# Free Will Burden Aff

## AC

### Overview

### Burden

#### The reasonable aff burden is to prove that addicts do not have the free will to choose to use illegal drugs while the neg burden is to prove that addicts do have the free will to choose to do drugs.

#### Prefer:

#### [1] Reciprocity: requiring me to defend all assumptions in the resolution gives me an infinite epistemological burden before I can even access offense. I.e. you wouldn’t expect proving that drugs or illegal things exist to be part of my burden. My burden gets rid of any nibs or permissibility arguments that structurally advantage one side by forcing the debate down to the existence of a particular factor – it’s a 1:1 reciprocal. Reciprocity key to fairness because it ensures equal access to the ballot.

#### [2] Topic lit: The question of whether or not addicts have the freedom to do drugs is a key factor in discussions about whether or not they should be punished.

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This notion of addiction is a second reason why we should care about reducing the negative outcomes of drug use. However, this comes with its own theoretical problem, such as what it means to be free. Can we, with confidence, say that injection drug users are not free and that they are not responsible for the state that they are in? To briefly answer this question, I will compare two opposing theories of liberty; negative and positive liberty. Negative liberty states that one is free when no others are coercing that person from doing things s/he would like to do (Berlin, 1958, p. 2-3). Positive liberty, on the other hand, states that one is free when s/he is provided with the support s/he needs to be able to do the things s/he would like to do (Berlin, 1958, p. 7-8). For example, a handicapped person in a wheelchair is free, in the negative sense, to go up the stairs, but is not physically able to do so without an elevator or a ramp. So, positive freedom would assert that this person needs to be provided with the necessary means for him/her to be able to get up to the top floor if s/he is to be called “free”. Another example is that of a drug addict. The addict, whose real intention is to quit, is too absorbed by his/her inclinations that s/he cannot abstain from drug injection on his/her own. In the positive sense, then, freedom means having the ability to accomplish one’s true intention (against one’s immediate desire to inject), which may require help from others. It does not mean to be left untouched. The medical aspects of addiction are not disputed. It is defined as a “... chronic, often relapsing brain disease that causes compulsive drug seeking and use, despite harmful consequences to the addicted individual and to those around him or her” (National Institute on Drug Abuse, 2012, p. 1). In other words, it is a serious condition and usually requires assistance to beat. Safe injection sites are sensitive towards this concern, which is the reason why they do not require immediate abstinence from drug users. On the other hand, the criminalization policy assumes that all drug users are free and have a choice to quit, thereby making it apparent that it values negative liberty over positive liberty. According to the criminalization model, then, the state needs to treat everyone equally, thereby not having to take into account the special circumstances of injection drugs users. The theory of positive liberty responds to this weakness, first by recognizing the reality of addiction/dependence, and secondly by considering the living contexts of people: most drug users come from low income families that live in poverty (Hickler and Auerswald, 2009, p. 824). Thus, to treat everyone equally would mean that the state should give special permissions to these persons so that they may one day live to beat their addiction. One such special permission is the permission to engage in illicit drug use in safe injection sites, which are facilities that also offer addiction support and withdrawal management programs.

#### Outweighs: a) we only have one tournament to debate this topic so the ed from it is uniquely key b) the topic is the most applicable to the real world c) Showing my burden is in the topic lit takes out all neg responses since you could have reasonably predicted it and prepped against it d) Means that even if you prove the burden false, the AC offense still substantively affirms the resolution by proving it is incoherent to punish drug users who didn’t have free will.

**[3] Clash – The burden forces the debate to the central question of the resolution, and encourages direct engagement between arguments at the core of the literature. My burden is best since a) it is the heart of the illegal drug discussion which means it’s the best clash b) it removes the ability for the neg to uplayer or moot the AC with questions of the assumptions of the topic c) It prevents ships passing in the night due to the vague wording of the topic and narrows the debate to direct analysis d) it’s key to division of ground since there are arguments on both sides, whereas the majority of the lit generally affirms.**

