Addiction and Autonomy: are Addicts Autonomous?

Frans Koopmans
De Hoop Foundation, Dordrecht, The Netherlands
f.s.l.koopmans@dehoop.org

Srđan Sremac
Vrije Universiteit Amsterdam
srdjansremac@yahoo.com

UDK: 616.89.179
Izvorni znanstveni rad
Primljeno: 1. travnja 2011.
Prihvaćeno: 30. travnja 2011.

Abstract

In the article, the authors deal with how addiction can be related to autonomy. First, they provide a definition of substance addiction and the way various theories have interpreted this phenomenon. Further, they give a general description of the concept of autonomy and relate this to the phenomenon of addiction. Subsequently, the authors deal with the way some explanatory models of addiction (the disease model, disorder of choice model, and existential disorder model) see the relationship of autonomy and addiction and focus on the following questions: How does addiction relate to autonomy? Does addiction make volitional choice impossible, i.e. are addicts out of control? Is addictive behavior a rational activity?

Key words: Addiction, autonomy, disease model, disorder of choice model, existential disorder model, spirituality.

Introduction

As a phenomenon, addiction can be evaluated from different perspectives.[1] Different models of addiction can be set up. Each model of addiction provides its own perspective on the nature of addiction, emphasizing some elements, passing over others. A model provides an explanatory framework, trying to make clear what the problem is, what its constituent parts are, and which perspective on the problem is valid within the parameters of the model. Knowing who the addict is, what his/her characteristic problem is, and how we should deal with both, is explained within the model. But as there are different models, there will also be divergent perspectives on the addicts, concerning their problem and what may be expected from them. A disease model of addiction will differ from a model that emphasizes the elements of choice and responsibility (as in a disorder of choice model) or from a model that emphasizes the more existential nature of addiction (as i.e. in a theological disorder model).[2]

In this paper, we will deal with the question of how the explanatory models mentioned above will view the concept of freedom. For with addiction we have a phenomenon that seems to be incompatible with freedom, or with full autonomy for that matter. *Is not addiction by definition a situation of non-freedom? And isn't an addict – the one suffering from addiction – therefore by definition in a situation of non-freedom? What does this tell us about his/her possibility of making choices? Is he/she entirely turned over, with hand and feet, to his/her compulsive habit? Is it impossible for an addict to make autonomous choices? Does he/she perhaps suffer from a defect of the will and is it impossible to hold him/her accountable; or is he/she, on the contrary, a rational being and are his/her addictive actions to be regarded as fully volitional?*

In what follows, we will give a general description of the concept of autonomy and will relate this to the phenomenon of addiction. Subsequently, we will deal with the way the models mentioned above see the relationship of autonomy and addiction and focus on the following questions: *How does addiction relate to autonomy? Does addiction make volitional choice impossible, i.e. are addicts out of control? Is addictive behavior a rational activity?*

Defining Substance Addiction

Addiction is one of the world's most widespread psychiatric disorders. In the *World Drug Report* of 2010, it has been estimated that at the start of the

[1] Robert R. WEST and Ainsley HARDY, *Theory of addiction*, Oxford, Blackwell Pub./Addiction Press, 2006.

[2] For this model, see: Christopher C. H. COOK, *Alcohol, addiction and Christian ethics*, Cambridge, New York, Cambridge University Press, 2006.

21st century there are 200 million people using illicit drugs, which is equal to 5% of the world's population aged 15-64. A further 76 million are suffering from alcohol addiction and 1 billion people smoke tobacco, which causes 5.4 million deaths per year.[3] Yet these statistics, as frightening as they are, still do not reflect the indirect sufferings in terms of broken families, children who suffer emotional and physical abuse, women involved in prostitution and so on. Also, drug use is a cause for other serious health problems, including HIV/AIDS, hepatitis, and, of course, overdoses. Obviously addiction is a worldwide problem. But what is addiction?

Addiction is an abstract concept. As we explore various theories of addiction, it will become clear that this phenomenon appears to have no objective existence or boundaries; it is interpreted in many different ways today. The definition of addiction in authoritative texts on the subject has changed over the decades. It cannot be said that one definition is exactly correct and another one incorrect, only that one is more useful or generally agreed upon by theorists in addiction science. In current addictionology there has been a huge debate concerning the nature of addiction. There is no single etiopathogenic model. The dominant view in addiction science sees addiction as a disease triggered by the substance; others see addiction either as a syndrome of varying degrees or as a behavioral pattern. There are numerous definitions of addiction which reflect the complexity of this phenomenon. They also mirror the diverse interests and perspectives of those who study and work in this field.

Traditionally, the term *addiction* has been used to identify self-destructive behavior that includes a pharmacological component.[4] But in recent times, the idea that addiction is a disease has become the prevailing view among theorists, clinicians, and the media. The medical discourse of addiction defines drug addiction as a chronically neurobiological disorder that is defined by two major characteristics: a compulsion to take the drug with a narrowing of the behavioral repertoire toward excessive drug intake, and a loss of control in limiting intake.[5] According to the *National Institute on Drug Abuse* (NIDA), addiction is defined as »a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain - they change

[3] WORLD DRUG REPORT, *United Nations Publications Sales*, New York, 2010, No. E.10. xi.13, p. 7.

[4] Carlo C. DICLEMENTE, *Addiction and Change: How Addicts Develop and Addicted People Recover,* New York, The Guilford Press, 2003, 3.

