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ORIGINAL PAPER

Addiction and Volitional Abilities: Stakeholders' Understandings and their Ethical and Practical Implications

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Abstract Addiction is a common condition affecting millions of people worldwide of which only a small proportion receives treatment. The development and use of healthcare services is influenced by how addiction is understood (e.g., a condition to treat, a shameful condition to stigmatize), notably with respect to how volition is impacted (e.g., addiction as a choice or a disease beyond one's control). Through semi-structured qualitative interviews, we explore the implicit views and understandings of addiction and volition across three stakeholder groups: people with lived experience of addiction, clinicians with experience treating addiction, and members of the public without lived experience of addiction. We notably examine whether three paradigms, i.e., three philosophical sets of understandings about the nature of reality and knowledge (realism, relativism, pragmatism) reflect how stakeholders envision addiction and volition in the context of addiction. The use of these paradigms allows for the characterization of different stances on addiction and volition and an assessment of the coherence of beliefs about these matters. Our findings demonstrate that few participants relied on a single epistemic paradigm when describing their views. Furthermore, there were notable differences in understandings of volition between the clinician group, who were more oriented toward pragmatism, and people with lived experience of addiction, who

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were less oriented toward realism. Despite its limitations, our study suggests that a greater appreciation for the complexity of views held by different stakeholders about addiction and volition could help critically assess the search for coherence expressed in academic and policy debates.

Keywords Addiction · Substance use disorder · Ethics · Free will · Volition · Qualitative research

Introduction

Drug addiction[1] is a common condition estimated to affect 35 million people worldwide who require treatment services while only one out of seven receives treatment [1]. In Canada, addiction affects one in five persons in their lifetime [2]. Yet, despite this high prevalence, which can vary according to definitions and diagnostic criteria used, people who use drugs (PWUD), and most specifically people who misuse drugs or develop substance use disorders, remain among the most discriminated and structurally vulnerable populations in healthcare [3–7]. There are well-known physical barriers to treatment for PWUD, such as geographical distance, issues of anonymity/registration requirements, and fear of criminalization [8, 9]. Moreover, even when services are tailored to the needs of the most structurally vulnerable users and aim to lower the effects of these physical barriers, issues surrounding trust and competence have been identified as greatly limiting access to these services [10]. Related to these issues are important questions of how disordered drug use is understood, notably with respect to how volition is impacted in addiction [11].

The lack of trust and understanding toward PWUD is considered to have many roots, one of which concerns the philosophy – or the "hidden arguments" – of clinicians [12, 13]. Clinicians' hidden arguments undeniably affect their practice, yet they are difficult to capture due to their implicit nature. Further, explicit and implicit understandings of the experience of struggling with disordered drug use are influenced by each person's own background and relationship to the phenomenon. For example, the disease framing of substance use disorders may encourage viewing it as an individual issue and carry assumptions about the role for volition in the context of disordered drug use – typically, that the brain is "hijacked" such that the person in question cannot make decisions of their own volition [14–16]. However, there could be different ways to internalize this framing according to one own's relationship to disordered drug use which entail different implicit understandings of the volitional abilities of PWUD. Drew [17] addressed this possibility by evoking the behaviours this belief could entail for PWUD and for clinicians. Namely, "[t]he disease concept introduces the danger that persons who are said to have the disease will abdicate personal responsibility, both for their behaviour and for their recovery, and that those who make the diagnosis will expect that they should be able to impose an effective cure." (p.264). Such implicit and rather philosophical assumptions about the nature and characteristics of disordered drug use and related understandings about volition and responsibility in this context have important practical implications. For example, as discussed earlier, viewing disordered drug use as a medical disease tends to lead to framing PWUD's decisions as purely compulsive, without providing full insight into the low retention rates of participants in clinical trials who receive a substitute for their substance of choice for free [18, 19] although other factors are likely at stake since methadone and buprenorphine are likely not the drug of choice. Conversely, viewing disordered drug use as a choice (e.g. [20],) is often criticized for limiting the possibility to engage with important observations about the neurobiology of substance use disorders [21, 22]. Furthermore, as indicated earlier, the use of drugs and access to services and support for problematic drug use is socially-shaped such that attribution of drug use to mere choice does not render justice to the significant impact of social determinants of health on PWUD [23]. Thus, the framing of disordered drug use (e.g., as disease, as a choice, as being socially shaped by social determinants of health) has potential impacts

[1] In this paper, we use the word addiction as minimally as possible, referring instead to disordered drug use, which we characterize as drug use that feels abnormal to the person, whether or not they qualify to or even seek a medical diagnosis of substance use disorder. Still, since at the time of conducting our research project, we focused on addiction, we must acknowledge that our research speaks to the stakeholders' understandings of addiction and refer to this term when referencing participants' understandings or experiences.

on health policy and public understandings of drug use more broadly.

In this paper, we explore the implicit views and understandings of addiction, drug use and volition through the analysis of qualitative interviews with three stakeholder groups: people with lived experience of addiction (PwLEA),[2] clinicians, and members of the public without lived experience of addiction. The inclusion of groups with different relationships to drugs is intended to allow comparisons in views held between groups and understand how different life experiences shape discourse about addiction and volition in the context of drug use. We also explore whether three paradigms, i.e., three sets of understandings about the nature of reality and knowledge (realism, relativism, pragmatism) [24–26] can reflect stakeholders' understandings of disordered drug use and volition. To simplify (see Table 1 in methods for greater elaboration), *realism (or objectivism)* admits that things exist independently of epistemic agents, such that objective knowledge about things is both achievable and accessible [27, 28]. *Relativism (or subjectivism)* holds that knowledge about the world is accessed through subjective experiences, where as humans, our views are shaped by our relative environment [29]. *Pragmatism (or interactionism)* posits that the world is constituted by interactions and that understanding these interactions (e.g., through intersubjective analysis) allows us to understand the effect that our interactions with the environment has on us and vice-versa [30, 31].