**[4] Interpretation: If the aff justifies their burden, and its text is that the aff burden is to prove that addicts do not have the free will to choose to use illegal drugs while the neg burden is to prove that addicts do have the free will to choose to do drugs, then the neg must concede to that burden as it is contextualized in the AC and debate under it. They must link all their offense to the burden. Violation: This is preemptive. Potential violations include reading theory on the burden or reading a separate mechanism to evaluate offense that function higher than the burden like a role of the ballot. To clarify, you can read a framework or offense underneath the burden to prove that we have free will to do drugs, but you cannot have a distinct evaluative mechanism or unrelated offense. Prefer – 1) Strat Skew: shifting the burden structure in nullifies 6 minutes of the AC and forces me to restart the debate in the 1AR at a massive time disadvantage. And, nullifying the AC kills both phil and topical education because we cant explore the benefits the substance of the aff. Also kills clash since a) they can read a position that does not engage with the AC and b) restarting the debate leads to terrible debates since there’s less time to develop arguments 2) Time Skew: 7-6, 4-3 rebuttal time difference is a problem. Helping me choose burden structure allows me to combat time skew since I can craft a framework that compensates for impossibly short 1Ars by preventing uplayering 3) Debateability: there are multiple contradictory interpretations of the resolution: the aff needs to be able to pick one in order to start the debate and form an advocacy, which means you should accept mine.**

### Contention 1: Determinism

#### Determinism is true and no free will exists:

#### [1] Causality: The first law of thermodynamics holds that nothing can be created or destroyed, thus everything must have a cause if something cannot come from nothing. This means that either A) free will, which definitionally causes it self, is illogical as it does not have one or B) our free will is caused by something which is a contradiction and proves determinism true.

#### [2] The best neuroscientific, psychological, and medical evidence evidence free will doesn’t exist. This article is a giant literature review of different fields published on a government website

Andrea Lavazza, Neuroethics, Centro Universitario Internazionale, Arezzo, Italy, Free Will and Neuroscience: From Explaining Freedom Away to New Ways of Operationalizing and Measuring It, 2016, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4887467/> ///AHS PB BRACKETED FOR CLARITY

All these experiments seem to indicate that free will is an illusion. Yet, these relevant experiments can be interpreted in many ways. A possible view is that, in some way, determinism can be observed directly within ourselves. This interpretation might lead to the conclusion that free will is just an illusion. In fact, if one considers as a condition of free will the fact that it should be causa sui (i.e., it should be able to consciously start new causal chains), such a condition is incompatible with determinism as it is usually defined. For it, in fact, all events are linked by casual relations in the form of natural laws, which started long before we were born and which we cannot escape. However, determinism has generally been regarded as a metaphysical claim, not refutable by empirical findings. One could properly talk of automatism in the brain, not of determinism, based on the evidence available. (In any case, endorsing indeterminism might lead to consider our behavior as the causal product of choices that every time produce different results, as if we rolled a dice. This doesn’t seem to make us any freer than if determinism were overturned; cf. Levy, 2011). Most importantly, another feature of freedom seems to be a pure illusion, namely the role of consciousness. The experiments considered thus far heavily question the claim that consciousness actually causes voluntary behavior. Neural activation starts the decisional process culminating in the movement, while consciousness “comes after”, when “things are done”. Therefore, [and] consciousness cannot trigger our voluntary decisions. But the role of consciousness in voluntary choices is part of the definition of free will (but the very definition of consciousness is a matter of debate, cf. Chalmers, 1996). Empirical research in psychology also shows that our mind works and makes choices without our conscious control. As proposed by psychologist Wegner (2002, 2003, 2004) and Aarts et al. (2004), we are “built” to have the impression to consciously control our actions or to have the power to freely choose, even though all that is only a cognitive illusion. Many priming experiments show that people act “mechanically” (even when their behavior might appear suited to the environment and even refined). Automatic cognitive processes, of which we aren’t always aware, originate our decisions, and they were only discovered thanks to the most advanced scientific research. Ultimately, consciousness, which should exercise control and assess the reasons for a choice, is thus allegedly causally ineffective: a mere epiphenomenon, to use the terminology of the philosophy of mind. This is what has been called Zombie Challenge, “based on an amazing wealth of findings in recent cognitive science that demonstrate the surprising ways in which our everyday behavior is controlled by automatic processes that unfold in the complete absence of consciousness” (Vierkant et al., 2013).