[5] AMERICAN PSYCHIATRIC ASSOCIATION, Diagnostic and Statistical Manual of Mental Disorders, Washington DC, American Psychiatric Press, 2004, 4th ed.; WORLD HEALTH ORGANIZATION, *International Statistical Classification of Diseases and Related Problems*, Geneva, World Health Organization, 1992, 10th ed.

its structure and how it works.«[6] Drugs bind to different receptors, so they have different pharmacological effects and different psychological effects. All drugs are addictive: they all increase brain levels of dopamine. There are two important aspects of NIDA's definition. First, addiction is a »chronic, relapsing disease«. The words »chronic« and »relapsing« indicate that most addicts fail in their attempts to achieve long-term abstinence; they do remain abstinent for a while but then return again to drug use. The second aspect is that drug addiction is a brain disease. It is a disease entity that is characterized by compulsion, loss of control, and its tendency to be repeated despite significant negative consequences. The disease is progressive and often fatal if untreated. Drug use significantly changes the brain function and these changes persist long after the individual stops using drugs. Thus, in clinical texts and textbooks of addiction, researchers, clinicians, and theorists argue that addiction should be grouped with such diseases as schizophrenia, diabetes, Alzheimer's and so on.[7] The disease paradigm identifies addiction as a treatable condition rather than criminal behavior and tries to place the issue of addiction in a public health and medical context.[8] However, most disease paradigms concentrate on the etiology of addiction rather than on how to effect change.

Carlo DiClemente, in *Addiction and Change*, defines addiction from a more behavioral angle. For him, addiction consists of »learned habits that once established become difficult to extinguish even in the face of dramatic, and, at times, numerous negative consequence.«[9] Likewise, Cami and Farre define drug addiction as a chronic condition in which compulsive drug-taking behavior persists despite serious negative consequences.[10] In a similar vein, Robert West sees addiction as a symptom rather than as a unitary disorder. He defines addiction as a syndrome in which reward-seeking behavior has spiralled out of control.[11] He proposes the term 'reward-seeking' to enable exclusion of involuntary actions and obsessive compulsive disorder.

Gene Heyman, in his provocative book *Addiction: a Disorder of Choice*, argues that the conventional perception about addiction – that it is a dis-

---

6 http://www.drugabuse.gov/scienceofaddiction/addiction.html (24.4.2010).

7 See: Thomas A. MCLELLAN et al., Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation, *The Journal of the American Medical Association* , 284, (2000), 1689-1695; Allan I. LESHNER, Addiction is a brain disease, and it matters, *Science*, 278 (1997), 45-47.

8 David E. SMITH and Richard B. SEYMOUR, The Nature of Addiction, *Handbook of Addictive Disorders: A Practical Guide to Diagnosis and Treatment,* New Jersey, John Wiley & Sons, 2004, 29. (ed. Robert H. COOMBS).

9 Carlo C. Diclemte, *Addiction and Change: How Addicts Develop and Addicted People Recover*, 4.

10 Jordi CAMI and Magi FARRE, Drug Addiction, *New England Journal of Medicine*, 10 (2003), 975-986.

11 Robert WEST, *Theory of Addiction,* Oxford, Blackwell Publishing, 2006, 10.

ease, a compulsion beyond conscious control – is wrong. Heyman claims that addiction is voluntary rather than compulsory, and is governed by personal choice; just as the path into it is about making the wrong choice, the path out of it is about making the right choice. He argues that many addicts actually quit their addiction without any help or treatment.[12] Drawing on psychiatric epidemiology and addicts' autobiographies, Heyman argues that most addicts will be ex-addicts by the time they are 30 years old. Hence, it suggests that the claim that addiction is a chronic disease may not be true, but a limited and, after some years, perhaps, self-correcting disorder.[13] Heyman posits that when addiction is a disease, science will soon find an effective treatment for it, as has been the case for many other diseases. If we follow the logic of a disease model, comparing addiction with other diseases as we have noted above, then it is cruel and unjust to treat addicts as criminals or even to stigmatize them. Heyman pointedly asks, Does the government need to provide the same insurance for heroin addiction as they do for traditional chronic diseases such as Alzheimer's or diabetes? If addiction is involuntary, how can punishment help?[14] Moreover, if addiction is a disease, how is it possible that religion has so much success in treating addictive behavior? At this point we think Heyman is quite right, although we would hesitate to claim that addiction is only governed by personal choice. One of our problems with the approach advocated by Heyman is that no one chooses to be an addict, yet people remain addicts for years. Also, if addiction is voluntary, why does it seem so hard to quit? Therefore, the assumption that voluntary behavior is always rational, makes no sense for some people. We have to be aware that for some people it is very difficult to freely make certain choices. However, having said that addictive behavior involves voluntary drug use rather than genetic predisposition, does not imply that quitting is easy.

Here it is good to mention John Booth Davies' social constructive understanding of addiction. In his book *The Myth of Addiction*, Davies tries to bring together two different views of addiction: a pharmacological and a choice aspect of addiction. He considers addiction to be an explanation that people offer for their behavior which attributes causality to external sources.[15]

For the purpose of this paper, however, it is important to bring the religious/theological understanding of addiction to the table. The *moral* or *religious model* advocates that addiction is the result of sin, evil, or moral

[12] Gene M. HEYMAN, *Addiction: A Disorder of Choice,* London, Harvard University Press, 2009.

[13] HEYMAN, *Addiction: A Disorder of Choice*, 76.

[14] George E. VAILLANT, If addiction is involuntary, how can punishment help?, *Drug Addiction and Drug Policy: The Struggle to Control Dependence*, Cambridge, London, Harvard University Press, 2001: 144-167 (eds: Philip B. HEYMAN and William N. BROWNSBERGER).

