Implications of Understandings of Addiction: An Introductory Overview

Bauer, Robert[1]; Eppler, Natalie[2]; Wolf, Julia[3]

1. Introduction

Albeit it seems that „thinking about addictions has been dominated by two models: the medical model, which treats addiction as a disease and related behavior as signs and symptom, and the moral model, which views addiction and related behaviors as indications of moral failure“[4], many more than these two understandings of addictions[5] are being discussed in the literature and the conflict about hegemony is far from being settled. This paper gives an introduction into the problems faced when understandings of addiction are being discussed. We will describe eight understandings of addiction, point out similarities and differences and group them in relation to each other. We will clarify two terms essential for understandings of addiction: disease and responsibility. Finally, we will discuss how understandings of addiction interact with the addict's self-understanding, society and the professional care system. We will close with a short conclusion on what should be observed when understandings of addiction are being discussed.

2. Eight Understandings of Addiction

Understandings of addiction are often seen as contradictory at first, but are integrated in practice to account for the various problems which are faced when it comes to evaluating and responding to addiction. Based on the taxonomy of understandings of addiction offered by Brickman et al.[6], we clustered the eight models in a two-dimensional space with one axis for the addicts responsibility for the onset of the addiction and another for its solution (confer figure 1).

1 Interdepartmental Centre for Ethics in the Sciences and Humanities, Tuebingen

2 Institute of Addiction Research of the University of Applied Science, Frankfurt am Main

3 Department for Medical and Health Ethics, University of Basel

4 Stephen J Morse: Medicine and Morals, Craving and Compulsion. In: Substance Use & Misuse 39 (2004) N. 3, p. 437–460, here p. 437.

5 In the literature, different words are used when what we mean with „understandings“ of addiction are being discussed, e.g. Brower et al. (1989) calls them models; Palm (2004) nature; Kalant (2008) concepts. All these words share the risk of misunderstanding them. Model e.g. implies a scientific background or nature reifies. Albeit sometimes using the terms synonymous, what we mean with „understanding“ is a conglomerate of assessments and assumptions about addiction of a specific social actor without assuming they are necessarily true or justified. In addition we perceive understandings as ideal types in a Weberian sense.