#### [3] Double bind: Denying the Determinist theory of causality proves that free will doesn’t exist

Colin McGinn. British philosopher. He has held teaching posts and professorships at University College London, the University of Oxford, Rutgers University and the University of Miami, Problems in Philosophy: The Limits of Inquiry. London: Wiley, 1993. P. 80, lol I copped this card off the big questions start pack so I guess I rehighlighted it. BRACKETED FOR CLARITY

The argument is exceedingly familiar, and runs as follows. Either determinism is true or it is not. If it is true, then all our chosen actions are uniquely necessitated by prior states of the world., just like every other event. But then it cannot be the case that we could have acted otherwise, since this would require a possibility determinism rules out. Once the initial conditions are set and the laws fixed, causality excludes genuine freedom. On the other hand, if indeterminism is true [not] , then, though things could have happened otherwise, it is not the case that we could have chosen otherwise, since a merely random event is no kind of free choice. That some events occur causelessly, or are not subject to law, or only to probabilistic law, is not sufficient for those events to be free choices. Thus one horn of the dilemma represents choices as predetermined happenings in a predictable causal sequence, while the other construes them as inexplicable lurches to which the universe is randomly prone. Neither alternative supplies what the notion of free will requires,, and no other alternative suggests itself. Therefore freedom is not possible in any kind of possible world. The concept contains the seeds of its own destruction.

#### [4] Compatibilism is impossible—Free will requires absolute control of ones actions and any interference denies it.

Kadri Vihvelin, Professor of Philosophy at USC Dornsife, Arguments for Incompatibilism First published Tue Oct 14, 2003; substantive revision Mon Sep 18, 2017, <https://plato.stanford.edu/entries/incompatibilism-arguments/#TwoReasForThinFreeWillIncoDete> ///AHS PB

2. Two Reasons for Thinking that Free Will is Incompatible with Determinism A common first response to determinism is to think that it means that our choices make no difference to anything that happens because earlier causes have pre-determined or “fixed” our entire future (Nahmias 2011). It is easy to think that determinism implies that we have a destiny or fate that we cannot avoid, no matter what we choose or decide and no matter how hard we try. Man, when running over, frequently without his own knowledge, frequently in spite of himself, the route which nature has marked out for him, resembles a swimmer who is obliged to follow the current that carries him along; he believes himself a free agent because he sometimes consents, sometimes does not consent, to glide with the stream, which, notwithstanding, always hurries him forward. (Holbach 1770 [2002]: 181; see also Wegner 2003) It is widely agreed, by incompatibilists as well as compatibilists, that this is a mistake. Empirical discoveries about our brain and behavior might tell us that we don’t have as much conscious control as we think we have (Wegner 2003; Libet 1999). (For critique of arguments claiming that recent scientific research has shown that “conscious will is an illusion”, see Mele 2009, some of the essays in Sinnott-Armstrong & Nadel 2011 and Roskies & Nahmias 2016.) And there are worries, arising from certain versions of physicalism, that our mental states don’t have the causal powers we think they have (Kim 1998). But these threats to free will have nothing to do with determinism. Determinism might imply that our choices and efforts have earlier sufficient causes; it does not imply that we don’t make choices or that our choices and efforts are causally impotent. Determinism is consistent with the fact that our deliberation, choices and efforts are part of the causal process whereby our bodies move and cause further effects in the world. And a cause is the kind of thing that “makes a difference” (Sartorio 2005). If I raise my hand because I chose to do so, then it’s true, ceteris paribus, that if my choice had not occurred, my hand-raising would not have occurred. Putting aside this worry, we may classify arguments for incompatibilism as falling into one of two main varieties: Arguments for the claim that determinism would make it impossible for us to cause and control our actions in the right kind of way. Arguments for the claim that determinism would deprive us of the power or ability to do or choose otherwise. Arguments of the first kind focus on the notions of self, causation, and responsibility; the worry is that determinism rules out the kind of causation that we invoke when we attribute actions to persons (“It was Suzy who broke the vase”) and make judgments of moral responsibility (“It wasn’t her fault; Billy pushed her”). Someone who argues for incompatibilism in this way may concede that the truth of determinism is consistent with the causal efficacy of our deliberation, choices, and attempts to act. But, she insists, determinism implies that the only sense in which we are responsible for what we do is the sense in which a dog or young child is responsible. Moral responsibility requires something more than this, she believes. Moral responsibility requires autonomy or self-determination: that our actions are caused and controlled by, and only by, our selves. To use a slogan popular in the literature: We act freely and are morally responsible only if we are the ultimate source of our actions. Each of us, when we act, is a prime mover unmoved. In doing what we do, we cause certain events to happen, and nothing—or no one—causes us to cause these events to happen. (Chisholm 1964: 32) Free will…is the power of agents to be the ultimate creators or originators and sustainers of their own ends or purposes…when we trace the causal or explanatory chains of action back to their sources in the purposes of free agents, these causal chains must come to an end or terminate in the willings (choices, decisions, or efforts) of the agents, which cause or bring about their purposes. (Kane 1996: 4)