Importantly, although philosophical reflection on paradigms and assumptions about drug misuse and substance use disorders is active and ongoing [32], few studies have tackled how disordered drug used is conceptualized at a more philosophical level by taking into account natural discourse, particularly the experience and first-person accounts of PWUD (for a rare exception, see [33]). Likewise, the role of volition in further understanding disordered drug use and related behaviours has seldom been explored qualitatively. It has been more common to measure concepts describing volition, such as free will and control, through quantitative scales [34, 35]. However, personal understandings of volitional abilities, and more generally the way they relate to views of the world, are important to gather, as they could bring new perspectives to ongoing discussions about PWUD and how drug policy focused on harm reduction ought to be developed with perspectives of PWUD integrated into ethical deliberations. This latter claim presumes an account of ethics (e.g., hermeneutical, pragmatist) that recognizes that a better understanding of human and social realities helps make sense of situations as they are experienced and such understandings help enrich and nurture creative reflection on possible scenarios to surmount ethical challenges [36, 37]. Within such a view, the traditional tension or dichotomy drawn between is and ought is reformulated as a tension between lived experience (current and past lived experience) and aspired or projected experience. In short it reinterprets the tension as a temporal tension within the existence and experience of people [38]. Also, because this ethical orientation brings attention to human growth and flourishing which tap into intrinsic motivations and personal narratives, it is of crucial importance to involve those concerned by situations to participate in sharing experiences about them and participate in the imagination of response to those situations [39–41]. This study is a modest step in this direction.

Methods

Study design and interviews

A qualitative study based on semi-structured interviews was conducted to provide insight into how disordered drug use (*addiction*) and volitional abilities are perceived. From a methodological standpoint, we did not pull from standard social science paradigms (as introduced by Guba and Lincoln [42]) because of the limitations of paradigm-based social science from the standpoint of hermeneutic and pragmatist scholarship which advocate for more open-ended use of empirical ethics research methods ([31, 43]). Also, we felt that this more open and simpler orientation helped avoid confusion between

[2] During recruitment, participants self-identified as having lived experience of addiction to a drug, with or without a medical diagnosis of substance use disorder. Hence, in this paper, we use the terminology people with lived experience of addiction (PwLEA). We recognize that terminology has evolved and therefore only use the term when referring to the participants in our study to respect how they chose to identify at that time.

Table 1 Overview of paradigms used in interpretative content analysis

	Realism	Relativism	Pragmatism	Other	Inconclusive
Concepts describing volition	Concepts are discrete, either wholly applying to individuals' experiences or not Concepts are static and fixed—they do not change over time or according to social/ individual factors Concepts are ultimately objective	Concepts are relative to social, cultural or individual factors (e.g., age, social group, impulsivity, level of intoxication, personality, mental health, etc.) Concepts are ultimately subjective; they vary from one person to the next	Concepts are co-constructed through interactions Concepts are dynamic and fluctuate according to the time, situation and the relationships at play Concepts are tools which help or hinder individuals in maintaining or building relationships	—	—
Inclusion	There is no difference between concepts (e.g., free-will and willpower) Concepts differentiate recreational use from compulsive drug use Concepts do not relate to addiction whatsoever (e.g., addiction is not a question of willpower)	Concepts (e.g., willpower) vary from one person to the next (based on vulnerability) Concepts (e.g., consent) are influenced by social, legal and individual factors (e.g., social standings, personality, level of intoxication)	Concepts involve a bi-directional interaction between personal and environmental factors Concepts are inscribed in and understood through intersubjective experiences Concepts are relational and operates on a continuum (not discrete)	Answers convey a coherent line of thought that does not align with any of the three paradigms	Answers are either *incomplete* (too short or lacking in depth), *vague* (detailed yet too ambiguous to interpret), or *implicit* (information that only implicitly responds to the question)
Exclusion	Concepts vary according to drug of choice, stage of addiction, age, etc. Concepts fluctuate and/or operate on a continuum	Concepts operate on a continuum and fluctuate There is no difference between certain concepts Concepts do not apply to a person's experiences	Concepts are particular to each and every individual apart from environmental interactions (e.g., free-will or willpower affected by level of impulsivity)	Answers align with one of the three paradigms	Answers align with one of the three paradigms or fits in the "other" category

Table 1 (continued)

	Realism	Relativism	Pragmatism	Other	Inconclusive
Addiction & drug use	Addiction is a static and discrete condition (all or nothing, the same across all individuals) The morality of drug use is either wholly right or wrong for all individuals Determinations of an addiction can be made via algorithmic, objective judgments Addiction can be treated according to one model applied to all individuals with addiction Addiction is rooted in unchanging factors common to all persons with addiction The impacts and effects of drug use are similar for all individuals, rooted in unchanging factors	Addiction and drug use are (or should be) construed relative to a social or scientific framework or according to subjective differences among individuals Drug use has a moral value according to social, scientific or political contexts (e.g., legality, medical prescription) Determinations of addiction (and whether it is problematic) are made relative to contextual and social factors (e.g., culture, legality, social acceptance, etc.) The impacts and effects of drug use are relative to social, cultural or individual factors	Addiction is dynamic; it is a process which fluctuates and changes over time Drug use has a moral value according to the interactions that individuals share with their environment Addiction is an intersubjective experience shaped by the interactions between individuals and their environment Drug use can hinder or help individuals maintain or build relationships The impacts of addiction and drug use are relational and intersubjective Addiction can be treated through dialogical approaches which engage those affected by drug use	––	––
Inclusion	Addiction makes people act the same way to obtain drugs even if some drugs involve different physical effects Addiction boils down to meeting certain criteria used in rehabilitation and recovery All forms of addiction stem from emotional problems, not being able to manage difficult experiences Anyone is at risk of developing an addiction	Addiction and drug use should be understood according to what is socially preferable (e.g., teaching addiction as a brain disease to reduce stigma) Addiction and drug use differ in impact and effect according to the substance of choice Addiction and drug use are encouraged by and involve society as a whole	Addiction progressively affects the social network or relationships of individuals Addiction impairs people's ability to be emotionally connected to others Addiction and drug use involve interactions between environmental and personal factors (e.g., divorce, family relations, mental health)	Answers convey a coherent line of thought that does not align with any of the three paradigms	Answers are either *incomplete* (too short or lacking in depth), *vague* (detailed yet too ambiguous to interpret), or *implicit* (information that only implicitly responds to the question)

Table 1 (continued)

	Realism	Relativism	Pragmatism	Other	Inconclusive
Exclusion	Drug use is situationally morally acceptable depending on whether it does harm to others Addiction varies in degree of severity and is multifaceted; it begins with a choice that gets progressively eroded	Addiction and drug use involve the same impacts and consequences for all substance (ab)users Addiction is compulsive, whereas recreational drug use is not; both are clearly differentiable from one another	Addiction boils down to the same condition in every person, even if some drugs are more harmful than others Addiction can be understood apart from the transactional experiences of individuals	Answers align with one of the three paradigms	Answers align with one of the three paradigms or fits in the "other" category

epistemic paradigms about addiction and volition in addiction, and social science paradigms.