6 Philip Brickman et al.: Models of helping and coping. In: American Psychologist, 37 (1982) N. 4, p. 368–384.

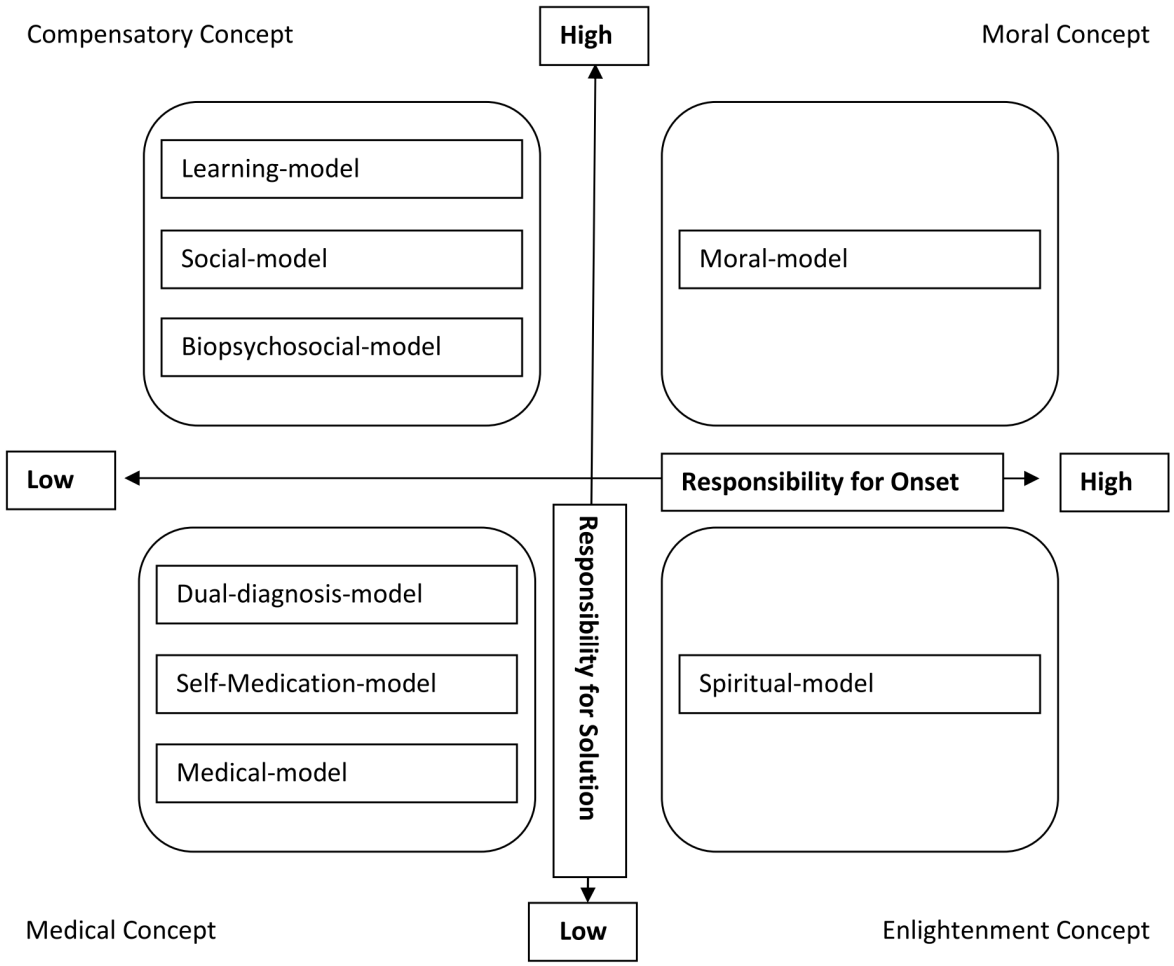

Figure 1: Various models integrated into a modified taxonomy based on Brickman et al. (1982)

The moral model is characterised by several aspects. First, the addict is seen as someone who is in control of his or her consumption: "The point is simply that the actions of addicts are actions and not mechanisms and thus they are potentially reason responsive"[7] . Second, the urge to use a substance is seen as a pleasure-oriented desire: "Addiction is nothing but the drive to experience pleasure"[8]. Consequently, addicts can be hold responsible for their consumption and any criminal behaviour to finance their drug "habit". This is often seen as an advantage of the model, ensuring justice.[9] It is argued that it is exactly this tension between personal rights and liberties versus social interests and duties which is one of the main ethical problems in the context of addiction.[10] But it could also be useful for treatment as moralizing addicts might get to the gist of addiction.[11] "Although blaming someone for being dependent on alcohol is generally counter therapeutic, holding people accountable for consequences may be useful in overcoming denial and increasing commitment to

7 As above p.448

8 Bennett, Foddy, et al.: Addiction Is Not An Affliction: Addictive Desires Are Merely Pleasure-Oriented Desires. In: American Journal of Bioethics 7 (2007), N. 1, p. 29–32.

9 Kirk J Brower et al.: Treatment implications of chemical dependency models: An integrative approach. In: Journal of Substance Abuse Treatment 6 (1989), N. 3, p. 147–157; Lars Lindström: Managing alcoholism. Matching clients to treatment. Oxford 1992.

10 Alois Rust: Ethische Aspekte. In: Suchtmedizin. München, ed. von Ambros Uchtenhagen, et al., München 2000 p.573-583

11 Felix Tretter: Ökologie der Sucht. Das Beziehungsgefüge Mensch-Umwelt-Droge. Göttingen 1998

change"[12]. Yet, on the other hand, shame and guilt could decrease self-esteem and self-efficacy of addicts, thus reducing their capability to control their consumption[13], but could also increase motivation to change[14]. Because of this sometimes paradoxical effects the moral model is very complex to handle during treatment. A variant of the moral model offering a better manageable approach to these problems of self-attribution and self-control is the spiritual model (e.g. 12-step-program). The spiritual model combines elements of the medical and the moral model.[15] Arguing that addicts have to accept that they are without power over their consumption, the 12 step-program integrates the notion of loss of control. Consequently, the substance user is judged to be responsible for the consequences of his consumption, but not for the termination of his addiction.[16] Paradoxically, it is the acceptance of a loss of control over the drug that allows to regain control.[17]

Loss of control is also a main element of the medical understanding. It "conceives addiction as an involuntary activity, characterized by loss of control. Here behaviour is considered to be caused and determined by forces external to the self".[18] The understanding of addiction as a disease has changed in the last 15 years. Then putting the focus on psychological factors, the argumentation now relies mainly on neurobiological factors. The medical model is thus judging addiction as a "chronic relapsing illness, characterized by compulsive drug seeking and use".[19] Although the idea of loss of control is the central point of this model, there is only limited clinical data upon which it could be grounded.[20] E.g. studies of controlled opiate use disprove the loss of control concept as an irreversible state.[21] Such, it is argued that "the medical label in this context has nothing to do with science, and everything to do with social expediency".[22] As Herwig-Lempp argues, the criterion of loss of control might become a self-fulfilling-prophecy.[23] It certainly limits the options of substance users as they could only choose between either compulsive consumption or rigid abstinence. An advantage of the medical concept is that it cautions against addictive effects of various substances[24] and ensures that treatment and research are funded.[25] A disadvantage is the possibility of a slowly progressing stigmatization of cultural, ritual or social regulations of consumption of various substances.[26] The model might ignore the unproblematic use of various substances in the general population. Rust

---

12 Lars Lindström: Managing alcoholism. Matching clients to treatment. Oxford 1992, here p. 13

13 Brower, Kirk J.; Blow, Frederic C.; Beresford, Thomas P. (1989): Treatment implications of chemical dependency models: An integrative approach. In: Journal of Substance Abuse Treatment, Jg. 6, N. 3, p. 147–157

14 Daniela Hosser et al.: Scham, Schuldgefühle und Delinquenz. In: Zeitschrift für Sozialpsychologie, 36 (2005), N. 4, p. 227–238.