#### And that affirms: If all actions are predetermined then the action to take drugs was also predetermined.

### Contention 2: Addiction

#### Even if some free will exists, drug users specifically don’t have the free will to control their addiction.

#### [1] Drug use impairs addicts free will, making it impossible for them to regulate their actions.

Jillian Hardee, PhD (Assistant professor in the Department of Psychiatry and a lecturer in the Department of Psychology at the University of Michigan). "Science Says: Addic­ tion Is a Chronic Disease, Not a Moral Failing." University of Michigan Health Blog. 19 May 2017. JDN. https://healthblog.uofmhealth.org/brain-health/science-says-addiction­ a-chronic-disease-not-a-moral-failing VBI RECUT AHS PB

In a November 2016 report, former Surgeon General Vivek Murthy, M.D., publicly con­ firmed what researchers have known for years: Addiction is a chronic illness accompanied by significant changes in the brain. Addiction does not occur because of moral weakness, a lack of willpower or an unwillingness to stop. This finding stems from decades of work investigating the effects of substance use on the brain. The first time in­ dividuals drink or take drugs, they do so voluntarily, and they believe they can control their use. With time, more and more alcohol or drugs are needed to achieve the same level of pleasure and satisfaction as when they first started. Seeking out and taking the substance becomes a near-constant activity, causing significant problems for them and their family and friends. At the same time, progressive changes in the brain drive the compulsive, uncontrollable drug use known as addiction. When this happens, individuals can no longer voluntarily choose to not use drugs or alcohol, even if it means losing everything they once valued. The brain on addiction. Research has identified a number of areas in the brain key to the development and persistence of addiction. In particular, pathways containing dopamine are where many drugs exert their effects. Dopamine is a small chemical in the brain important for carrying signals from one brain cell to the next, similar to how a train carries cargo between stations. Pathways where dopamine is present are involved in many different functions, one of which is reward-motivated be­ havior. In the healthy brain, dopamine is released in response to natural rewards, such as food or exercise, as a way of saying, "that was good." But drugs hijack dopamine pathways, teaching the brain that drugs are good, too. For example, some drugs have a structure similar to other chemical messengers in the brain, allowing them to bind to brain cells and release dopamine. Therefore, taking a drug produces a euphoric feeling, which in turn strongly reinforces drug-using behavior.

#### [2] Addiction is caused by pre-birth genetic factors:

Steven Melemis (Physician; M.D. and Ph.D. from the University of Toronto; Postdoc­ toral Fellowship from the University of California at Berkeley; Fellow of the Royal So­ ciety of Medicine). "The Genetics of Drug and Alcohol Addiction." Addictions and Re­ covery. 25 September 2018. JON. [https://www.addictionsandrecovery.org/is-addiction­ a-disease.htm](https://www.addictionsandrecovery.org/is-addiction%C2%AD%20a-disease.htm) VBI Recut AHS PB BRACKETED FOR CLARITY

Addiction is due 50 percent to genetic predisposition and 50 percent to poor coping skills. This has been confirmed by numerous studies. One study looked at 861 identical twin pairs and 653 fraternal (non-identical) twin pairs. When one identical twin was addicted to alcohol, the other twin had a high probability of being addicted. But when one non-identical twin was addicted to alcohol, the other twin did not necessarily have an addiction. Based on the differences between the identical and non-identical twins, the study showed 50-60 percent of addiction is due to genetic factors.(1) Those numbers have been confirmed by other studies.(2) The other 50 percent is due to poor coping skills, such as dealing with stress or uncomfortable emotions. The children of addicts are 8 times more likely to develop an addiction. One [another] study looked at 231 people who were diagnosed with drug or alcohol addiction, and compared them to 61 people who did not have an addiction. Then it looked at the first-degree relatives (parents, siblings, or children) of those people. It discovered that if a parent has a drug or alcohol addiction, the child had an 8 times greater chance of developing an addiction.(3)