The protocol and study materials were approved by the Institut de recherches cliniques de Montréal ethics review board to ensure consistency with provincial and federal research ethics policies. An interview guide using open-ended questions was developed by CB and ER. The interview guide was also translated to French by MR and reviewed by ER. The interview questions aimed to capture participants' understandings of addiction, i.e., how they understood the nature of addiction; whether they agreed with and knew of existing models of addiction; and what factors impacted addiction and drug use-related behaviours. The questions also targeted participants' understandings of volition: whether or when PWUD demonstrated volitional abilities in decision-making; whether there was a difference between different concepts describing volition (e.g., free will, willpower); and whether volition was necessary for treating addiction. A total of 48 interviews were conducted between April and August 2019; 44 in English and four in French. The interviews were transcribed either by a professional transcription service ($n=45$) or by a research team member ($n=3$). French interviews ($n=4$) were transcribed in the original language, then translated by a team member. All material was anonymized.

Selection and recruitment

Stakeholders were selected based on the relationship they had with addiction: PwLEA, clinicians with professional expertise in the field of substance use disorder, and members of the public, without any personal experience of addiction. Recruitment was undertaken via advertisements posted online targeting people living in or in the vicinities of Toronto, Vancouver, and Montreal, as well as snowball sampling. The postings were made on a common Canadian online multi-purpose community platform (Kijiji). For clinicians, we recruited additionally through peer networks.

Participants

Sixteen members of each group were recruited, for a total of 48 interviews averaging 60 min each. The interviews were done over the phone and in person (as possible given the location of participants). Clinicians

had anywhere from eight to 44 years of practice in addiction ($n=14$; mean = 19.07; SD = 10.64). Their specializations were the following: addiction counselling ($n=4$), family medicine ($n=3$), addiction medicine ($n=2$), addiction psychiatry ($n=2$), clinical psychology ($n=2$), nursing ($n=2$), and infectious diseases ($n=1$). Members of the public were between 23 and 70 years of age ($n=16$; mean = 40.25; SD = 16.15). PwLEA were between 22 and 55 years old ($n=15$; mean = 36.53; SD = 10.34) and described having a past or present addiction to the following drugs: alcohol ($n=7$), cannabis ($n=7$), prescription drugs ($n=3$), cocaine ($n=3$), crack cocaine ($n=2$), nicotine ($n=2$), hallucinogens ($n=1$), cough syrup ($n=1$), ketamine ($n=1$) and amphetamine ($n=1$). Almost half of the PwLEA group reported having current or past problems with more than one substance ($n=7$).

Coding and analysis

Thematic content analysis

Transcripts were imported into MAXQDA software for coding. An inductive and iterative method of thematic analysis (as outlined in [44] but with some accommodation to describe quantitatively some patterns of data, see note below) was applied to the transcripts to capture the more explicit content related to the nature of addiction and volitional abilities therein. After a first read-through of the transcripts, MV and MR produced preliminary themes to initiate the coding process. Then, additional themes were piloted by MV using a sample of the coded segments for each theme and submitted to MR and ER for review against the dataset. This step allowed for revisions of the coding guide to better fit the data and ensure rigour in the process. Moreover, 10 percent of all coded segments were reviewed by MR for accuracy and coherence with the coding guide. ER also reviewed all coding: once halfway through, and once at the end of the coding process. As a final step, MV produced and refined definitions of the themes (addiction and drug use; concepts describing volition) and related subthemes. Addiction/drug use was divided into four sub-themes: (1) the nature of addiction/drug use; (2) evaluations of addiction; (3) the impact of addiction/drug use; and (4) the morality of addiction/drug use. Content related to volition was divided into 2 subthemes: (1) the nature of the concept describing volition; and (2) evaluations of whether persons displayed or possessed volition.

Interpretative content analysis

Additionally, a more interpretive content analysis (as used for example by [45]) was conducted, consisting in an iterative process of articulating the specific aspects of epistemic paradigms in the context of addiction. This content was more implicit and required greater interpretation and contextualization on behalf of the coders. First, three paradigms were selected by MR, MV and ER for relevancy on the topics of addiction and volition: realism, relativism and pragmatism. Definitions were elaborated by MR and MV based on philosophical content from journal articles and the Stanford Encyclopedia of Philosophy [27–31, 46]. These definitions were then further detailed to capture how the themes identified in the previous step related to the sub-themes of addiction and volition (see Table 1). The paradigms used serve as Weberian ideal types to help bring coherence to the data, notably the relationships between sub-themes. We recognize that these paradigms are simplified accounts of the positions they express and are used only to help organize and interpret the data from an empirical research standpoint. Their virtue is chiefly to help characterize views about addiction and volition and assess whether participants hold a coherent view on these matters. They do not serve a justificatory function in a broader philosophical sense.

We compiled the number of segments from each participant in every theme/sub-theme and every paradigm to explore whether the paradigms could represent an individual's opinion on addiction or on volition. After piloting with one quarter of the participants, it was convened that participants' views on addiction and/or volition were well represented by one paradigm when most of the views they expressed on a given topic were associated to this paradigm. The use of quantification was limited to helping in creating this categorization, which is mobilized in the results section in discussing the internal coherence of

participants' adherence to paradigms as well as group patterns. When no single paradigm represented participants' views well for a given theme, the category of "mixed views" was attributed. When the participants conveyed a coherent line of thought that did not align with any of the three paradigms, the category of "other" was assigned. When no paradigm could be attributed and no coherent line of content would be identified, coding was inconclusive and suspended (this occurred only once for participant P13 with respect to theme 1, views on addiction).

Data presentation

Tables with citations are used to illustrate specific aspects of the thematic content analysis while qualitative text syntheses are used to report observations stemming from the interpretive content analysis and observations made thereon, notably with respect to paradigms. Quantification is used sparingly given the qualitative nature of the study such as in the description of patterns of alignment of participants with the three epistemic paradigms. In this respect, we depart slightly from a focus on purely qualitative ways of presenting data as suggested by Braun & Clark's [44] standard thematic analysis. For the epistemic paradigms, we report on salient content in each paradigm and give a sense of the coherence of the sub-themes within paradigms. Given that no participants would explicitly call upon these paradigms, we use expressions such as "content aligning with paradigm 1, 2, 3" and "views corresponding to", but these should be interpreted with the current data analysis strategy in mind. We use acronyms representing their stakeholder group (C for clinician, P for public, PwLEA for people with lived experience of addiction) and a specific number to identify each participant. Addiction and drug use are considered two different concepts as participants often drew a distinction between them. Where the terms "addiction & drug use" is used, the reader should understand that we mean the statement in question concerns both concepts. Although separate citations for the four sub-themes of addiction and drug use as well as the two sub-themes of the concepts describing volition are provided, this is a simplification, since participants' views on these sub-themes were intricately related, and most participants addressed many sub-themes simultaneously. Definitions for the more specific sub-themes are provided in the results section of this paper (in Table 2 for addiction and in Table 3 for volition; the full coding guide is also available as supplementary material).