15 Kirk J Brower et al.: Treatment implications of chemical dependency models: An integrative approach. In: Journal of Substance Abuse Treatment 6 (1989), N. 3, p. 147–157; Lars Lindström: Managing alcoholism. Matching clients to treatment. Oxford 1992

16 Kirk J Brower et al.: Treatment implications of chemical dependency models: An integrative approach. In: Journal of Substance Abuse Treatment 6 (1989), N. 3, p. 147–157

17 George Ainslie: Breakdown of will. Cambridge, New York 2001; John Booth Davies: The myth of addiction. New York 2006

18 Jeffrey A. Schaler: Addiction is a choice. Chicago 2000, here p. 68

19 A. I. Leshner: Addiction is a brain disease, and it matters. In: Science 278 (1997), N. 5335, p. 45–47 here p.45

20 Stephen J. Morse: Medicine and Morals, Craving and Compulsion. In: Substance Use & Misuse, 39 (2004) N. 3, p. 437–460, here p. 437.

21 Stanton Peele: The Meaning of Addiction. Compulsive Experience and Its Interpretation. Lexington 1985

22 John Booth Davies: The myth of addiction. New York 2006, here p. 75

23 Johannes Herwig-Lempp: Von der Sucht zur Selbstbestimmung. Drogenkonsumenten als Subjekte. Dortmund 1994

24 Lars Lindström: Managing alcoholism. Matching clients to treatment. Oxford 1992

25 A. I. Leshner: Addiction is a brain disease, and it matters. In: Science 278 (1997), N. 5335, p. 45–47

26 Alois Rust: Ethische Aspekte. In: Suchtmedizin. München, ed. von Ambros Uchtenhagen, et al., München 2000 p.573-583

therefore criticizes the idea that a specific chemical substance causes addiction and stresses the importance of social factors.[27]

Taking a closer look at social factors leads us to the next concept of addiction, the social model. In this model the "substance abuser is viewed as a product of external forces such as poverty, drug availability, peer pressure, and family dysfunction".[28] Uchtenhagen criticizes that on the one hand this concept helps to understand substance use, but on the other hand it doesn't explain the mechanism of becoming addicted.[29] The model allows to clarify social and cultural influences and facilitates research on psychosocial factors. While the model might elucidate why some cultures or societies do not have a problem with a certain drugs and give valuable advice for prevention, it offers only limited advice on how to solve the problems of individual addicts. The model therefore often integrates the learning model, in which the addict is seen as someone who learned maladaptive habits and has developed a certain disposition towards consumption. Decisions about consumption happen between set (internal factors) and setting (external factors). Brower argues that the learning model holds substance users responsible for seeking help but not for becoming addicted.[30] As treatment focuses on learning new ways to deal with external influences, it aims at strengthening self-control. The notion of self-control can therefore also be found in the learning model. Yet, in contrast to the disease concept it allows to choose between controlled use or abstinence. The individual preferences of addicts are therefore probably better acknowledged in this model.[31] A problem of both the social and the learning model is that it could facilitate denial of the addiction as a distinct problem necessitating change. In the social model, the power of external factors might be overestimated, thus reducing motivation to change. A naïve labeling approach might lead to the misinterpretation that there are no real problems in dire need of help. In the learning model, the possibility of a controlled use might lure abstinent addicts to test their ability to control consumption – with ambivalent results ranging from success to disillusionment to full relapse. This risk of denying addiction as a distinct problem is shared by the self-medication-model, where addiction is seen simply as a symptom of another, underlying mental illness, putting an "emphasis on psychopathology as etiology".[32] In this model, drug consumption is purely an individual attempt to cure an underlying psychological problem by using drugs. Treatment therefore focuses on the psychopathology, arguing that once this problem is solved, the addiction will vanish. While it allows to take problems beside the use of drugs into account and help in a holistic sense, the danger of ignoring the addictive effects of drugs and seeing compulsive substance use as distinct problem needing specific treatment is evident.[33] An improvement of the self-medication model to deal with this problem is called the dual diagnosis model. Here mental disorder and addiction are seen as distinct, but reciprocally supporting

---

27 As above.

28 Kirk J Brower et al.: Treatment implications of chemical dependency models: An integrative approach. In: Journal of Substance Abuse Treatment 6 (1989), N. 3, p. 147–157, here p. 152

29 Ambros Uchtenhagen: Suchtkonzepte. Theoretische Modelle zur Erklärung von Abhängigkeit. In: Suchtmedizin ed. von Ambros Uchtenhagen et al.. München 2000 p. 193-195

30 Kirk J Brower et al.: Treatment implications of chemical dependency models: An integrative approach. In: Journal of Substance Abuse Treatment 6 (1989), N. 3, p. 147–157, here p. 150

31 W. Feuerlein et al.: Alkoholismus. Mißbrauch und Abhängigkeit. Stuttgart 1998

32 Kirk J Brower et al.: Treatment implications of chemical dependency models: An integrative approach. In: Journal of Substance Abuse Treatment 6 (1989), N. 3, p. 147–157, here p. 151

33 Lars Lindström: Managing alcoholism. Matching clients to treatment. Oxford 1992, here p. 77

causes. Treatment therefore focuses on both causes at the same time. This concept of addiction integrates the disease and the self-medication model.

