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Addiction: Between Disease and Moral Responsibility

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ABSTRACT: In most interpretations, addiction has been conceptualized in medical terms as a chronic brain disease. Although it has made positive contributions, this model has not been without its critics, as it has failed to yield treatments with conclusive results and presents a reductionist view of addiction, focusing exclusively on neurological mechanisms. Most researchers believe that addiction represents a complex interaction of biological, psychological, social, and spiritual factors rather than the result of changes in the brain, and the brain disease model tends to disregard these factors. In contrast to the brain disease model, several other models have been proposed in an effort to better explain what addictions are and how they can be effectively addressed. The moral model, based on the premise that addiction is more a matter of personal choice than a brain disease, appears to be diametrically opposed to the brain disease model. This article seeks to present both models in relation to moral responsibility. While the disease model tends to exclude factors related to responsibility, the moral model encourages the assumption of responsibility, particularly in the choice to commit to recovery from addiction.

KEYWORDS: Addiction, Disease Model, Moral Responsibility, Choice Model

1. Introduction

The way addiction is defined has profound implications for the treatment and moral responsibility of the addicted person. However, formulating a definition of addiction is challenging, as addictions are complex problems with multiple biological, psychological, and spiritual dimensions. Analyzing the definition of the American Society of Addiction Medicine, Maté observes that addiction extends beyond substances and encompasses a universal process of dependence that underlies all addictive behaviors. This perspective is not based solely on a medical or biologically biased view, but recognizes addiction as a common and widespread aspect of human behavior (American Society of Addiction Medicine, 2024). He shows that addiction can be understood as

> complex psycho-physiological process that is manifested in any behavior in which a person finds short-term pleasure or relief and therefore craves; from which they suffer longterm negative consequences, whether physical, mental, social or economic; which they are reluctant or unable to give up despite negative consequences; and which, on suddenly ceasing, leaves them with intense craving, irritability and dissatisfaction. (Maté, 2022, p. 432)

According to this definition, addiction can encompass a wide range of potentially addictive behaviors, including sexual addiction, compulsive eating, compulsive shopping, gambling, video game or internet addiction, betting, and similar behaviors. The key point is that addiction is defined not by the specific behavior but by its relationship to the individual (Maté, 2022). While some have expressed skepticism, as the brain disease theory is shrouded in uncertainty (Heather et al., 2022), others have proposed numerous alternatives to the model of addiction as a brain disease, introducing a different perspective that acknowledges the importance of neurobiology while criticizing the limited scope of the disease model in

the holistic understanding of addiction. They have proposed an alternative framework that views addiction as a disorder resulting from the emergence of preference-based decision-making processes. In this context, the importance of decision-making trends within a comprehensive biopsychosocial model is partially examined. Rather than dismissing the neurobiological basis of addiction, the authors integrate neurobiological evidence into a broader model that also encompasses other perspectives on addiction, such as the role of trauma in addiction or aspects related to spirituality. In this section, we are offered alternative approaches to understanding addiction that do not necessarily fall into the trap of simplistic arguments between models of brain disease and those of morality, habits, or choice (Heather et al., 2022).

Although addiction has most often been explained in terms of a brain disorder, the uncertainty surrounding this characterization stems from the certainty that addiction is sufficiently complex to not be confined to a single explanatory model. This complexity is reflected in the debates among addiction researchers. The scientific discussion on addiction has focused primarily on the brain disease model and the choice-based model (Morse 2004; Uusitalo & Kuorikoski, 2013). The first model views addiction as neurobiologically determined, while the second model involves willpower, motivation, and moral responsibility. Thus, addictions have been viewed as a moral failing and a problem of willpower. However, some researchers have observed that addiction cannot be fully classified as either involuntary determinism or voluntary choice. The following sections examine these two models in relation to moral responsibility.

2. Addiction as a disease

A significant portion of the scientific community in the medical field advocates for defining addiction as a brain disease; however, there are also voices that either oppose this view or propose alternative theories. Furthermore, there is a considerable body of fundamental scientific literature that highlights the lack of consensus regarding the definition and understanding of addiction as a disease. This divergence has led to the adoption of varied and sometimes contradictory positions among researchers. A recent study provides an analysis of the various perspectives researchers hold regarding the perception of addiction as a brain disease (Heather et al., 2022).