Results

Understandings of addiction & drug use

Overall, some participants expressed views about addiction that aligned with realism (N = 3; 1C/2P), relativism (N = 8; 3PwLEA/2C/3P), and pragmatism (N = 7; 3PwLEA/3C/1P), however, the vast majority had mixed views (N = 26; 10PwLEA/9C/7P), some held other views (N = 3; 1C/2P) and one was inconclusive (P13).

Table 2 reports content for the four sub-themes of addiction & drug use as they are associated with each paradigm and example citations. The nature of addiction (sub-theme 1) and the impacts of addiction (sub-theme 3) were most extensively discussed by the participants. They were also often tied together in participants' views. For example, in the following description of addiction: "addiction is losing control", the nature of addiction is tied to a perceived impact (sub-theme 3). In general, neither the morality of addiction nor the morality of drug use (sub-theme 4) was as closely connected to other sub-themes. Most often, addiction was considered as neither the person's choice nor something for which they should be blamed. Only one participant claimed that addiction was morally wrong. Importantly, only in the context of this sub-theme were drug use and addiction always distinguished.

Realism

Content related to realist sub-themes tended to be interconnected. For example, participants who identified the nature of addiction (sub-theme 1) as independent from social and personal factors often also considered that evaluations of addiction (sub-theme 2) could be premised on objective and tangible criteria (See PwLEA12, Table 2: sub-theme 2/realism). Similarly, a realist understanding about the impacts of addiction (sub-theme 3) was commonly paired with statements which ascribed a fixed nature to addiction (sub-theme 1) while endorsing objective, standard criteria for evaluating addiction (sub-theme 2). There were also connections

Table 2 Views on adivtion and drug use with respect to three epistemic paradigms

	Realism	Relativism	Pragmatism
Sub-theme 1: Nature of addiction/drug use	Addiction/drug use is a static and generalizable state, rooted in unchanging factors, wholly applying (or not) to persons' experiences	Addiction/drug use is, or should be, construed relative to a social or scientific framework, or to perceived differences among individuals	Addiction/drug use is dynamic, operates on a spectrum, and can be understood via dialogical, participative approaches
Illustrative citations	"I've seen my addiction present itself in other ways, not just in the use of drugs. You know, I've seen it present itself in the spending of money, I guess, poor, impulsive decision-making. So, I think that the drug does play a role. Just physiologically, the drug definitely varies. But when it comes to addiction, I think addiction is addiction is addiction, you know?" (PwLEA3)	"Personally, I feel that it's more of habits, but according to what I'm hearing now from doctors and other people, people seem to be preferring to refer to it as a brain disease, so I'm kind of willing to go along with that." (PwLEA11)	"I think it's true that the substance itself has some influence on the brain functioning so that the salience of drug gets higher so that the patient […] has some kind of crooked perception of advantages and disadvantages related to the drug. But at the same time, it's also true that there is a lot of other influences, the social influences in the environment, and also even the personality of the person, and the support system she might have." (C2)
Sub-theme 2: Evaluations of addiction	Evaluations of whether drug use is problematic can be made via algorithmic, objective judgments	Evaluations of whether drug use is problematic are made relative to contextual and social factors	Evaluations of whether drug use is problematic involve interactions
Illustrative citations	"But to me, an alcoholic is just filling up the list that they have in specialized rehab centres. They have like five questions. Has it affected your life, your family life, your professional life? Have you tried to stop drinking and not been able to? Have you lost relationships because of it? Have you had drinks in the morning? You know, that is an alcoholic." (PwLEA12)	"I guess it's more recreational […] as long as […] there's not harm to them or others. I think that's the thing, is like, you know, they're not harming themselves or others. Now, that's a very broad thing, and that harm can come in many ways, but I think the idea, insomuch as use of a substance doesn't lead to harm […], I'm not going to be hung up on just because it's a drug and somebody gets high." (C5)	"A drug impacts the welfare of a community, the resources of a community. Drugs influence families. So, certainly that impacts… The addict isn't in isolation, and behaviour isn't in isolation, so therefore, it becomes problematic. And I think when the user's behaviour impacts detrimentally to his or her community, then we have a problem that has to be addressed." (P12)
Sub-theme 3: Impacts of addiction/drug use	The impacts of addiction/drug use are similar for all individuals, whether some drugs are more addictive than others or not	The impacts of addiction/drug use are judged relative to social, cultural, or individual factors	The impacts of addiction/drug use are inscribed in context and shaped by the environmental settings of an individual

Table 2 (continued)

	Realism	Relativism	Pragmatism
Illustrative citations	"It's not as simple as making a choice. There's biochemistry at play that makes it challenging […]. People have a biological illness, and that illness is impacting their ability to make a decision. So, medicines are required […] to help people make certain decisions around drug use." (C16)	"So much of what's harmful about addiction is how other people perceive you. And that's less of a choice [or] a willpower thing. That's more just how society is sort of structured." (PwLEA8)	"If I bump into someone on the street that I know, and they offer me some drugs, it's very easy for me to just say no and walk away. But, if I'm hanging out at someone's house, and it's a comfortable setting, in four walls, nobody else is there, it's very difficult for me to walk away from that situation." (PwLEA4)
Sub-theme 4: Addiction/drug use morality	The morality of addiction/drug use is objective and applies to everyone	The morality of addiction/drug use is determined relative to social, scientific, or political contexts	The morality of addiction/drug use involves transactional experiences
Illustrative citations	"If I [had] the power, I would just take that out of the street, especially cannabis, because […] when people take [drugs], they don't know what they're doing. They kill. They do kind of crazy stuff." (P7)	"I would say [morality] is not part of how I view substance use. What I would be more moved is certainly the consequences and how society reacts to substance use and addiction and people with addiction. That I would be probably reacting more from a moral standpoint but not necessarily towards people who actually use but more about how society reacts to those people." (C7)	"I don't think [drug use] is morally wrong in and of itself. Like, I think sometimes it can become a moral choice when it's affecting other people and when other people are telling the person that it's having a negative effect on them." (P4)

Table 3 Views on concepts describing volition with respect to three epistemic paradigms