Besides the uni- or bimodal concepts listed above there are also integrative models. Most critics of the two main models described above propose that addiction has to be seen as a complex structure with personal, biological, and social issues.[34] In this view, addiction has a multitude of causes and is connected to an individual variety of accompanying problems, necessitating treatment adjustment on a case-by-case basis. This only seems possible by transcending the boundaries of uni- and bimodal understandings. Brower therefore describes integrative models as the combination of basic models to deal with different problems of addicts.[35] Lindström also emphasizes that there "is a great need for a biopsychosocial theory that can describe and explain the interaction between biological and psychosocial processes during the various phases of the addictive cycle".[36] In his analysis of integrative concepts, Lindström distinguishes between individual and sociocultural characteristics and multivariant conceptions.[37] The need to understand addiction in the light of system theory combining biological, social and psychological aspects in an etiological sense as well as using the motivational effects of labeling them causes in treatment gives an apparent advantage.[38] Yet it has been criticized from a scientific perspective that „it doesn't actually have any details. It consists of just three words: 'The Biopsychosocial Model', and nothing more".[39] Vagueness and case-by-case thinking are flexible, but also a hindrance for professional debate and for formulating a consensus about addiction.

3. Finding a Perspective: Disease and Responsibility

3.1. Responsibility

There is a broad philosophical consensus that responsibility should be understood as a relational term, albeit there is a controversy about the number of relations. Lenk and Maring treat responsibility as a scheme with six aspects, Ropohl postulates a seven-digit relationship and Auhagen and Graumann favour a three-digit concept. [40] A well manageable number is from Düwell et al. who describe responsibility in four digits: A subject (1) is responsible for something (2) towards an authority or addressee (3) due to certain normative standards (4).[41] It should be noted that responsibility can additionally be assigned in retrospection (as blame) or in prospection (as a duty). When these aspects of responsibility are not defined in advance this could lead to many conflicts arising from confusion about exactly what kind of responsibility is meant. Addicts can be made

34 Stephen J Morse: Medicine and Morals, Craving and Compulsion. In: Substance Use & Misuse 39 (2004) N. 3, p. 437–460, here p. 457.

35 Kirk J Brower et al.: Treatment implications of chemical dependency models: An integrative approach. In: Journal of Substance Abuse Treatment 6 (1989), N. 3, p. 147–157

36 Lars Lindström: Managing alcoholism. Matching clients to treatment. Oxford 1992, here p. 85

37 B. Kissin: Theory and practice in the treatment of alcoholismus. In: The biology of alcoholism. Treatment and rehabilitation of the chronic alcoholic. (ed. B. Kissin et al.) pp. 1-51. New York 1977; E.M. Pattison et al.: Emerging concepts of alcohol dependence. New York 1977

38 Felix Tretter: Ökologie der Sucht. Das Beziehungsgefüge Mensch-Umwelt-Droge. Göttingen: Hogrefe 1998

39 N. McLaren: The myth of the biopsychosocial model. In: Australian & New Zealand Journal of Psychiatry, 36 (2002) N. 5, p. 701

40 Hans Lenk, et al.: Verantwortung. Normatives Interpretationskonstrukt und empirische Beschreibung. In: Ethische Norm und empirische Hypothese. ed. von Lutz H. Eckensberger, et al., Frankfurt am Main 1993, p. 222–242; Ann Elisabeth Auhagen: Die Realität der Verantwortung. Göttingen (1999); Carl F. Graumann: Verantwortung als soziales Konstrukt. In: Zeitschrift für Sozialpsychologie, 25 (1994), N. 3, p. 184–191.

41 Marcus Düwell, et al.: Handbuch Ethik. Stuttgart 2006

responsible (or exculpated) for various events and actions. Douglas Husak sums up that „blame might be imposed for the act of using addictive drugs. Second, blame might be imposed for the condition of being addicted. Third, blame might be imposed for further risks persons are likely to undertake once they have become addicts“.[42] Richard Bonnie proposes that the „terrain is divided into three parts: responsibility for becoming addicted, responsibility for behaviour symptomatic of addiction, and responsibility for amelioration of addiction“.[43] Brickman et al. made a taxonomy for models of helping and coping based on the distinction „whether or not people are held responsible for causing their problems and whether or not they are held responsible for solving these problems“.[44] The correct attribution of responsibility is additionally linked to certain ethically justifiable criteria of accountability. One prominent criterion is the free will of the agent, another is the agent's rationality – both concepts are often interwoven.[45] Regardless of the broad philosophical discussion on moral responsibility, the criteria and aspects which are used to infer responsibility of addicts are often not clarified. Usually a vague concept of control impairment is referred to. As control impairment is one of the diagnostic criteria of addiction,[46] it seems this would imply a general reduction of responsibility. But “none of the current views conceives of the addicted person to be devoid of all voluntary control and thus absolved of all responsibility for self-control".[47] Even if control impairment would be accepted as sufficient ethical criterion, the inferred responsibility of addicts relies on the situation at hand, the time span covered and the behavior seen as mandating responsibility attribution.