[15] John B. DAVIES, *The Myth of Addiction*, Amsterdam, Harwood, 2000 2nd ed.

weakness and that the addict is personally responsible for his or her action.[16] In strictly theological terms, addiction may also be seen as a form of idolatry. For chemically dependent people, drugs become their counterfeit god, false savior or pseudo–messiah, which is then perceived as ultimate reality.[17] Addicts believe that drugs will anesthetize and comfort the brokenness of life, and provide liberation from pain, suffering, and loneliness. Other theorists have suggested that substance addiction is a spiritual illness: a condition resulting from a spiritual void in one's life or from a search for connectedness.[18] Therefore, addicts may be unconsciously seeking to fulfill their spiritual need with drugs.[19] *But does that mean that freedom from addiction can be found only through religious faith? Is the religious model excluding all other models of addiction? Is repentance an answer for addiction?* For Cornelius Plantinga[20] such an understanding of addiction as sin is simplistic and inconceivable. He prefers to understand addiction as a tragedy, in which sin is only one of a number of factors involved. Plantinga points out that sin and addiction have overlapping realms. Therefore, sin is not always addiction, and addiction is not always sin, although the two often overlap. We ought not to forget that there are many addicts who are deeply religious but still experience many problems in overcoming their addiction. However, sin and addiction are not opposed, nor are they purely analogous. The proponents of a disease model would argue that it is not primarily a matter of moral culpability that one suffers from addiction.

All of these definitions imply a negative judgment on drug use, but because addiction is so complex, no single definition is likely to be completely adequate. For most theorists in addiction science, there is neither a stable specific psychological structure, nor a specific personality disorder. Based upon this review of addiction we would suggest that addiction is not only a disease, a disorder of choice or moral weakness, and neither should it be understood as caused by deterministic forces in which the sufferers are passive victims of genes. Addiction appears to be an interplay of different factors such as

[16] Christopher C.H. COOK, *Alcohol, Addiction and Christian Ethics*, 17.

[17] Christopher D RINGWALD, Spirituality: An evidence based practice for treatment and recovery, *Counselor* 4 2003 (3), 32-37; Oliver J. MORGAN and Merle R. JORDAN, *Addiction and Spirituality: A Multidisciplinary Approach*, St. Louis, Chalice Press, 1999.

[18] William R. MILLER, Researching the spiritual dimensions of alcohol and other drug problems, *Addiction*, 93 1998, 979-990.

[19] For more theological understanding of addiction see: Christopher C.H. COOK, *Alcohol, Addiction and Christian Ethics*; Oliver J. MORGAN and Merle R. JORDAN, Addiction and spirituality: a clinical-theological reflection, *Addiction and Spirituality: a Multidisciplinary Approach*, St. Louis, Chalice Press, 1999, 251-267 (eds. Oliver J. MORGAN and Merle JORDAN).

[20] Cornelius PLANTINGA, *Not the Way It's Supposed to Be: A Breviary of Sin*, Grand Rapids, Eerdmans, 1995, 129-149.

environment, psychosocial predispositions, religious background and so on. Therefore, subjects are neither entirely responsible, nor entirely without responsibility for their behavior. That leads us to the question of autonomy.

Autonomy

What is (individual) autonomy? Autonomy, a basic moral and political value within the liberal political morality, refers to the capacity »to be one's own person, to live one's life according to reasons and motives that are taken as one's own and not the product of manipulative or distorting external forces.«[21] Autonomy might be defined as the freedom to make self-regarding choices, in which a person expresses his/her own authentic self. »The root idea of autonomy is that in making a voluntary choice a person takes on responsibility for all the foreseeable consequences to himself that flow from this voluntary choice.«[22]

The notion of autonomy is quite a modern one, i.e. mainly a product of Enlightenment humanism. Within this framework, the person is seen as independent of any metaphysical ('oppressive') order whatsoever (i.e. Christianity) as well as independent of specific social structures and political institutions. The focus is on the individual's ability to govern himself or herself.

In bioethics, to give an example, there is great respect for the values of personal autonomy and patient self-determination.[23] All political authority and all morals are in essence subservient to this idea of the self-governing individual.[24] This concept of autonomy is, however, not undisputed. Philosophers differ radically about both the nature and the value of autonomy. Can autonomy be an unqualified value for all individuals?

---

[21] Edward N. ZALTA, CENTER FOR THE STUDY OF THE LANGUAGE AND INFORMATION (U.S.). Metaphysics Research Lab. Stanford encyclopedia of philosophy. Stanford, Calif., Metaphysics Research Lab, Center for the Study of Language and Information. S.v. 'Autonomy' http://plato.stanford.edu/entries/autonomy-moral, (7. 04.2011).

[22] Richard J. ARNESON, Mill versus Paternalism, *Ethics*, 90 (1980) 4, 470-489, 475.

[23] Cp. Tom L. BEAUCHAMP and James F. CHILDRESS, *Principles of biomedical ethics,* New York, Oxford University Press, 2001. Over the last forty years, there has been a shift away from a more paternalistic model of health provider-patient relationships ('paternalism') towards more respect for self-determination. Cp. Arthur CAPLAN, Denying autonomy in order to create it: the paradox of forcing treatment upon addicts, *Addiction*,103 (2008), 12, 1919-1921, 1919.

[24] There is quite some controversy about the exact content of this concept. For one might pose other central values than that of autonomy, for example within alternative frameworks such as that of an ethic of care, utilitarianism or virtue ethics.