	Realism	Relativism	Pragmatism
Sub-theme 1: Nature of concepts	Concepts are static and fixed; they never change	Concepts are relative to social, cultural, or individual factors	Concepts are dynamic and fluctuate according to the time, situation, and relationships at play
Illustrative citations	"I think if you're addicted, you don't have free will **free will**. No matter what your addiction is, at one point you're going to hit rock bottom." (PwLEA3)	"There are as many possibilities within **control** as there are addicts. In the sense that it depends where they're at […], [if] they're heavily using. Especially like for example, what I notice, is the youngest. They're harder to help achieve **control** [because] they're in the here-and-now." (C12)	"I would say there's times when I feel myself to be very strong willed s**trong willed** and there's times when I feel myself to be very **weak willed** and it's really fluid and can oscillate between the two extremes pretty heavily. […] [I attribute my] **will** to return to a nourishing mind state partially [to] my body and my brain wanting to survive and partially [to] a relationship with my environment where I've been fortunate to be surrounded by resilience influencers." (PwLEA2)
Sub-theme 2: Evaluation of concepts	Concepts are objective; they discretely apply to persons' experiences	Concepts are subjective; they apply differently from one person to the next	Concepts are intersubjective; they are tools, which are co-constructed through interactions
Illustrative citations	"If they would do some decisions that are based on **control**, they would probably […] decide to ask for help. So, they don't **control**. And they can't **control**." (P6)	"Everyone's choices are limited to varying degrees, and we don't have a perfectly **'free' will** ever. I think everyone is constrained in certain areas and then **free** in others." (P3)	"I would not go as far as saying as soon as they are using regularly […], they lose their capacity to **choose**. I wouldn't go there – that's too far. I think there's also, again, an interaction with their mental health […], so, when do they lose their capacity in that continuum? I don't know if I have the answer." (C2)

*Words in bold characters call attention to which concept describing volition are called upon in the corresponding citations

between a realist view on the nature of addiction and participants' judgments of the morality of addiction. This was represented by statements such as: 'I definitely don't see it as morally wrong. I see it as you may do some very amoral and immoral things while under the influence, but it's an illness' (C3). Overall, the realist paradigm was most often associated with considering addiction/drug use as morally neutral.

Relativism

For views related to relativism, the nature of addiction (sub-theme 1) tended to be more concretely described. Likewise, the evaluation of addiction (sub-theme 2) was made based more on subjective experience and whether it impacted others. The impacts of addiction (sub-theme 3) varied based on a person's social environment and accepted social norms. Interestingly, there was less cohesion between the three sub-themes as compared to realism. This is also evidenced by the fact that relativist view on sub-themes of addiction could more easily coexist with other paradigms. Within relativist views, the impacts (sub-theme 3) and morality (sub-theme 4) of addiction were seen as highly contingent on individual, social, or political determinants, and not as being based on objective, universal criteria. Relativism was the most widely used paradigm when addressing features of drug use morality (sub-theme 4). Participants in all groups commonly framed their moral views of addiction and drug use as contingent on certain behaviours deviating from social norms. For example, drug use was considered morally neutral, unless the person using drugs stopped taking their parental responsibilities seriously or started stealing to obtain their drugs (i.e., drug use is morally wrong if it affects others).

Pragmatism

Participants whose views were consistent with pragmatism recognized not only an influence from but an interaction between personal and social factors as constitutive of the nature of addiction (sub-theme 1). When participants described the nature of addiction (sub-theme 1) as inherently dynamic and contextual, their conception of evaluations of addiction (sub-theme 2) tended to be equally rooted in dynamic and contextual factors. Such a relationship was not as evident between the other sub-themes. Only a small proportion of participants viewed evaluations of addiction (sub-theme 2) and drug use morality (sub-theme 4) as aligned with a pragmatic paradigm. Within pragmatic views, the impacts of addiction (sub-theme 3) were described as dynamic and different from one person to the next, not because PwLEA passively received pressures from the environment, but because they interacted with these factors – time, willpower, capacity to reach out for support, discomfort, impulsivity, ability to cope, desire for the drugs are all everchanging factors that the person juggles with, has power to act upon, etc. As such, the nature of addiction (sub-theme 1) was here best disclosed by engaging in dialogue with those concerned. Relatedly, pragmatic views on addiction were different from both the realist and relativist views insofar as multiple perspectives were considered. One way the interactionist characteristics of pragmatism revealed themselves in people's personal and relational autonomy, in terms of how participants interpreted, lived, and coped with the pressures of their environment, their behaviour, and the impacts of drug use, while considering their own active role in it.

Understandings of concepts describing volition

Overall, with respect to views about volition, participants aligned with realism (N = 10; 3PwLEA/1C/6P), relativism (N = 7; 4PwLEA/1C/2P), but again the vast majority had mixed views (N = 28; 8PwLEA/13C/7P) and some held other views (N = 3; 1PwLEA/1C/1P). No participant's views were predominantly aligned with the paradigm of pragmatism.

Participants tended to consider PwLEA as having volition but had different ideas about how and whether different concepts describing volition played a role in addiction (Table 3). For instance, some considered that PwLEA had free will but could not act on it because of their compulsions. They also claimed that PwLEA had the capacity for choice, but lack of control over their drug use prevented them from enacting it. For others, free will and willpower were always available to PwLEA, but these individuals consistently made the choice not to cease their drug use – even if this choice might not have been free from external influences. There was limited overall consistency in the adhesion to a single paradigm with respect to the nature of one concept describing volition (sub-theme 1) and the evaluation of the same concept (sub-theme 2). Across all three paradigms and concepts describing volition, several factors were identified and agreed upon as affecting

negatively volitional abilities: withdrawal/physical dependence, intoxication, changes in brain circuitry, personal resources (e.g., intellectual, financial, psychological), and social pressures (e.g., peer pressure, social/cultural expectations and norms, pressure of performance).

Realism Views aligned with the realist paradigm described concepts of volition as rather static and fixed, and as applying discretely to persons' experiences. Personal factors, such as physical dependence to drugs, were sometimes acknowledged but did not profoundly affect respondents' views of whether PwLEA could possess volition. For example, a member of the public stated: "I think that people have the ability to choose to do other things, like even if they are addicted to a drug. People always have the ability to choose to do otherwise." (P4) The two realist sub-themes were more often coupled together in participants' views. For example, P4's reasoning cited above speaks to the unwavering nature of choice (sub-theme 1), which could prompt one to say that choice can always be evaluated by a third party (sub-theme 2). Other participants holding realist views on concepts of volition could also advance the opposite; that PwLEA never have the ability to make free choices as long as they continue using drugs (see Table 3: nature of concepts/realism). Finally, invoking a realist account of the nature of free will (sub-theme 1) was frequent. Participants specifically attributed a fixed, all-or-nothing nature to the concept of free will, often noting that it was an illusion. This view, namely that "free will" inherently requires absolute or unobstructed "free" will, was reflected by some participants and how they denied that the concept exists at all (e.g., "I think we have a certain amount of control but certainly not the way people talk about free will, like if you want it bad enough you can just do it. I don't think that's possible", PwLEA6).

