the various notions of vulnerability carry different normative force. However, I suggest that the concept still serves as a useful tool, for instance in research and treatment: not only does it indicate points of potential interventions, but also enables individuals to employ their vulnerabilities in a productive manner in the ways in which they wish to live their lives.

The agency of addicted individuals is as complex as any other agent’s agency even if it may seem that they are driven by only one motivation: to continue drug use. A view focusing only on that aspect of their agency

fails to understand that addressing the problems in addiction need not concern the cessation of that substance but to address the context and the reasons involved in the consumption of the drug (cf. Collins, Koroshetz and Volkow 2018). Understanding that drug use has different purposes and functions we are able to see that drug use *per se* does not make the individuals vulnerable (nor addicted), but contextual elements need to be taken into account in order to make an evaluation whether the use makes the individual vulnerable and, further, whether the vulnerability undermines autonomy or agency (and requires measures).

NOTES

- 1 It is important to understand the significance of this difference in the views. As the sources of vulnerability differ, also the potential harms that we are concerned with differ: the harms of drug use and addiction in the context of brain function are different from the harms caused by undesirable societal regulation of those substances. The measures to prevent, protect, and help are consequently different as well.
- 2 Steve Koester, University of Colorado, Denver presented the case of Denver in the Contemporary Drug Problems conference in Helsinki in late August 2017, where he discussed a case he had encountered in which basically criminalizing homelessness by municipal regulation has given rise to use of meth even among individuals who had reportedly taken a hostile attitude toward meth use prior the regulation.
3. The concept of autonomy has maintained its status as the contrast for vulnerability in the theoretical discussions (see for instance ten Have 2016) even if it has received extensive criticism (see for instance Straehle 2017). I will elaborate what I mean by it in the next section.
- 4 The characterization I provide is not meant as a complete understanding of addiction, nor is it meant to determine the phenomenon in a thorough way, but help our discussion of vulnerability in this context.
- 5 This is not to suggest that these synonyms would be any more precise and unambiguous than the phrase ‘being addicted to’, rather to point out that even a dictionary agrees with a variety of meanings to which ‘being addicted to’ is assigned.
- 6 As we are interested in vulnerability, it is important to mention that individuals who have been abstinent for a while, actually have a higher risk of overdose in case they start using again. Thus, addiction is not simplistically and short-sightedly a disorder that occurs only in individuals who are using drugs at that time.
- 7 It is a matter of debate whether this impairment is constituted by ‘a brain disease’ that is addiction (Koob and Volkow 2016) or whether it is something else (Heather et al. 2017), such as a disorder of choice (see Heyman 2009; Heyman 2013) or natural habit learning (Lewis 2015).
- 8 In bioethics and Anglo-American style analytical philosophy both ‘vulnerability’ and ‘autonomy’ have various meanings. (See for instance ten Have 2016; Straehle 2017.) The purpose of this article is not to argue for the “right” meaning of either, but to consider the most useful ways of understanding the concepts in this context, i.e. in understanding the agency of addicted individuals.
- 9 Not only are the policies making the drug users vulnerable in terms of sanctions, but the lack of surveillance in illegal drug markets poses another threat. For instance, heroin in the streets has been the source of vulnerability for the users in many respects; the uncertainty of its quality, the illegal measures in obtaining it, illegal status of consuming it, the potentially challenging hygiene in consumption, and so on.
- 10 This kind of view has raised criticism. Arguments against the concept of vulnerability claim that it is too broad and consequently loses its relevance. It becomes vacuous in a sense insofar as we want to single out special vulnerabilities. (Luna 2009: 128). However, the point is surely not to say that treating people *qua* finite human beings is irrelevant in many cases.
- 11 Here I do not consider it an instance of diminished autonomous agency if the agent being lost asks for advice (and receives it) from a local, for instance. Being autonomous does not mean that one has to be completely independent of others. Certain kind of dependencies in fact enable agency even though they may make us more sensitive to harms. Being in a loving relationship is an example of this kind of dependence. The person who is the object of love is in the position to cause greater emotional

harm to the person who loves them. This kind of vulnerability does not seem to affect one's agency in a detrimental way, necessarily.

- 12 Another way would be to justify paternalism with the principle of respect for autonomy (Beauchamp and Childress 2001). In this case, the agent who is the target of paternalistic measures has agreed to the intervention prior the situation. An example of this kind of paternalism would be a case in which an addicted individual signs up for a treatment programme that prohibits the individual from leaving the programme before they have successfully completed the programme. Even if the individual changes his or her mind during the programme, they are not allowed to leave.
- 13 For a brief review of the discussion see, for instance, Uusitalo and Broers 2015. Furthermore, for now, I am discussing treatment and research together though different regulations apply for consent in those areas. I do so because the differences the consent involves does not make a difference in the point I am making.
- 14 In any case, the discussion about research on heroin-assisted treatment has now taken new dimensions and is gaining more nuances (e.g. Steel et al. 2017). For instance, Steel and his colleagues suggest that there are analogical features in this kind of research to be found to the topic of non-exploitation in research in the developing countries. The financial interests of international pharmacological industry may drive research in the developing world in problematic ways. The situation of individuals in those countries may be such that a novel research on different diseases by the industry may well be *the only way* to have treatment for these ailments.
- 15 It should be noted that the critics of the brain disease view very rarely, if ever, claim that addicted individuals should be denied of treatment and other kind of help, rather they are interested in the kind of agency the addicted individuals are expected to have. The agency of addicted individuals implied by the brain disease model may well be counter-effective in its aims, as it highlights the diminished agency addicted individuals have due to drug use and thus hinders or even prevents the addicted individuals' beliefs and motivation in gaining control over their everyday lives (see e.g. Heather et al. 2017).

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<accessed 9 May 2019>

SUSANNE UUSITALO
UNIVERSITY TEACHER IN PHILOSOPHY
DEPARTMENT OF PHILOSOPHY,
CONTEMPORARY HISTORY AND
POLITICAL SCIENCE
UNIVERSITY OF TURKU
susuus@utu.fi