3.2. Disease

As Parsons points out, the label disease allows subjects to take the “sick role”. This role (1) frees from usual duties and normal role performance and (2) exculpates from responsibility for the condition. Yet it demands from the sick person (3) to be motivated to become healthy again and (4) to seek professional treatment and show compliance.[48] Attributing responsibility easily comes in conflict with how suffering from a disease is usually understood. The social premises that allow addicts to take and make the sick role are, in addition to the notion of impaired control, that the onset of the problem was without culpable influence of the addict (again referring to criteria for responsibility) and that there is agreement about a treatment aim, often abstinence. As the sick role is already demanding that addicts are not responsible, it would in this case not be due to their disease that they are absolved. The „crucial reason for attributing responsibility is not - or ought not to be - the insanity or mental illness as such; it is a question of whether the agent fulfils the accountability

42 Douglas N. Husak: The Moral Relevance of Addiction. In: Substance Use & Misuse, 39 (2004), N. 3, p. 399–436, here p. 399

43 Richard J. Bonnie: Responsibility for addiction. In: J Am Acad Psychiatry Law, 30 (2002) N. 3, p. 405–413, here p. 405

44 Philip Brickman et al.: Models of helping and coping. In: American Psychologist, 37 (1982) N. 4, p. 368–384, here p. 369

45 Eduard Dreher: Die Willensfreiheit. Ein zentrales Problem mit vielen Seiten. München 1987; Henrik Walter: Neurophilosophie der Willensfreiheit. Von libertarischen Illusionen zum Konzept natürlicher Autonomie. Paderborn 1999.

46 APA: DSM-IV-TR. Diagnostische Kriterien des Diagnostischen und statistischen Manuals Psychischer Störungen. Göttingen 2003; Horst Dilling, et al.: Taschenführer zur ICD-10-Klassifikation psychischer Störungen. Bern 2006

47 Steven E. Hyman: The Neurobiology of Addiction: Implications for Voluntary Control of Behavior. In: American Journal of Bioethics, 7 (2007) N. 1, p. 8–11., here p. 9

48 S. J. Williams: Parsons revisited: from the sick role to…?. In: Health 9 (2005) N. 2, p. 123–144.

conditions or not".[49] How far the implications of perceiving addiction as disease and its connection with responsibility attributions reach is therefore discussed very controversially.

Hofmann found in the literature over 80 different attempts to define disease.[50] In the shortness of this article we can not possibly discuss all definitions. To limit ourselves, and as the hegemonic biomedical understanding of addiction rests on the idea that disease can be defined from a factual point of view, we are especially discussing this approach. Within this approach, the very influential idea that disease is „the inability to perform all typical physiological functions with at least typical efficiency"[51] has been formulated. This view of disease is bound to a reference class for comparison. This can be a problem, because it has been argued that no such reference class exists.[52] Boorse argued that the reference class is the species design, consisting of the biological functions relevant for individual and species survival. While obviously chronic drug abuse comes with reduced chances for survival, it can be questioned whether consumption already constitutes a functional impairment. Choosing control impairment (as a more adequate example of a function impairment) is also problematic, as "on the one hand, behavioural and neuroimaging studies have revealed impairments in cognitive-control functions in drug addicts, whereas, on the other hand, drug addicts often exhibit considerable long-term planning and self-control in their desire to procure and use drugs".[53] A further argument is that „the concept of disease does not in fact play the crucial role in clinical decision making that many seem to think".[54] Toon argues that the question "what constitutes a disease" should be broken into three essential aspects: „1) How do we decide whether an individual's state is good or bad? 2) If the state is in any way undesirable, how do we decide that it is undesirable in a way that indicates that […] intervention is required? 3) What is the nature of the categories which doctors use to divide up phenomena and which they generally call diseases?".[55] A factual approach could only answer the third question sufficiently and partially the first. Although it might reach consensus more easily, it can - due to problem of the naturalistic fallacy - not justify why and which actions ought to follow from this ascription[56] and might even wrongfully restrict the cases for which help is funded. Ethical questions are thus only postponed, not solved. Because of these shortcomings, output-oriented definitions like pragmatic, normative or subjective concepts of disease that take into account the moral, legal and social claims involved have been proposed. Disease can thus be understood in two ways. In a factual way, necessitating an ethical theory to justify response or in an evaluative way, as being constructed with normative premises in mind and therefore already implying that certain responses are justified.