Relativism Content aligned with the paradigm of relativism described volition as relative to social, cultural, or individual factors. Physical dependence was often identified as a factor limiting PwLEA's volition (i.e., more physically dependent PwLEA have more constrained volition). Another limiting factor was the subjective feelings of PwLEA in dealing with physical dependence. Illustratively, one participant with lived experience highlighted that: "We tend to gravitate towards behaviours that we perceive to be of benefit to us […], so I believe we make decisions based on what we perceive to be in our own best interest, and the trick is 'what we perceive'" (PwLEA8). On the whole, participants with relativist views recognized minimal agency for persons in interacting with and modifying their environment, alternatively viewing individuals more as a product of their circumstances and recipients of rather unilateral influences.

Pragmatism Content aligned with the paradigm of pragmatism described volition concepts as dynamic and fluctuating according to the time, situation, and relationships at play. For example, one clinician mentioned how for PwLEA, "[Decision-making is] compromised in that they make the decision to come; they don't come; they cancel; they have three days sober with good determination to continue; they pass a bar; and it's over. The decision is compromised. There's triggers that will definitely… Even many years into sobriety, there are still triggers." (C3) In this case, the nature of volitional abilities (sub-theme 1) was situated in an environment and in time (volition can affect the decisions made, and the decisions made can affect volition); hence, the evaluation of volitional abilities (sub-theme 2) as compromised was heavily influenced by a dynamic, fluctuating context. As was the case for the topic of addiction and drug use, participants' pragmatic views on concepts describing volition were the most heterogeneous out of the three paradigms. Participants expressing pragmatic views on volition were the most likely to have overall mixed views.

Coherence of Participants' Views within Paradigms The interpretive content analysis of paradigm-related content undertaken could suggest that respondents held philosophically coherent ideas about sub-themes consistent with a single paradigm. However, less than half of participants had views associated with a clear, dominant paradigm, in either of the two main themes (understandings of addiction/drug use, and understandings of volition). In particular, the numerous participants with mixed views on addiction or mixed views on volition, conceived of these topics in ways that drew on characteristics of multiple paradigms (see Table 4). Table 4 illustrates how single participants held such mixed views pulling from

Table 4 Illustrations of Pluralism in Use of Three Paragdigms

	Realism	Relativism	Pragmatism
	Views on Addiction and Drug Use (Sub-theme 1: Nature of addiction/drug use)		
Participant	Addiction/drug use is a static and generalizable state, rooted in unchanging factors, wholly applying (or not) to persons' experiences	Addiction/drug use is, or should be, construed relative to a social or scientific framework, or to perceived differences among individuals	Addiction/drug use is dynamic, operates on a spectrum, and can be understood via dialogical, participative approaches
C13	"I think if you talk to anybody who has an addiction, they will talk about stuff that happened to them […]. Addiction's an escape, you know, it's a medicate, and it's a way not to stay in reality; it's a way to escape from the reality; it's a way to numb out."	"For some, the person, you know, it's not saying one drug is better than the other. We all say they're all equally as destructive. I'm just saying something like crack/cocaine is so powerful that the minute someone… is in their system, they're gone. Alcohol, it's more gradual […], it's usually a progression of getting addicted."	"Exposure, early exposure is a big thing. You know, family history, you know it's a genetic piece, is very powerful. The research shows maybe 70 percent have addicts in their family […] but it's like being predisposed to diabetes or heart disease. You know, it isn't necessarily going to manifest. But if it's in the environment, you know, it's also going to amplify, yeah. So, I think there's a combination."
PwLEA2	N/A	"Because ketamine is a harder drug and it's not normalized, I have to… when I decide to do it or not, the choice is a lot more mindful as opposed to just having a glass of wine at work. I'm really enjoying that. It's really a lot less normalized. It's not chill. It's not chill in mainstream society to abuse these drugs in the same way as alcohol, and that's what I like. My intention is not to use drugs as casually as alcohol."	"I definitely stole from friends. I was staying with a friend who had some codeine in his cupboard, and I remember taking some of that. And […] I realized that […] other people have left over prescriptions from surgeries they've had or something and they just have them in their house. And I remember being like 'That's crazy to have this… If I had this, it would be gone in two weeks of course. I would never last'."
	Views on Concepts Describing Volition (Sub-theme 1: Nature of concepts)		
Participants	Concepts are static and fixed, they never change	Concepts are relative to social, cultural, or individual factors	Concepts are dynamic and fluctuate according to the time, situation, and relationships at play
P4	"Even if they aren't quitting, they have the option to […] seek support that could lead to them quitting or seek information about quitting. So, I think free will is always involved."	"If people drink to the point of […] not even necessarily blacking out but just like being really drunk, or [do] some other drugs […], I would say people have less control when they're on them because sometimes they're not even really aware of what they're doing."	"People who have [naturally] more willpower, if they made the decision that they wanted to quit doing whatever drug they were addicted to, they would find it easier to just make that decision and then act on it. Whereas, people who have less willpower, maybe would need more in terms of like seeking medical support or medical programs or having social support. I guess it kind of goes both ways, though, because having social support I think makes it easier to have willpower."

Table 4 (continued)

	Realism	Relativism	Pragmatism
C13	"Addiction changes the brain, impacts the brain. So, willpower really isn't there when you're in the midst of this. I mean, that's why people put themselves down so much [with] 'I should have', […] you know, 'I'm going to control this'. And we tell: 'No, you need to surrender to this. It's not about trying to control this. You've tried to control it, and it hasn't worked'."	"In their addiction, no, I don't think they're capable of… depending of course on their drug of choice. You know, somebody who's on crack cocaine is in la-la-land […]. There's no choice point, I believe, once you're in it. But maybe there are some choices before you get into it."	"I talk very clearly with clients around 'neurons that fire together wire together' […] So you're walking down a familiar street where perhaps you would get your drug of choice and pick up a prostitute. So, the neurons are all firing: going down the street – firing, firing, firing. So, you can go down another street, that's your choice, right? [Or] you make a choice to do something different. You make a phone call: 'Oh my goodness. I'm finding myself in this area of town where I used to get into a lot of trouble', and you call somebody. So, there are choice points along the way."

different epistemic paradigms to describe both addiction and volition therein. For example, a clinician (see Table 4, C13; nature of addiction) thought simultaneously that addiction has a fixed nature in that it is the same for everyone (characteristic of realism) but that there is room for substances to affect in determined ways the shape that addiction takes in someone's life (characteristic of relativism), and that the way people and their genetic predispositions interact with their environment can also affect what addiction looks like (characteristic of pragmatism).