#### [3] A variety of social factors cause individuals to abuse drugs.

Mackenzie Whitesell, Department of Environmental and Radiological Health Sciences, Colorado State University, USA, Annette Bachand, University of Colorado Denver, USA, Jennifer Peel, Department of Environmental and Radiological Health Sciences, Colorado State University, USA, and Mark Brown, Clinical Sciences at Colorado State University, USA , [ET AL] Review Article Familial, Social, and Individual Factors Contributing to Risk for Adolescent Substance Use, Journal of Addiction Volume 2013, Article ID 579310, 9 pages<https://www.hindawi.com/journals/jad/2013/579310/> ///AHS PB

There are an extensive number of risk factors that may contribute to the onset of substance use among adolescents. Herein, selected risk factors for adolescent substance use are divided into three primary categories: familial, social, and individual. A comprehensive review of all risk factors is not practical with the scope of this paper. Thus, for the purpose of this paper, the most common and serious risk factors have been highlighted. 3.1. Familial Risk Factors Familial risk factors include childhood maltreatment (including abuse and neglect), parental or familial substance abuse, marital status of parents, level of parental education, parent-child relationships, familial socioeconomic status, and child perception that parents approve of their substance use. Child maltreatment has been classified for the purpose of this paper as a familial factor, though it is important to note that not all maltreatment is perpetrated by a family member. The federal Child Abuse Prevention and Treatment Act (CAPTA) defines maltreatment as child abuse or neglect, which encompasses any act or lack of an act by a child’s caretaker that results in physical or emotional harm [28]. Childhood maltreatment, including physical abuse and neglect, has been linked to increased risk for adolescent substance use, with one study reporting 29% of children who experienced maltreatment participating in some level of substance use and another reporting 16% of maltreated children abusing substances [29, 30]. 3.2. Physical and Sexual Abuse In most states, the legal definition of physical child abuse entails any act that causes a child to experience physical harm that is not accidental [31]. The effects of physical and sexual abuse, specifically, on adolescent behaviors regarding substance use have been examined, with researchers consistently reporting a statistically significant relationship between physical or sexual abuse and adolescent use of nicotine, marijuana, and alcohol [32–34]. There is also some evidence that higher levels of illicit drug use, including cocaine, heroin, and barbiturates, are associated with physical and sexual abuse [34]. Being a victim of physical or sexual assault increases the risk of an adolescent getting involved with substance use from two to four times [29, 33–35]. However, different studies have shown varying specific results regarding which type of abuse is the strongest contributor, with some reporting a higher risk associated with sexual abuse, while others report a higher risk associated with physical abuse [29, 34]. Posttraumatic stress disorder (PTSD) is also associated with increased likelihood of developing a substance use disorder, particularly with marijuana or hard drugs (including LSD, cocaine, heroin, inhalants, and nonmedical prescription drugs) [33]. This increased risk may be a result of the fact that trauma that typically leads to PTSD is highly stressful and may lead PTSD sufferers to cope with intense stress through substance use [33]. Males are more likely to be physically abused, whereas females are generally more likely to be sexually abused [36]. However, generally speaking, gender differences with regard to substance use vary widely across the literature. Age, though, shows consistent patterns, with older adolescents participating in substance use more often than their younger counterparts, with risk increasing each year from ages 10 to 17 [29, 30, 33, 34]. One review of thirty-five studies indicated that most findings consistently show that childhood maltreatment is a risk factor for earlier onset of substance use [32]. This may be because victims of maltreatment use drugs and alcohol as coping mechanisms rather than purely for social reasons. Thus, their onset is less dependent on the time other adolescents begin to use substances [32]. The association between being a victim of physical or sexual abuse during childhood and adolescent substance use may be linked to the effects of stress on the brain and, specifically, the amygdala [37, 38]. The amygdala is responsible for transmitting emotional information to the body based on memory when responding to stressful situations [37]. When stress, such as that resulting from abuse, arises, the amygdala is overstimulated and excess dopamine is produced as a result, thus suppressing the function of the prefrontal cortex [37, 39]. This cascade of events can lead to limited functions related to attention and learning. Likewise, susceptibility to paranoia has been linked to PTSD [37, 39]. As has been discussed previously, increases in dopamine levels also play a role in addiction to drugs such as opiates, nicotine, ethanol, and cocaine [25, 37]. 3.3. Emotional Abuse According to a legal definition, emotional child abuse encompasses a situation whereby the child’s “intellectual or psychological functioning or development” is hindered [31]. Research shows that experiencing emotional abuse can lead to increased risk for adolescent substance use, though it does not have as much influence as experiencing physical or sexual abuse [34, 40]. It has also been found that witnessing violence can increase an adolescent’s risk for developing a substance use disorder with alcohol, cigarettes, marijuana, or hard drugs by as much as two to three times [33, 35, 40]. This is likely because witnessing violence creates great stress, especially in the case of a child witnessing domestic violence [33]. Therefore, substance use becomes a coping mechanism [33]. It has also been speculated that, in some cases, substance use may precede witnessing violence because such acts of violence may occur within the context of a delinquent peer group where substance use is prevalent [33]. However, there is comparatively little literature that focuses on emotional abuse, including witnessing violence, and its relationship to adolescent substance use and abuse [32]. 