---

49 L. Nordenfelt: On the relevance and importance of the notion of disease. In: Theoretical medicine, 14 (1993) N. 1, p. 15–26, here p. 24

50 Bjørn Hofmann: Complexity of the Concept of Disease as Shown Through Rival Theoretical Frameworks. In: Theoretical Medicine and Bioethics, 22 (2001) N. 3, p. 211–236.

51 Christopher Boorse: Health as a Theoretical Concept. In: Philosophy of Science, 44 (1977) N. 4, p. 542-573. here p. 542

52 Germund Hesslow: Do we need a concept of disease. In: Theoretical Medicine and Bioethics, 14 (1993) N. 1, p. 1–14.; József Kovács, Kovács: The concept of health and disease. In: Medicine, Health Care and Philosophy, 1 (1998) N. 1, p. 31–39.

53 Gerhard Bühringer, et al.: Why people change? The role of cognitive-control processes in the onset and cessation of substance abuse disorders. In: International Journal of Methods in Psychiatric Research, 17 (2008), N. S1, p. S4-S15

54 Germund Hesslow: Do we need a concept of disease. In: Theoretical Medicine and Bioethics, 14 (1993) N. 1, p. 1–14. here p. 2

55 P. D. Toon: Defining "disease"--classification must be distinguished from evaluation. In: Journal of medical ethics, 7 (1981) N. 4, p. 197–201, here p. 199

56 Eve-Marie Engels: George Edward Moores Argument der naturalistic fallacy in seiner Relevanz für das Verhältnis von philosophischer Ethik und empirischen Wissenschaften. In: Ethische Norm und empirische Hypothese. ed. von Lutz Eckensberger, et al., Frankfurt am Main 1993, p. 92–132.

4. Implications for practice and evaluation

The different explanatory models offered by various authors shape the understanding of addiction, and thereby influence how society, professionals and addicts respond to addiction. How disease and responsibility are understood has a great deal of impact on such responses. However decisions are not solely based on scientific concepts. Economical factors play a growing role and choosing the response might depend primarily on the costs involved. Yet, the complexity of addiction necessitates a variety of different response options. As following financial criteria limits the range of appropriate responses to the heterogeneity of addiction and funding is most easily attained by arguing in the medical model, different response strategies are often reframed according to fit into the model. Yet what is actually carried out refers to different understandings. This gives the medical model an apparent dominant position. To analyze the consequences of the factually effective variety of addiction models, we take a look at three different dimensions of practical work in the context of drug dependency:

1. the professional care system
2. the social and political perspective
3. the self-understanding of addicts

4.1. The Professional Care System

There are several treatment approaches for addiction, ranging from pharmacotherapy, cognitive-behavioural therapy, psychoanalysis and spiritual conversion to sociotherapy or supervised accommodation. The numerous forms of addiction and the different substances in use make good professional care complex and demanding. Yet, nearly all models used in professional care would refer to the low-onset-responsibility-axis (compare figure 1) to ensure that the intervention is being funded. However different treatment options imply different assumptions on the nature of addiction - its causes, courses and outcomes. In many biomedical settings addicts are defined as suffering from reduced control ability. On the other hand many psychosocial settings are based on the assumption of autonomy and the possibility to willingly change behaviour and attitudes when helped to do so. In practice the models of addiction used in professional care lead to coexisting treatment options for addicts. A multitude of treatment options is seen as a “diversification of treatment“ and perceived as an adequate way of coping with the heterogeneous group of drug addicts and the substances they use. Furthermore, “Case Management” is regarded as a key concept in treatment of addicts. Certainly one advantages of a plural care system is that it might adequately adjust to the heterogeneous variety of addicts. But this also means that all possible interventions are competing in terms of funding of treatment and research, social acceptance and customer’s demand. The allocation of research funding and sponsorship raises further ethical problems, touching concepts of justice and fair distribution of resources as well as professional integrity. In treatment research questions concerning informed consent of drug dependent research participants are also an important ethical issue which is influenced by the preferred understanding of addiction. The preferred model also has an impact on the treatment objectives and shapes the professional-addict-relationship. It influences attribution of responsibility and capabilities of addicts. Thus it affects the ascribed ability to give informed consent to any form of intervention as well as the scope for coercion and compulsive treatment. Different understandings are often combined in a pragmatic way depending on what seems to be the most appropriate and useful approach to professionals and

addicts in a specific context. This results in a rather untransparent decision about treatment options and objectives. This might lead to confusion or even to treatment rejections for some addicts, because they are not able to play the different roles expected in different treatment settings by different professionals.