Further contextualizing Table 4, it was rare for participants to pull on resources from different paradigms to explain their views on the same sub-themes of addiction and drug use. A common line of reasoning invoked by some participants across all groups was that the nature of addiction is fixed (sub-theme 1/realism), but that the ways addiction impacts people depend on the individual's society and what it considers 'normal' functioning (sub-theme 3/relativism). The appeal to characteristics of the different paradigms was especially evident within concepts describing volition, with participants attributing a fluctuating, dynamic nature to one concept (characteristic of pragmatism) and an all-or-nothing view to another (characteristic of realism), resulting in a 'mixed' viewpoint when considering the entirety of concepts describing volition. Although general coherence was limited, so was local incoherence, with very few clear contradictions for a given sub-theme for each participant.

Stakeholder trends across paradigms

There were various combinations of paradigms across each participant from each stakeholder group, but there were also distinctive patterns in how the views of the members of each group coalesced with paradigms. PwLEA were the least cohesive with respect to all four sub-themes of addiction. PwLEA were the only group where no participant's view of addiction and drug use was well represented by a realist paradigm. Additionally, PwLEAs were the only group that thoroughly explored the importance of the concept of autonomy as attached to decision-making in the context of addiction, whereas other groups talked more about control over addiction.

Clinicians' views were more aligned with relativism when describing the nature of addiction/drug use (sub-theme 1 of addiction/drug use) and the impacts of addiction/drug use (sub-theme 3 of addiction/drug use), as being relative to people's substance of choice (characteristic of relativism). Clinicians also tended to express more than other groups that the nature of addiction is very complex, and more often rejected the idea that adopting any one account of addiction alone is sufficient for understanding it. Clinicians were also more likely to explain the nature of addiction/drug use (sub-theme 1 of addiction/drug use) in ways aligned with pragmatism (without falling fully and squarely within that paradigm). They were also the group with the most homogenous conceptualization of addiction/drug use morality (sub-theme 4 of addiction/drug use), holding the view that drug use and addiction do not have moral aspects whatsoever, except for one participant. However, many added that drug-use-related behaviours can be immoral. Last, clinicians' understandings of volitional abilities aligned more often than other groups with a realist paradigm, being most contrasted with the PwLEA's interpretation of these concepts (for example, see Table 4, C13; evaluation of concepts/realism). Clinicians often collapsed concepts describing volition onto issues of consent for both features of concepts (nature and evaluation).

Members of the public had the most distinctive patterns as compared with the two other groups. Almost half of participants belonging to this group had views that featured characteristics of realism (without necessarily exhibiting a dominant for that paradigm). At the same time, they had extremely varied views on drug use morality, viewing the morality of drug use as relative to, for example, the identity and age of the user, the effects of drug use, its frequency, purpose, consequences, and causes.

Discussion

This article examined how addiction and volitional abilities were described by three stakeholder groups (PwLEA, clinicians, and members of the public) and how their views related to three broad epistemic paradigms (realism, relativism and pragmatism). Our results show that the three paradigms only partially described how different stakeholders view addiction/drug use and volitional abilities. Importantly, only a portion of the participants' understandings of addiction/drug use and volition were well explained by a single paradigm: most participants' understandings aligned with multiple paradigms. Further, the groups of stakeholders exhibited different patterns of engagement across the different paradigms, where clinicians and members of the public held the most contrasting views. Many participants reported having never considered whether the concept of free will is relevant to understanding volitional abilities in the context of addiction. They frequently employed other concepts such as control and choice, as found in other qualitative studies exploring addiction [47–49]. We discuss our findings in light of: (1) the ethical implications generated by the pluralism manifest between different stakeholders' views, and (2) the challenges of pursuing greater coherence with respect to views about addiction and volitional abilities as sometimes implied in academic literature and public policy.

Pluralism between stakeholders

Our results – showing how understandings of addiction and volitional abilities therein are multifaceted – help explain the complexity of discussions surrounding ethical aspects of clinical care, research, and policy on disordered drug use. Numerous debates have surfaced in the literature with respect to the nature of addiction, notably the volitional abilities of people who use drugs [11]. For example, the ability to freely consent has been discussed with respect to clinical trials of drugs prescriptions [50]. Likewise, policy debates about appropriate descriptions of addiction as a brain disease have surfaced, given that descriptions of addiction have been claimed to exacerbate and engender stigma by implying that people who use drugs cannot control themselves [14, 51, 52]. Our findings show that this debate, when parsed out in terms of how different groups envision addiction, as alongside volitional abilities within addiction, involve substantial pluralism and lack of coherence, specifically when coherence is operationalized in terms of broader epistemic paradigms. There were notable differences between the clinician group (more oriented toward pragmatism, with a narrower understanding of volitional abilities viewed mostly in terms of consent) and the PwLEA group (less oriented toward realism, broader understanding of volitional abilities in terms

of autonomy). It is easy to imagine how concrete and even more complex practical decisions (e.g., specific treatment decisions) generate misunderstandings. Our findings speak to challenges for drug policymaking, where the diversity and complexity across stakeholders' views of addiction and volitional abilities complicates communication and public policy debates. This can be seen with Canada's legalization of cannabis, in how debates concerning changes to drug policy were subject to considerable complexity across stakeholders' views [53]. Consider how other potential changes such as the decriminalization of other illicit substances, and programmes such as safe injection sites, raise even more controversy [54]. Acknowledging how much diversity there is across the views of only three small groups of participants helps lend appreciation to the difficulty of creating open, rational public debate on public policy changes.

One response to these observations could be to reinforce more top-down policymaking to eliminate pluralism and not attend to the experiential connection between people's experience with drug and disordered drug use and policy. This has very much been part of the tendency to criminalize various drugs based on the views of policymakers, often based on prejudice and racism rather than on evidence [55, 56]. There is also a possibility that legalization of drugs borrows from similar authoritarian reflexes, namely that policymakers adopt, for example a liberal stance, which does not take heed of the experiences of users, including those who struggle to use responsibly and keep a balanced life. For example, the legalization of cannabis in Canada, although officially motivated by a risk-mitigation philosophy, has tended to side with a liberal and commercial view which does not really provide substantial additional education or support to those with disordered drug use or tackle specific ongoing and emerging issues (e.g., regulation for dosage, increase in usage, online marketing, interprovincial inconsistency in minimal legal age) [57–59]. An alternative in keeping with the hermeneutic and pragmatist orientation of this study is to see policymaking – at least within a democratic regime – as an exercise in liberating human experience from the shackles of authoritarianism and dogma [60, 61], including both the human desire to explore psychoactive substances [55] and the risks that these substances pose to those who have been rendered vulnerable due to the shortcomings of our societies [56]. In this respect, exposing the experiential embeddedness of discourse and implicit ideas (such as ideas about volition with respect to drug use) is part of an effort to bridge current lived experiences with experiences which are aspired to at the policy and regulatory levels. Such a process may not be well captured through the traditional description of an is-ought tension or dichotomy (and the hurdles it tends to creates for empirical ethics) but perhaps more as a social and political process by which the complexity of human experience, including those of drug use and disordered use is used to think more openly and creatively about desired futures, in keeping with insights from hermeneutical and pragmatist ethics [41, 62] as well as advances in social studies of science [63].