Addiction and Autonomy

Addiction seems incompatible with a full capacity of self-determination or autonomy as addiction is often being equated with loss of control, powerlessness, and unmanageability.[25] If autonomy consists of rationality and volitional control, does addiction impair these? And if it does, might that then have exculpatory significance? Universally, drug use is seen as impairing autonomy. But there seems to be something strange going on here: on the one hand, criminalizing specific addictive substances is regarded to be illiberal; on the other hand, drug users are typically regarded as not in control of their consumption, and should therefore not be punished. Where the first affirms the capacity for individual autonomy, the latter denies just that.[26]

According to Husak, we have to notice there are degrees of autonomy. He makes the comparison with infants: initially they completely lack in autonomy but during their development toward maturity they gradually become more autonomous. Autonomy can be seen as a continuum. Some choices that human beings make are more or less autonomous than others. If we apply this to addictive acts, the question according to Husak is not whether or not addicts use drugs non-autonomously, but how much autonomy is exemplified in their use of drugs. Every human being, the addict included, finds him/herself somewhere on the continuum between fully autonomous and wholly non-autonomous, »probably much closer to the latter end of the continuum«.[27] Buchmann and Russel follow the same line stating that addiction is about degrees. According to them, autonomy is presented in a too extreme way, »To say an addict cannot be a fully free, autonomous agent presumes that people usually are. This is questionable. Recent debates about autonomy as a 'hypervalue' and the corrective of relational autonomy warrant more contextualized use of autonomy in discussions about addictions.«[28] There seems to be, then, a qualified relationship between addiction and autonomy. It appears to be too easy to conclude that addiction excludes autonomy. On the other hand, addiction 'does' something with the autonomy of the person. The three explanatory models mentioned earlier have their own specific perspectives on this issue.

---

[25] Ibid.; cp. Thomas SZASZ, The Fatal Temptation: Drug Prohibition and the Fear of Autonomy, *Daedalus*,121 (1992) 31, 161-164, 161: »If the right to autonomy – to our bodies, minds and selves – means anything, it means a right to suicide. And if pro-choice means anything, it must mean the right to use or abstain from using any particular drug.« N.B. 'Right' does not mean that it is desirable or morally meritorious per se. The right to die then would include the right to use drugs.

[26] Gary WATSON, Excusing addiction, *Law and Philosophy* , 18, (1999), 589-619, 589.

[27] Douglas N. HUSAK, Addiction and criminal liability, *Law and Philosophy* 18, (1999), 655-684.

[28] Daniel Z. BUCHMAN and Barbara J. RUSSELL, Addictions, autonomy and so much more: a reply to Caplan, *Addiction* 104 (2009), 6, 1053-1054; author reply 1054-1055., p. 1053.

Addiction, Autonomy and the Disease Model

Elementary to the disease model of addiction is the notion that addictive behavior is compulsive. Compulsion is doing something because one experiences one has to do it. The urge is irresistible. One does the specific act repeatedly and is unable to stop it. It is not something that you do out of free choice. Where addiction is defined as a 'chronic relapsing brain disorder', as it is within the modern day disease model, compulsion is central. The idea is that addicts, because of their addiction and the inherent lack of concern for their health, are viewed as being mentally incompetent to make real choices or to consent to anything. They suffer from decisional impairments, from invalidating decision-making capacities. Disease, then, seems fully incompatible with the responsibility of the addict. Perhaps responsibility for the disease of addiction can be applied to the beginning stages of the disease. But 'disease' consists of irreducible, pathological mechanisms in the body over which conscious choice does not hold sway. »The signs and symptoms of the disease [...] are seemingly the mechanistic consequence of pathological biological structures and functions over which the addict has no control once prolonged use has caused the pathology.«[29]

Connected with compulsion, is the opinion that addicted drug-users contravene their true desires. One has to differentiate here between so called first and second order desires. According to Harry Frankfurt, »Addicts are not free because they have a first order desire to take heroin but a higher second order desire not to desire to take heroin. [...] Freedom of the will occurs when our first order desires are in line with our second order desires: we do what we desire to desire to do.«[30]

In the case of addicts, from the perspective of the disease model one can speak of autonomy impairment. There is a conflict in the volitional hierarchy of the person: the person does something that he/she really does not want to do, so he/she acts against his/her will: »Addicts change their minds: the opportunity for consumption arises, or the cravings begin, and the pleasures of the drugs begin to weigh more heavily with them than the goods achievable through abstaining.«[31] Therefore, the addict seems to sacrifice his/her longer term interest by giving in to his shorter term interest, i.e. the use of drugs. Even though he/she might originally have opted for the longer term interest, a judgment shift occurs in the addict and he/she ends up choosing

[29] Stephen J. MORSE, Hooked on hype: addiction and responsibility, *Law and Philosophy* , 19 (2000), 3-49, 5.

[30] Bennet FOODY and Julian SAVULESCU, Addiction and autonomy: can addicted people consent to the prescription of their drug of addiction?, *Bioethics* , 20 (2006a), 1, 1-15, 5.