4.2. Social and Political Perspective

In contrast to the perspective on professional intervention socio-political discussions are focused on assumptions about drugs and drug actions rather than on the afflicted people. In consequence many political discussions are centred on questions about the legal status of various drugs, effective ways of prohibition and deviant behaviour. Political arguments are centred on conflicts between the interests of individuals and society. According to Rust, in addiction policy individual rights of autonomy, risk-taking and respect of individually chosen life-styles are opposed by interests of public health, child-welfare, social costs and prevention of crime.[57] This allows to limit civil liberty framed by certain understandings of addiction. While policies regarding legal drugs are usually based on compensatory or medical models, regulating illegal drugs and their resulting problems is usually seen as a primarily political tasks following the ”enlightenment” type (compare figure 1).[58] In democratic societies responsibility for the problems of drug consumption is seen as a reciprocal concept or „as an equal exchange of interests between individuals“ in order to form a community of interests.[59] Thus regulation develops into a concept of shared responsibility and extends the responsibility for legal and illegal drugs. Consumers as well as society and caregivers take up a certain degree of responsibility for problems as well as for their solutions. Under the principle of reciprocity or referring to Rawls „principle of fairness“ this could be defined as an act of solidarity by helping addicts to help themselves,[60] best described by a reflective equilibrium of autonomy, beneficence and care.[61] Such a reflective equilibrium of autonomy and responsibilities for addicts and societies can be integrated best within the scope of a combined concept of addiction, taking up both models - the medical model as well as the moral understanding of addiction in an integrative way. According to Cochrane a medical perspective defines the problem on a physiological and psychological level.[62] The moral model on the other hand offers information on how we interact with each other and how we evaluate drugs and drug consumption in time and place. Furthermore it facilitates disclosure and reflection of the moral values buried in political and social debates on addiction. In some ways both models refer to different perspectives of analysis which are both equally needed in the addiction debate. An ethical reflection on normative concepts of addiction and medical understandings hopefully increases the quality of professional treatment and political interventions in the future.

4.3. Responses and Self-Understanding of Addicts: Rights and Duties of Addicts?

---

57 Alois Rust: Ethische Aspekte. In: Suchtmedizin. München, ed. von Ambros Uchtenhagen, et al., München 2000 p.573-583

58 Some legal drugs are even socially accepted and regulated. Due to taxing this can lead to substantial financial income for many western countries.

59 F.J. Illhard et al.: Medizinische Ethik, Berlin 1985.

60 John Rawls: Eine Theorie der Gerechtigkeit, Frankfurt a.M. 1990.

61 According to Geisler within such a reflective equilibrium autonomy could be defined as a concept which relates to a social context by an interplay of demands and interests of all stakeholders involved. Confer to: Linus Geisler: Der Krebskranke zwischen Autonomie und Fürsorge, Vortrag vom 29.10.2005. Medizinische Wochen Baden-Baden. http://www.linus-geisler.de/vortraege/0510mw_autonomie.html

62 Thomas I. Cochrane: Brain Disease or Moral Condition? Wrong Question. In: American Journal of Bioethics, 7 (2007), N. 1, p. 24–25

Caregivers often perceive addicts as difficult patients or clients. This distinguishes them from other sick people who are expected to be thankful and cooperative in terms of general treatment and social support. Scientifically analysing the self-understanding of addicts, different methods and criteria are used. Studies on the self-understanding of addicts either refer to narrative stories, or to a paradigmatic thinking as a method of psychological research.[63] Furthermore studies can vary in descriptions of addicts in the process of dependency and addicts who matured out of addiction – either by themselves or by accepting help of any kind. Addicts seem to intentionally organise their life around drugs and their addiction. Yet, rationality, free will and responsibility might be compromised at times of drug seeking and drug taking.[64] In other times addicts might feel "normal" and "capable" of most daily life routines and taking responsibility in form of guilt and blame. This might lead to the perception of a diachronous responsibility, in which addicts are excused and excuse themselves for the proximate effects of drugs and drug seeking, but not for the "failure" to quit in the long run. In narrative stories addicts describe their feelings on grounds of their own social context and values: "While under the control of an addiction, an addict operates in a manner that is totally self-serving. […] And guilt can only send you in one direction, back to your addiction".[65] But moral maturation can also be a factor enhancing abstinence.[66] This implies that whether taking responsibility for future plans and personal values is beneficial highly depends on the circumstances.[67] According to O'Connor et al. feelings of shame, guilt and depressions in addicts are related to their sex, personality and social background. In addition own feelings of shame and guilt might also depend on the status of the drug. Hidden consumption of drugs might relate to more intense feelings of failure and guilt. It is plausible that in addition to these factors addicts understanding of addiction influences how they see their capabilities and thus has an impact on their consumption. After relapse, addicts might favour concepts that exculpate[68] while relapses of other addicts are evaluated more strictly than one´s own relapses.[69] If consumption is currently under apparent control, those exculpating understandings might be rejected in favour of those arguing that control exists and enhancing self-worth. This biased attribution might facilitate the progress of addiction, stabilise consumption in the face of problems and prevent maturing out. Flexibility to approach addicts in their current mode of understanding and guiding them towards a beneficial understanding or demanding consistency to prevent shifting could be a useful tool in addiction care. This would also be open to consumers reflecting about their own situations and might explain how maturing out without professional aid works.