3.4. Neglect A legal definition of child neglect includes any situation where a child’s caregiver does not provide adequate living necessities, including protection, clothing, health care, and/or food [31]. Studies have consistently shown that victims of neglect are at increased risk for substance use [41–43]. Additional research has begun to explore the effects of child neglect on adolescent brain development. Because children in adolescence are undergoing developmental changes, neglect during this period can have long-term effects [41]. It is difficult to study the ramifications of neglect on the brain because of the existence of other contributing factors, such as domestic violence, socioeconomic status, and prenatal exposure to substances [39]. It is also more likely that females’ relationship with their parents or conflict within the home will be linked to their choice to use substances than males’ [44–46]. This may be because many females respond to stress (as may occur in a negative family environment) by avoiding coping with a situation and increasing attentiveness to emotions, which can heighten depression and lead to substance use, whereas males are often more directly confrontational [47]. These styles of coping may be a result of sociallydefined parameters of gender expectations [47]. 3.5. Social Risk Factors Social factors that contribute to increased risk for adolescent substance use include deviant peer relationships, popularity, bullying, and association with gangs. Social influences and familial influences are often present simultaneously. This interaction creates a complex system of risk factors that predicts adolescent substance use, which is important to take into consideration. 3.6. Deviant Peer Relationships The influence of peers on adolescent substance use often exists in the form of deviant peer relationships, wherein an adolescent associates with a group of people who use substances, or in the form of perceived popularity [48–53]. Research has shown that deviant peer relationships are positively associated with adolescent substance use [51, 53]. It is possible that a shared inclination to use drugs and alcohol attracts deviant individuals to form peer groups or that, in order to gain social standing or join a group, individuals are motivated to use substances and thus form a deviant peer group [52, 54]. Entry into deviant peer groups has also been shown to be significantly associated with negative parent-child relationships, which can cause adolescents to seek deviant connections in their social sphere [51]. Conversely, parental involvement and respect for parents have been negatively associated with substance use [52]. This is consistent with the aforementioned findings regarding positive parent-child relationships as a protective factor [29, 42, 44, 45]. This is an example of a way in which factors from familial and social spheres may work for or against each other in leading to adolescent substance use. Some researches have also found that adolescents who grow up in unstable community environments (defined to include lower levels of employment and less access to resources) are actually less susceptible to deviant peer influences [50]. This may be because privileged adolescents may not be exposed to substance use except via peers, whereas underprivileged adolescents face more risk factors, and thus peer influence decreases comparatively [50]. It may also be a result of lower perception of risk of mild experimentation with substances within privileged communities [50]. 3.7. Peer Pressure and Popularity Similarly, peer pressure and perceived popularity have been shown to be associated with increased risk for adolescent substance use [48, 49, 52, 55]. Specifically, when adolescents believe that their popularity within a peer group increases with the use of substances, they are more likely to participate in such substance use [48, 49]. Adolescents who self-identify as popular have shown to have increased prevalence of substance use when compared to adolescents who do not identify this way [49]. There may also be a greater correlation between substance use and self-identification of popularity than between substance use and popularity as assessed by peers [49]. Though research into specific types of social motivation is limited, one study revealed that adolescents who seek to be the leader of a group or to stand out above others are more inclined to smoke cigarettes, which can be perceived as an association with maturity, whereas those who seek to be accepted by a group are more inclined towards alcohol use, which is perceived as a communal activity [48]. Boys may also be more likely to engage in smoking to improve their social image, whereas girls more often do so as a form of stress relief [35]. Much of the literature regarding the influences of peer relationships on adolescent substance use focuses primarily on alcohol and cigarette use [48, 52, 53]. Though these areas are important to address, it will be necessary for future research to also focus specifically on marijuana and synthetic marijuana use and prescription drug abuse. 3.8. Bullying The National Institutes of Health define bullying as a series of interactions whereby a group or individual verbally or physically assaults a victim who is perceived to be weaker [56]. All adolescents who participate in bullying, whether they are the perpetrator, the victim, or a combination of both roles, have been shown to have increased risk of mental health disorders and psychosocial problems when compared with those who do not participate [57, 58]. Some research shows that females are more likely to be bullied via verbal attacks and gossip than males, who are usually physically bullied [57]. Males also participate in all roles of bullying at a higher level than females [57, 59]. Research has revealed that playing the role of the bully has been positively associated with increased alcohol use [57, 58]. Interestingly, being a victim of bullying has an inverse association with alcohol use [57, 58]. However, those studies also indicate that victimization is positively associated with other forms of substance use, including marijuana, inhalant, and hard drug use [57, 58]. This is consistent with another study, which found that victims of bullying were more likely to engage in substance use than uninvolved youth [60]. Adolescents who fill the role of both the perpetrator and victim tend to have the highest susceptibility to mental disorders, such as depression and anxiety, though it is not clear whether mental disorders precede bullying or vice versa [58]. The effects of bullying on mental health of participants have shown to be similar among males and females [58].