[31] Neil LEVY, Autonomy and addiction, *Canadian Journal of Philosophy* , 36, (2006b) 3, 427-448, 434.

for the immediate gratification of the desire. The latter seems to him/her at that specific point in time to be more 'rational' than choosing abstention. By sacrificing his/her shorter term interests for the longer ones, he/she would have been capable of pursuing his/her own conception of the good.[32]

Levy describes the addict as a less unified self, as somebody who is unable to effectively exert his/her will across time, as somebody who is lacking the capacity for self-government, which shows itself in preference reversals.[33] Lack of a unified self can be compared to the empirical experience that addicts stop their normal development the moment they start using drugs. Their selves are more fragmented ('disunified'): »They lack the capacity to unify themselves to a sufficient degree to begin to formulate plans and policies, in the realistic expectation that they will abide by them.«[34] And so they are less able to delay gratification. Here, Levy brings in the notion of ego-depletion. Even though he does not fully agree with the notion that addiction destroys all autonomy, he still holds on to a certain measure of autonomy impairment: »After all, not only is there the phenomenological evidence, to which many of us can attest, that breaking addiction is difficult, there is also the evidence that comes from the fact that addicts slowly destroy their lives and the lives of those close to them.«[35] Ego-depletion, Levy states, causes self-control to diminish over time. The length of time this takes depends on how many self-control resources there are in the life of the addict and how much of those resources are already spent. What addicts need to do, then, is to take care to avoid cues that trigger craving. For, within the disease model, it is the craving that makes addicts give in to their first order desires and thereby squander their true good. Addicts still have some basic autonomy, Levy holds, »The minimal status of being responsible, independent and able to speak oneself.«[36] But where true autonomy (or: ideal autonomy; or: maximal authenticity) consists essentially in the exercise of the capacity for extended agency,[37] addiction undermines

[32] Cp. Neil LEVY, Self-Deception and Responsibility for Addiction, *Journal of Applied Philosophy* , 20 (2003) 2, 133-142. Levy, 2003, 138: »They are better explained by the mechanism of hyperbolic discounting, the mechanism by which rewards which are nearer to us in time are temporarily endowed with much greater value than more distant rewards«.

[33] Neil LEVY, Autonomy and addiction, *Canadian Journal of Philosophy* , 36 (2006b) 3, 427-448, 440 note: »Addicts lack autonomy when they suffer regular and uncontrollable preference reversals, such that they find themselves, when in the grip of their addiction, doing things that at other times they would prefer not to do.«

[34] Ibid., 443

[35] Neil LEVY, Addiction, autonomy and ego-depletion: a response to Bennett Foddy and Julian Savulescu, *Bioethics*, 20 (2006a) 1, 16-20, 17.

[36] Neil LEVY, Autonomy and addiction, *Canadian Journal of Philosophy* , 3 (2006b), 427-448, 429.

[37] Levy defines this 'extended agency' as a unified self that has come into existence on the basis of cooperation of the different subpersonal mechanisms, a unified self with a more or less consistent set of preferences, dispositions and desires (in short: a character). Postpon-

this »so that addicts are not able to integrate their lives and pursue a single conception of the good.«[38] Caplan holds that an addict might be capable of, what he calls, reason-autonomy; that is, being able to make decisions, setting goals, etc. But according to him this is not sufficient for autonomy. »Being competent is a part of autonomy, but autonomy also requires freedom from coercion.«[39] This would make (temporary) infringement of autonomy possible in order to restore the autonomy of the person for the long term.[40]

Does addiction create a defect of the will?[41] A defect of the will means that the actor cannot choose otherwise. This only counts when the actor's choice is inconsistent with his/her ordered preferences, with his/her higher desires, and so: against his/her will.[42] The addict knows the choice he/she ought to make; he/she also wants to make that choice, but he /she is unable to take the course of action or it is unreasonably difficult for him/her to do so. So it seems to be a matter of compulsion; the state that addicts literally cannot resist their urge to procure and take the drug. However, does compulsion really exist? Levy denies this. The idea of the unwilling addict is a myth, he states. There is no such person, »because there is no such thing as an irresistible or compulsive urge to consume drugs, and because the addict who is moved by a force which is wholly alien to her is a myth.«[43] Addiction provides the motives for action, certainly, but that is not equivalent to saying that those motives are irresistible (i.e. compulsive). The addict is not helpless.

The helpless addict in the grip of a compulsion provides a false picture of addiction. Still, it is the picture that is made possible, and made prevalent, within the disease model of addiction. In that model, in principle, one cannot hold the addict responsible for his/her actions. For the disease model basically holds to biological determinism. It is a naturalistic way of looking at the addiction problem. Within that model, loss of control is dominant. But when the addict really loses control when using drugs or being addicted, can he/she still

ing short term rewards in order to obtain long term, greater rewards, also serves as making people, as unified agents, capable of pursuing their own conception of the good (the self extends itself). »The unified agent is then able to act on her own preferences and values, without fearing that her plans will be short-circuited when the opportunity for some more immediate reward presents itself«. (Ibid., 439)

[38] Ibid., 427.

[39] Arthur CAPLAN, Denying autonomy in order to create it: the paradox of forcing treatment upon addicts, *Addiction*, 103 (2008), 12, 1919-1921, 1919.

[40] Caplan (2008) makes a claim for mandatory prescribing naltrexone in the case of drug or alcohol addiction, thereby relieving its coercive effects, in order to make it possible for those addicted to reclaim their autonomy

[41] In ancient Greek this was called *akrasia*, literally the lacking of command over oneself. One acts against one's better judgment.

[42] Michael L. CORRADO, Addiction and responsibility: an introduction, *Law and Philosophy* , 18 (1999), 579-587, 586.