Among the proponents of the theory that addiction is a brain disease are Leshner (1997), Volkow et al. (2016), Epstein et al. (2016), Everitt and Robbins (2016), and Berridge (2016). They argue that long-term physiological changes are the primary cause of problematic behavior, and that these changes "constitute a disease" (Uusitalo, 2022). According to this perspective, addiction hijacks the brain in such a way that the individual loses the ability to control their behavior; even when facing negative consequences, they continue the behavior or substance use despite the negative consequences, because they are trapped in the "grip of addiction" (Elliot, 2002).

The first definition of addiction in terms of a disease is attributed to Benjamin Rush, who, in 1784, described addiction as "a disease of the will" (Stanford, 2010). Building on this work, Jellinek (1960) successfully identified no fewer than 115 different descriptions of alcoholism in the scientific literature, in which context the theory of addiction as a brain disease emerged as a cutting-edge discovery, embodying an enhanced theoretical sophistication within the ongoing tradition of understanding addiction. In the same vein, Fields shows that the American Medical Association identified the following criteria by which alcoholism can be classified as a disease:

> (1) Alcoholism has a known etiology (cause), (2) the symptoms get worse over time, and (3) alcoholism has known outcomes. The outcomes of alcoholism are dependence, physical symptoms, and eventual death. For more than 30 years,

> research has indicated an increasingly strong case for a genetic component of alcoholism; this validates the disease model. The disease model is the foundation of Alcoholics Anonymous and many other self-help programs (Fields, 2016).

These criteria suggest that a person becomes addicted due to genetic factors, ruling out the possibility of choice. Furthermore, this rhetoric eliminates the human responsibility involved in addiction. In addition to these studies, Volkow discussed the recognition of addiction as a disease, stating:

> Today, thanks to science, our views and our responses to addiction and the broader spectrum of substance use disorders have changed dramatically. Groundbreaking discoveries about the brain have revolutionized our understanding of compulsive drug use, enabling us to respond effectively to the problem. (National Institute on Drug Abuse, 2007, p.1)

There was thus an expectation that such a perspective would facilitate effective treatments for addiction. This view was also supported by DiClemente, who notes that the promotion of the disease theory was essential "in shifting society's view of alcohol dependence from one of moral deviance and sinful behavior to one that promotes understanding and treatment" (DiClemente, 2018). This approach contrasts the brain-based model of disease with the choice-based model, presenting itself as a welcome alternative to models of addiction that stigmatize and induce guilt.

Similarly, Leshner (1997) argues that addiction is a disease, based on studies in neuroscience and behavioral science that allow us to better understand the biological factors contributing to the development of addiction. Furthermore, he supports his argument by stating that addiction alters both the structure of the brain and human behavior, causing significant damage to its functioning (Leshner, 1997). Thus, according to researchers, addiction is not just any disease, but specifically a disease localized in the brain, chronic in nature, for which treatments are available, though with few possibilities for a holistic cure.

The disease model of addiction has contributed positively to the development of certain treatments and their free provision to people with addictions. Another positive factor arising from the disease model of addiction is its contribution to reducing the stigma attached to people with addictions. Being considered sick is more socially acceptable than being considered addicted. Nevertheless, this model has also faced substantial criticism and objections.

3. Objections to the disease model

Criticism of the brain disease theory comes from researchers who have put forward a number of arguments, including: the brain disease model has failed to deliver the expected benefits in terms of treatment and public policy; factual hypotheses regarding the nature of addiction have not been demonstrated; it encourages viewing the phenomenon of addiction from a single perspective; and, last but not least, it has generated a negative influence on the understanding of and response to addiction (Heather et al., 2022). In this context, Graham argues that describing addiction as a disease can be detrimental to a person struggling with addiction:

> What is problematic is when this conclusion is further extrapolated to excuse the full spectrum of addictive behaviors... The disease concept of addiction is still an area of controversy, with scientific findings being used to defend both sides. The difficulty with focusing on addiction as a disease occurs when the disease becomes an excuse for addiction. (Graham, 2006, pp.19-20)