### Underview

**[1] AFF theory is no RVI, Drop the debater, competing interps, under an interp that aff theory is legit regardless of voters a) infinite abuse since otherwise it would be impossible to check NC abuse b) it would justify the aff never getting to read theory which is a reciprocity issue c) Time crunched 1ar means it becomes impossible to justify paradigm issues and win the shell. And, reject theory on spikes since it would be a contradiction since they indict each other, but prefer mine since they are lexically prior. This means all contradiction flow aff since I spoke first which makes any contradictions their fault. AFF fairness issues come prior to NC arguments a) The 1ar can’t engage on multiple layers if there is a skew since the speech is already time-crunched b) Sets up an invincible 2n since there are a million of unfair things you can collapse to to win every round.**

**[2] No 2n theory arguments and paradigm issues. a) overloads the 2AR with a massive clarification burden b) it becomes impossible to check NC abuse if you can dump on reasons the shell doesn't matter in the 2n. There will always be multiple conflicting interpretations of the resolution but the aff has to start somewhere, which means you should accept mine. And, all neg interps are counter interps since the aff takes an implicit stance on every issue which means any neg theory interp requires an RVI to become offensive.**

**[3] The neg may not read negating is harder arguments a) norms – you can read them in response to any shell which allows you to avoid justifying a specific practice that is good b) – infinite abuse since you never have to defend your practice and can just prep a neg is harder dump Evaluate the theory debate after the 1AR since a) the 6 min 2n can dump on theory making the 3 min 2AR impossible b) we both get 1 speech on theory.**

**[4] If I win one layer vote aff a) The NC is reactive and has the ability to uplayer to exclude or preclude the layer I spend half the round justifying what makes mooting that layer extremely unfair b) I don’t have time to win multiple layers since I have to preclude your 2n responses, answer nc arguments, and extend my own in 4min.**

**[5]** **Presumption and permissibility affirm – a) We always default to assuming something true until proven false, or it would be almost impossible to make any claim at all because if the entire burden of proof is to show truth b) If agents had to reflect on every action they take and justify why it was a good one we would never be able to take an action because we would have to justify actions that are morally neutral ie drinking water is not morally right or wrong but if I had to justify my action every time I decided upon a course of action I would never be able to make decisions.**