[43] Ibid., 137.

be held accountable? The idea behind this is that drug-craving limits the scope for volitional control of behavior. Addiction results in a progressive loss of volitional control over drug taking, overwhelming rational deliberations. And this would exclude accountability. For as someone has lost the power of self-control, it would seem that he/she cannot be held responsible in the absence of that power. And that would mean that such a person should be protected from such a state, i.e. by restrictions on certain drugs. And that could mean that criminal penalties are not to be inflicted on a person when that person is in a condition that he/she is not capable (does not have the power) to change. You do not punish somebody for being sick. Summarizing, we can say that a disease model of addiction emphasizes compulsion and loss of control, which seems hard to equate with full blown autonomy. Instead, it advocates a position of non-autonomy, or, at best, reduced autonomy.

Addiction, Autonomy and a Disorder of Choice Model

Basic to a disorder of choice model is that – contrary to the disease model – addiction is not compulsive. In a disorder of choice model, one holds to the notion that addicts are morally responsible persons who are quite able to make rational, volitional choices. As Foddy and Savulescu indicate, »the evidence that drug users do in fact respond to powerful incentives is a strong indicator that their behavior is not compulsive.«[44] As also Levy points out, »If addictive desires were compulsive, it is difficult to see how addicts could give up voluntarily.«[45] And when addiction is not compulsive, i.e. when addiction/addictive desire(s) is/are not irresistible, it follows that addicts cannot be regarded as 'mindless automata' that are forced to act on the basis of the cravings the lack of drugs produce.[46] And when the desires are not irresistible, it means that addicts are not deprived of their possibility to make volitional choices.

In an earlier article, Levy states that the core issue of (the continuation of) addiction is not craving or compulsion; the use of drugs is better explained by the mechanism of hyperbolic discounting, by existential dependency and by life problems. The first refers to the mechanism that rewards that are closer to us in time gain the preference over the rewards that are more long term. The second points to the fact that the addict forms his/her life around the drug,

[44] Bennet FOODY and Julian SAVULESCU, Addiction and autonomy: can addicted people consent to the prescription of their drug of addiction?, *Bioethics* , 20 (2006a), 1, 1-15, 5.

[45] Neil LEVY, Autonomy and addiction, *Canadian Journal of Philosophy* , 36 (2006b) 3, 427-448, 431.

[46] Cp. Stephen J. MORSE, Hooked on hype: addiction and responsibility, *Law and Philosophy* 19 (2000), 3-49, who phrases this view of compulsion as (p. 3): »A puppet pulled by the narcotic strings of a biological disease«.

and that the drug in turn provides the framework for living. The last refers to the observation that the consumption of drugs is a way to deal with life's problems, albeit it »an extremely flawed solution.«[47]

According to Foddy and Savulescu, addiction is not really very different from drug-oriented and other appetitive desires, like eating, just that it is stronger. And whereas appetitive desires must be considered valid sources of rational, volitional choice, this also applies to chemical addictions. Therefore, in their opinion, choices of addicts, even when desiring drugs, are authentic choices: »It may be that desire for drugs harms a person or leads a person to do what he has good reason not to do, but we should not say these desires are unreal or inauthentic.«[48] Within a disorder of choice model a conclusion can be upheld that, contrary to a disease model, addiction is not compulsive and addicts keep on exercising some degree of control over their consumption behavior.[49] They are still in the possession of their volitional resources. Addictive behavior is intentional behavior, i.e. the addict plans, purchases drugs, consumes them and so on. And all these acts are deliberate acts. It is equivalent to saying that it is his/her choice to do these things. »That is precisely what makes addiction such an interesting issue in the study of responsibility: the addict knows what she is doing and chooses to do it, and yet we want to say that, in some sense or other, she is not in control of her behavior.«[50]

Even when we would recognize disease elements in addiction – which in our opinion can be admitted – »[t]he presence of a disease per se does not answer the question of responsibility within a moral and legal model, even if the presence of the disease and its signs and symptoms are uncontroversial.«[51] One can even admit, with Levy, that there is a measure of autonomy impairment in the addict. But how does one measure the impairment of autonomy? As Husak holds, »the amount of autonomy that must be lacking in order to excuse an act may not be identical to the amount that must be lacking in order to justify its proscription.«[52]

Contrary to a disease concept, within a disorder of choice model, addicts are not regarded as automatons. That is to say, addicts are not determined

---

[47] Neil LEVY, Self-Deception and Responsibility for Addiction, *Journal of Applied Philosophy* , 20 (2003) 2, 133-142, 138.

[48] Bennet FOODY and Julian SAVULESCU, Addiction and autonomy: can addicted people consent to the prescription of their drug of addiction?, *Bioethics* , 20 (2006a), 1, 1-15, p. 14.

[49] For example, consumption appears to be price-sensitive, which is incompatible with addictive desires being compulsive.

[50] Michael L. CORRADO, Addiction and responsibility: an introduction, *Law and Philosophy*, 18 (1999), 579-587, 581.

[51] Stephen J. MOORSE, Medicine and morals, craving and compulsion, *Subst Use Misuse*, 39 (2004) 3, 437-460, 444.

[52] Douglas N. HUSAK, Addiction and criminal liability, *Law and Philosophy*, 18 (1999) 655-684, 668.

to (continue to) use drugs. When an addict is able to make other choices, it means he/she is not determined, that he/she is free to choose. Corrado differentiates as to a defect of the will between those who hold to the notion and those who do not. The first are those who hold that the person cannot choose otherwise, which he/she equates with the position of the disease theory of addiction. Those who hold the latter position (i.e., that there is no defect of the will), he subdivides in those who hold to rational addiction (addiction is just behavior as any other, rationally pursuing an increase in pleasure (or utility), and so has no bearing on responsibility), addiction as duress (addiction is a rational response to a coercive situation and so is not responsibility after all; addiction serves as an excuse, rationally avoiding pain), and addiction as distortion, as a defect of rationality (the addict's behavior is irrational in the sense that he or she brings about consequences that he/she would prefer not to bring about, and fails to bring about consequences he/she wants to bring about. Thus, his or her beliefs do not respond to the evidence, distorting the addict's relationship with reality).