Paradigmatic coherence with respect to addiction and volitional abilities

It is important to note that paradigmatic coherence, as idealized in the form previously outlined in assessing the logical coherence between different aspects of addiction and volitional abilities, does not fully reflect how people perceive addiction and volitional abilities related to addiction/drug use. Although we did not presume such coherence, wanting only to investigate the question openly, our results clearly show that participants frequently pulled from characteristics of multiple paradigms in describing their views on addiction and volition. Few participants held highly coherent views – from the standpoint of a single epistemic paradigm – on the relationship between, for example, the nature of addiction/drug use, evaluations of addiction, the impacts of addiction/drug use, and the morality of addiction/drug use.

These findings are interesting insofar as they bear on debates surrounding "models" of addiction, such as the brain disease model, which tends to preclude volitional abilities [64], or alternate models stressing the importance of choice [65] (see also [20, 66]). This debate also pervades the public sphere. In a study sampling American news media, researchers found that writers tended to present addiction and willpower as mutually exclusive, and to equate addiction with biology, and willpower with moral

character [67]. Our findings suggest that the kind of philosophical coherence encountered in the literature does not correspond to the rather fluid perspective of stakeholders engaged in the current study. This could help explain why, despite heated academic debates on different models of addiction, their impact on actual behaviours and on stigma appear rather limited. For example, an experimental large-scale survey found that providing neuroscientific explanations of addiction as a brain disease did not significantly change people's attributions of responsibility and free will [68]. Likewise, quantitative and qualitative studies reviewed in [69], showed that clinicians adopted brain disease models concurrently with volitional models in order to suit complex clinical realities. Our study comes in support of others (e.g., [34]) in showcasing that participants did not ordinarily see an incompatibility between the existence of neurobiological components of addiction, or descriptions of addiction as a disease, and the possibility of accounting for people's volitional abilities. It also lends evidence to findings which emphasize the limitations of simplified models of addiction and volition and their impact on people with addictions [14, 15, 70]. For example, it is not uncommon for treatment centres to use statements suggesting lack of volition, making claims such as "The domino effect of addiction begins once […] chemicals begin to alter brain processing and bodily functions, creating an uncontrollable pattern of compulsive use. No amount of willpower can completely combat this result" [71]. Centring addiction discourse around PwLEA's inability to combat addiction is a simplification, and one which fails to recognize the large proportion of PwLEA who successfully learn to regulate behaviours on their own [47, 72].

Limitations

This qualitative study intended to better understand perspectives on addiction and volition in addiction within three groups of stakeholders: clinicians, PwLEA, and those without experiences of addiction. Given the study design and nature of the study, we are unable to draw generalizations between these three groups, but the results help investigate whether different experiences relayed (as a PwLEA, a clinician who takes care of people of PwLEA, or being a member of the general public) shape opinions and discourse. In this study, the use of epistemic paradigms helps identify trends which could lend themselves to more experimental and quantitative investigation (e.g., identify whether dominant paradigms are validated within larger groups of participants; assess more experimentally the impact of the uptake of a specific paradigm on other beliefs or behaviours such as the use of health services, adherence to treatment, or communication processes).

Also, the current study alludes to stigma in the context of addiction as one background social phenomenon that motivates the study notably because certain models or accounts of addiction and volition therein have claimed a potential to destigmatize addiction. The current study was not intended to investigate stigma and tackles more directly perspectives on addiction and volition. However, the lack of clear coherence between different ideas about addiction and about volitional abilities in addiction cast doubts on the ability of certain promulgated ideas (e.g., a brain-based model of addiction as a strategy to reduce attribution of volution and thereby reduce attribution of blame and stigma) to really have a powerful role in practice to destigmatize. This has been further supported by previous research [68, 69].

Finally, having different backgrounds, the participants of the three groups can be presumed to have different abilities to express ideas about addiction and volition in addiction. Whenever participants have less familiarity with a topic or have less education or training about a topic, there is a risk that they might struggle to articulate the ideas they would like to express. At the same time, this is very much the reality we live in and, in this sense, understanding implicit views or ordinary ways of understanding addiction and volition provides insight into how people make sense of their own agency and their own freedom. Granted that our own sense making is recognized as being important and potentially at cause in actual behaviors as suggested by some studies (e.g., as to whether we are free or not, see [73]), then this complexity is something to factor in. In short, one's own understanding of the concepts describing volition is part of acting freely and voluntarily. We also factored this challenge into our interviewing process in a sense since our probing questions pulled at or invited further elaboration. These opportunities provided moments for the participant to delve deeper into what was shared to provide further clarity. But in the end, the responses gathered

are those that participants could offer in the context of the interviews, given their past experiences and current abilities. Thus, differences in experiences, and differences in expression about experience are interconnected such that we tackled these as being part of a bundle with which we wanted to work because it is part of reality itself.

Conclusion

Addiction is a prevalent and impactful condition worldwide, and the role of volitional abilities therein is subject to considerable debate. Little is known about how stakeholders actually make sense of addiction and of its impact on volition, even though this question is central to treatment and policy matters. In light of this, we undertook a qualitative study to explore stakeholders' views. We found that few participants held views highly consistent with three, broad epistemic paradigms (realism/relativism/pragmatism), but that nonetheless, these paradigms helped identify salient differences and incoherence across participants' views. Addiction – and subthemes associated with addiction – were understood in many different forms, sometimes standing in tension with one another. The same goes for volitional abilities in the context of addiction. There were also differences between stakeholder groups such as clinicians' views leaning towards relativism, while there was greater alignment with realism for members of the public and limited alignment with realism for PwLEA. These initial observations warrant further validation and investigation, but they suggest that the relationship between different life experiences and views on addiction and volition therein merit more attention and integration in debates about drug policies. Despite its limitations, our study also suggests that a greater appreciation of the complexity of the views held by different stakeholders could help critically assess the search for coherence expressed in academic and policy debates.

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Declarations

Ethics approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institution who approved this study.

Conflict of interest The authors declare no conflict of interests.

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