When addiction becomes an excuse to absolve oneself of responsibility for a behavior and its consequences, using medical terminology to explain a particular addictive behavior can

be problematic. If an addicted person is considered sick, then they cannot be held accountable for their addictive behavior, nor can they be expected to exercise personal agency or take steps toward change. In the same vein, Lewis (2015) believes that defining addiction as a disease is ineffective, incomplete, and even harmful, as it can excuse the addicted person for their behavior. Moreover, there are studies that refute the notion that addiction is chronic, as most addicts have managed to overcome their addiction in a non-medical setting (Dunnington, 2011). One example of this is the soldiers who fought in the Vietnam War, 75% of whom quit using heroin after returning from the war (Lewis, 2015). In addition to these data, extensive epidemiological research indicates that a significant proportion of people struggling with addiction naturally quit around the age of 30, without needing formal clinical intervention. This transition is often attributed to the responsibilities and opportunities that come with maturity, such as becoming a parent or securing a stable job (Pickard, 2019). Heyman (2009) notes that most people who have recovered from addiction did so without medical treatment. Such examples were intended to challenge the notion that addiction is a chronic disease for which individuals bear no responsibility.

Maté (2022) reaches a similar conclusion, noting that the limited scope of the biological model of brain disease—which operates on the premise that addiction is triggered by the interaction of drugs with a genetically vulnerable brain—does not adequately explain addictive behaviors. Scientists and researchers who have studied addiction without relying on functional magnetic resonance imaging, genetic sequencing, or other biomedical technologies have raised serious concerns about labeling addiction as a chronic, relapsing brain disease (Hammer, 2013). They suggest that "disease" is an unnecessary and commonly negative frame that distracts from the positive and hopeful messages that can accompany a biological understanding of addiction (Hammer et al., 2013).

Heather founded a network of researchers with the primary aim of challenging the disease model (Heather et al., 2018). They highlight the neglect of other factors that contribute to the development and maintenance of addiction and trigger feelings of pessimism and helplessness regarding recovery (Heather et al., 2022). In addition, the brain disease theory has pragmatic limitations. It has neither explained addiction nor offered options for recovery or prevention. Furthermore, viewing addiction exclusively in terms of disease is myopic because it focuses only on neurobiological aspects and disregards the other factors involved in the mechanism of addiction (Hall et al., 2022). Erikson (2007) notes that one of the effects of this theory on the addict is "alleviating embarrassment, shame, guilt, fear, and denial", emotions that can hinder the search for help. Furthermore, these effects can lead to the perception that the person struggling with addiction is passive, lacking any motivation or sense of responsibility in the recovery process.

4. Moral model of addiction

It is precisely against this backdrop that the moral model of addiction comes into play, which holds that addiction is a matter of choice and "it adopts a critical moral stance against this choice" (Pickard, 2017). From this perspective, the addicted person is responsible for the choices they make. Researchers who challenge the brain-disease theory argue that addiction is instead a disorder that impairs an individual's ability to make choices (Heyman, 2009). This view holds that addiction is more a matter of behavior and human responsibility than a chronic illness that suggests a person is incapable of making choices due to changes in the brain. Frank and Nagel (2017, pp. 135-136) observe that "if addiction is a disease, then there is no place for choice and self-control. If it is a matter of choice, then the concerned are to be held responsible for it—with all the social, legal, and health consequences there are."

Human responsibility is linked to the ability to choose, which presupposes human freedom: “Responsibility stems from man’s condition of freedom, forcing man to give or to give himself account of his participation in the various social reports of the social process” (Rotaru, 2016, p. 36). Thus, responsibility entails personal commitment and participation. From this perspective, the moral model appears to make positive contributions by encouraging individuals to seek help and remain actively engaged in the recovery process.