A disorder of choice model denies the metaphor of 'mechanism' within the disease model as »the most misleading source of the intuition that some people cannot control actions intended to satisfy some desires, especially if we believe that the desires are produced by neurochemical or other brain abnormalities.«[53] Morse, referring to Odysseus, argues that the addict has a duty to take steps to bind him/herself to the mast »when his desires are less insistent, especially if the addiction-associated behavior is legally forbidden or if the costs are externalized because the behavior harms families, friends, and society more generally.«[54]

Up until now in western democracies, the law in general also does not regard addiction – and this applies perhaps to most mental and physical diseases – as something that exculpates the addict when committing criminal offences.[55] The courts have not excused the addict's behavior as non-responsible. And that is equivalent to saying that addiction is not regarded as a disabling condition. And even when it would be conceded that addiction does infringe on responsibility (i.e. does result in volitional impairment), it seems impossible for the law to point out where to draw the demarcation line. Law does not base itself on the latest biomedical research. The latter cannot tell

[53] Stephen J. MOORSE, Medicine and morals, craving and compulsion, *Subst Use Misuse*, 39 (2004) 3, 437-460, 444.

[54] Ibid., 454.

[55] Michael L. CORRADO, Addiction and responsibility: an introduction, *Law and Philosophy*, 18 (1999), 579-587, 580. »The law responds to our ordinary conception of what addiction is.« Cp. MORSE, 1999, 6: »Most mental and physical diseases suffered by people who violate the criminal law, even severe diseases, do not have these exculpating effects because they do not affect agency concerning criminal activity.« Cp. HUSAK, 1999, 658.

how the law ought to respond.[56] The law as an instrument of social control must be kept in place.

Within a disorder of choice model, addicts are responsible for their addiction and for the behavior connected with it. It is the addiction that motivates the person to act. And the way he/she does that, is remarkably similar and familiar to the way any human being acts.

> They engage desire, because they promise rewards for drug-ingestion, and because they promise relief from pain, physical and psychological, whether the pain that often leads addicts to seek out drugs in the first place, or the pain that is the result of drug-withdrawal. Addiction provides strong motives for action, but there is no reason to believe that these motives are irresistible.[57]

A disorder of choice, then, negates the compulsiveness of addiction and adheres to the conviction that addicts make volitional choices, also when choosing to procure and use drugs. The model recognizes that addicts can be regarded as autonomous in the latter sense.

Addiction, Autonomy and an Existential Disorder Model

Like a disorder of choice model, an existential disorder model does acknowledge the fact that addicts are morally responsible agents. They are not victims of their disease, they are not suffering from a compulsive disorder, and they are not forced to use drugs. In an existential disorder model we recognize that addicts take drugs because they want to (so, this constitutes a volitional act). Still, their own testimony is that they use against their will. Levy understands this unwanted addiction as characterized by an oscillation in the preferences of the addict. The experience of craving induces a judgment shift in the addict.[58] But still, an existential disorder model does recognize that there is more the matter than just disease or choice. Within this model, addiction is a way to cope with life's basic issues. That is equivalent to saying that addiction is, when considered in-depth, an existential problem.

Both a disorder of choice model and an existential disorder model refuse to acknowledge the notion that addiction is equivalent to the hijacking of the brain, as is assumed in a disease model. In the latter model, in the case

---

[56] Morse holds that most addicts should be held responsible for most criminal behavior motivated by addiction, »but that addiction can in some cases affect the agent's ability to grasp and be guided by reason.« Stephen J. MORSE (2000). Hooked on hype: addiction and responsibility, *Law and Philosophy*,19 (2000), 3-49, 4. This would lead to 'partial responsibility'.

[57] Neil LEVY, Self-Deception and Responsibility for Addiction, *Journal of Applied Philosophy*, 20 (2003), 2, 133-142, 137.

[58] Neil LEVY, Autonomy and Addiction, *Canadian Journal of Philosoph* , 36 (2006b), 3, 427-448, 435.

of addiction, there is an impairment of autonomy. The first two models substantiate their view by pointing out that were addictive desires compulsive, no addict would give up voluntarily. But the fact is that they do. Where loss of control in a disease model seems to be connected with exculpatory significance, in an existential disorder model the element of responsibility is upheld. It holds that 'loss of control' as an independent state or condition that undermines responsibility does not gain much support from related scientific or clinical data.[59] Perhaps with Levy the existential disorder model will give some room for the recognition that addiction might result in some impairment of autonomy, but then again that is something that might apply to many more activities human beings pursue. Addicts are held responsible for their addiction and for the behavior that they commit under the influence of drugs. As Watson writes: »Even if addictive conditions are in some (not yet well understood) way responsibility-undermining, addicts are complicit in their own impairment.«[60] And a few pages later, »Citizens have a standing legal duty to develop and maintain sufficient capacities of self-control to enable them to conform to the law.«[61]

In an existential disorder model, the possibility of moral choices within an existential framework is held on to. And with this the dignity of the human being as a responsible creature. Carrying responsibility is what honors a human being as a human being. In a disease model, the addict is more often than not regarded as a victim. But when the addict does not experience the consequences of his/her own freely chosen actions, or when the consequences of his/her actions are either removed or softened, this can be seen as incompatible with true human flourishing.[62] Human life is worth the name when people who voluntarily engage in specific kinds of acts, also experience and are responsible for the consequences of those actions. Herein consists the dignity of the human being: that he/she is a responsible person and can be held accountable for his/her actions and the results of those actions. Removing the consequences is equivalent to diminishing the dignity.

Medicalization of addiction does not do justice to a problem that, in essence, is an existential one. Addressing addiction asks for more than a

---

[59] Stephen J. MORSE, (2004). Medicine and morals, craving and compulsion, *Subst Use Misuse*, 39 (2004) 3, 437-460, 450.

[60] Gary WATSON, Excusing addiction, *Law and Philosophy* , 18 (1999), 589, 590.

[61] Ibid., 597, 598.

[62] Theodore C. DALRYMPLE, *Romancing Opiates: Pharmacological Lies and the Addiction Bureaucracy*, New York, Encounter Books, 2006, 41: »If consequences are removed from enough actions, then the very concept of human agency evaporates, life itself becomes meaningless, and is thenceforth a vacuum in which people oscillate between boredom and oblivion.« And further (Ibid., 109): »The ways we treat addicts appears to be generous, »but which are actually dehumanizing because they reduce addicts to the status of mere physiological specimens or preparations in a laboratory, addiction is a moral weakness par excellence.«

technical solution to the medical problem. It means that questions need to be answered as to the purpose of human existence, the existential questions regarding human life, the questions as to why somebody wants to avoid pain and pursue pleasure as the highest purpose of life. And such questions can only be answered by those who have asked those questions first of themselves. One might even endeavor to say that, in the end, addiction is a problem of the heart. But when the addiction problem is reduced to its technical dimensions, the heart is lost sight of. Addiction seems much more to be an existential problem. As Dalrymple remarks: »The addict has a problem, but it is not a medical one, it is an existential, spiritual one: he does not know how to live.«[63] And when addiction is not a medical problem, medical interventions will not solve it. Addicts will have to be given a reason for living.

Dalrymple's remark points towards a central element in the existential disorder model. Even when there would be a (partial) recovery of autonomy, when this autonomy is not connected with the experience of 'belonging', of 'liberation', this concept remains empty. That is to say, when the dimension of meaning is left out of the discussion, at best we will arrive at superficial solutions that do not do justice to what a human being is. In a disorder of choice model, these existential notions of addiction are not part of the concept, just as they are not part of the concept of a disease model. Only within a model that addresses these deeper issues, justice is done to what addiction is all about. In an existential disorder model, room is made for these existential questions that are elementary to addiction, by including spirituality as a factor in the understanding and treating of addictive behaviors. Here, addiction is concerned with the way in which relationships are disordered by making a particular substance or behavior an object of desire for its own sake. Within a deterministic, naturalistic view of addiction these aspects of addiction are lost sight of.

An existential disorder model is a model one might place between a disease model that perhaps aims too low, and a disorder of choice model that perhaps aims too high. Cook's theological disorder model, as a specimen of an existential disorder model, tries to 'normalize' addiction as something that is inherent in every human being. By choosing only for a medical view of addiction or, conversely, only for a moral view of addiction, »we protect ourselves from the implications of admitting the divisions of self that we experience and yet deny. Instead, we label the addict as either sinful or sick, projecting on to them the pathology that we disown within ourselves.«[64] Without denying the medical and moral aspects of addiction, the experience of addiction, then, is something that is, as Cook phrases it, »not completely alien to any

[63] Ibid., 109.
[64] Ibid., 198.

human being.«[65] Recognizing that addiction has to do with divisions of the will, with first-order volitions to continue drug use despite first-order volitions to discontinue, it will lead to the awareness that only grace (however defined) is able to set people free from their captivity.

Sažetak

Ovisnost i autonomija: jesu li ovisnici autonomni?

Glavno pitanje na koje autori pokušavaju odgovoriti je: na koj su način autonomija i slobodni izbor povezani s ovisnošću. Logika istraživanja naložila je da se u prvome dijelu teksta uoče različite definicije substantivne ovisnosti i načini na koje različite teorije tumače i shvaćaju ovaj fenomen. Promišljanje o ovisnosti ponajprije zahtijeva koncizno određenje koncepta ovisnosti od droga, tj. razmatranje objašnjenja stručne javnosti o ideji ovisnosti. Ovdje valja istaći da ne postoji jedinstveni model etipatogeneze. Brojne definicije supstantivne ovisnosti koje su predstavljene u radu samo dokazuju složenost ovog problema. Nadalje, autori daju uopćeni opis koncepta autonomije povezujući ga s fenomenom ovisnosti. Autori se također bave različitim eksplikativnim modelima ovisnosti kao što su, ovisnost kao bolest (disease model), poremećaj kao (osobni) izbor (disorder of choice model) i model egzistencijalnog poremećaja (existential disorder model) – pokušavajući sagledati kompleksan odnos autonomije, slobodnog izbora i ovisnosti. Dakle, pitanja na koja autori pokušavaju odgovoriti su sljedeća: kako je ovisnost povezana s autonomijom i koji je njihov međusobni odnos? Da li ovisnost onemogućuje dobrovoljni izbor prekida uzimanja droga? Da li ovisnici nemaju kontrolu nad svojom bolešću i je li to razlog stalnih recidiva? Je li adiktivno ponašanje racionalna aktivnost?

Ključne riječi: ovisnost, autonomija, ovisnost kao bolest, ovisnost kao poremećaj (osobnog) izbora, model egzistencijalnog poremećaja, duhovnost

[65] Ibid.