Such an interpretation shows that addiction does not eliminate a person’s ability to choose, because just as someone chooses to use drugs, drink alcohol, or gamble, a person can choose to end their addiction; it is rather a matter of personal will (Davies, 1992). Labeling an addicted person as suffering from a chronic illness places them in the category of those who are incapable of making choices, which cannot be said of people with addictions. Davies (1992) argues that the motivation behind why people use substances or engage in addictive behaviors stems as much from personal choice as it does from the enjoyment of the experience. In fact, people become addicted because they choose to be, and overcoming addiction is also a matter of personal choice. In his view, the medical community is interested in classifying addiction as a disease so that it can then provide treatment, and replacing the term “disease” with one that implies choice will lead to the disappearance of services in this field (Booth, 1992). Defining addiction as a disease is, in essence, the most powerful marketing strategy employed by the recovery industry. In the same vein, Sullender notes that we live in a society that encourages addiction, using the same rhetoric to condemn addiction and "promotes addictive behaviors, in part because addiction fuels the economy" (Sullender, 2013). Such voices not only offer different perspectives on understanding addiction but also vehemently oppose medical explanations of addiction. Among those who have formulated similar theories are philosophers, sociologists, psychologists, psychiatrists, and neurologists who unanimously challenge the idea that addiction is a chronic disease that affects the brain.

Lewis, for example, proposes an alternative to the disease model of addiction, one that does not seek to alter the existing biological processes but rather offers a different interpretation of them. He agrees with the medical community that addiction causes changes in the brain, but in his view, these changes have more to do with learning and change than with disease (Lewis, 2015). The changes that occur in the human brain as a result of substance use or certain behaviors are not, in and of themselves, a sufficient explanation for addiction in terms of a brain disease, since any new learning experience has a shaping effect on the brain, causing changes in the way the brain functions (Satel & Lilienfeld, 2014). For example, someone learning to play an instrument undergoes neural changes as a result of the learning process. This does not mean that the musician is unable to control their engagement with playing the instrument (Dunnington, 2011). Thus, the changes in the brain caused by addiction highlight its neuroplasticity rather than its pathology. Lewis considers the classification of addiction as a disease not only incorrect but also harmful, because, despite alleviating shame and condemnation, it can have negative effects on the addict’s self-esteem and self-image, which will discourage them from seeking help for recovery. Furthermore, the diagnosis of a “sick brain” can have a counterproductive effect on the individual, leading to a loss of a sense of responsibility and “motivation to participate in treatment” (Uusitalo & Kuorikoski, 2022). Lewis argues that addiction is more the result of habits developed through learned patterns of thought and behavior, defining recovery from addiction in terms of freedom rather than cure (Lewis, 2015).

Pickard largely agrees with Lewis’s position regarding the rejection of the disease model, but not with the rejection of the moral model of addiction (Pickard, 2017). In her view, there are two reasons why this model should be taken into account. The first reason is that ”the evidence is strong that drug use in addiction is not involuntary: addicts are

responsive to incentives and so have choice and a degree of control over their consumption in a great many circumstances." A second reason is "the process of overcoming addiction through a sense of agency, empowerment, and personal growth and self-understanding itself presupposes that addicts have choice and a degree of control." It offers a "responsibility without blame" framework that supports the recovery of those struggling with addiction and acknowledges the truth about the importance of choice.

Furthermore, an important factor in understanding how moral responsibility operates in the context of addiction is linked to the affective dimension of morality. Yong argues that morality is rooted in affective experience:

> human cognition in general, and human morality in particular, not only revolves around the emotions and the affections, but these are the core elements that both impinge on our representations of pleasure or pain and also are involved in the activation or deactivation of our senses that look for rewards or punishments. Here the biological rootedness of morality also comes into play: what is satisfying and elicits feelings of happiness and joy is valuable and, by extension, moral; while what produces fear, disgust, sadness, and so on, is repulsive and, by extension, immoral. In short, emotions inform moral judgments indirectly in terms of motivating pleasurably relevant action, rather than influencing or shaping the content of moral judgment. (Yong, 2013)

This insight helps us see that the neurobiological mechanisms of reward and moral judgment are interconnected rather than opposed.

Conclusions

This article has examined the addiction model—understood as a brain disease—and the moral model in relation to moral responsibility. Addiction is a complex phenomenon that transcends the simplistic biological concept of a brain disease. Although medical interventions play an important role, they cannot independently ensure a complete recovery. While the disease model may alleviate certain negative emotions generated by addiction, it often overlooks factors related to responsibility. On the other hand, the moral model encourages the assumption of responsibility as an important motivational factor for change. It recognizes the individual's capacity to take action and actively engage in recovery. An analysis of the two models shows that addiction remains a complex problem, and a single explanatory model is insufficient to encompass the multidimensional nature of the phenomenon known as addiction.

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