5. Final Remarks

There is not yet a single understanding that could explain the full complexity of addiction. What should be observed when it comes to discussing understandings of addiction is that each of them

---

63 Vilma Hanninen et al.: Narratives of recovery from addictive behaviours. In: Addiction 94 (1999) 12, p. 1837-1848

64 Stephen J. Morse: Medicine and Morals, Craving and Compulsion. In: Substance Use & Misuse, 39 (2004) N. 3, p. 437–460.

65 John Glynn: Understanding an Addict - Part I. http://thetaximantalks.blogspot.com/2007/06/understanding-addict-part-i.html

66 Ernst Kern: Entwicklung als Ziel von Psychotherapie. Ein salutogenetisches Modell über Veränderungen im innermoralischen Selbstbezug von Suchtkranken im Verlauf einer stationären Entwöhnungstherapie. Hamburg 1999

67 Lynn E. O'Connor, et al.: Shame, guilt, and depression in men and women in recovery from addiction. In Journal of Substance Abuse Treatment, 11 (1994) N. 6., p. 503-510

68 Stephan Rinckens: "Eine Ausrede findet sich immer!". Die subjektive Rückfallbegründung alkoholabhängiger Patienten. Bonn 2003

69 Hyranthi Seneviratne, et al.: An Investigation of Alcohol Dependent Respondents' Attributions for Their Own and Others Relapses. In: Addiction Research & Theory, 8 (2000), N. 5, p. 439–453.

offers unique options and restricts others. Shifting between understandings can be a useful tool, but can also have negative effects on different levels. In the societal, political, individual und professional level competing interests for funding and short-term interests come in conflict with the aims achievable only by flexible accounting to the complexity of addiction. Depending on the understandings preferred and how flexible they are handled, justification strategies have to be developed that ensure that in the long-term efficient care, social legitimacy and maturing out are not severely hindered.

Literaturverzeichnis

Ainslie, George: Breakdown of will. Cambridge, New York 2001.

APA: DSM-IV-TR. Diagnostische Kriterien des Diagnostischen und statistischen Manuals Psychischer Störungen Göttingen 2003

Auhagen, Ann Elisabeth. Die Realität der Verantwortung. Göttingen 1999

Bonnie, Richard J.: Responsibility for addiction. In: J Am Acad Psychiatry Law, 30 (2002), N. 3, p. 405–413.

Boorse, Christopher: Health as a Theoretical Concept. In: Philosophy of Science, 44 (1977) N. 4, p. 542-573.

Brickman, Philip; Rabinowitz, Vita Carulli; Karuza, Jurgis; Coates, Dan; Cohn, Ellen; Kidder, Louise: Models of helping and coping. In: American Psychologist, 37 (1982) N. 4, p. 368–384.

Brower, Kirk J.; Blow, Frederic C.; Beresford, Thomas P.: Treatment implications of chemical dependency models: An integrative approach. In: Journal of Substance Abuse Treatment, 6 (1989) N. 3, p. 147–157.

Bühringer, Gerhard; Wittchen, Hans-Ulrich; Gottlebe, Katrin; Kufeld, Claudia; Goschke, Thomas: Why people change? The role of cognitive-control processes in the onset and cessation of substance abuse disorders. In: International Journal of Methods in Psychiatric Research, 17 (2008) N. S1, p. S4-S15.

Davies, John Booth: The myth of addiction. 2. ed. New York 2006

Dilling, Horst: Taschenführer zur ICD-10-Klassifikation psychischer Störungen. Mit Glossar und Diagnostischen Kriterien ICD-10: DCR-10. 3., vollst. überarb. und erw. Aufl. unter Berücksichtigung der German Modification (GM) der ICD-10. Bern 2006

Dreher, Eduard: Die Willensfreiheit. Ein zentrales Problem mit vielen Seiten. München 1987

Düwell, Marcus; Hübenthal, Christoph; Werner, Micha H.: Handbuch Ethik. 2. Aufl. Stuttgart 2006

Engels, Eve-Marie: George Edward Moores Argument der naturalistic fallacy in seiner Relevanz für das Verhältnis von philosophischer Ethik und empirischen Wissenschaften. In: Ethische Norm und empirische Hypothese. Ed.. von Eckensberger, Lutz H.; Gähde, Ulrich Frankfurt am Main 1993, p. 92–132.

Feuerlein, W.; Küfner, Heinrich; Soyka, Michael: Alkoholismus. Mißbrauch und Abhängigkeit. 5. Aufl. Stuttgart 1998

Foddy, Bennett; Savulescu, Julian: Addiction Is Not An Affliction: Addictive Desires Are Merely Pleasure-Oriented Desires. In: American Journal of Bioethics, 7 (2007) N. 1, p. 29–32.

Geisler, Linus: Der Krebskranke zwischen Autonomie und Fürsorge, Vortrag vom 29.10.2005. Medizinische Wochen Baden-Baden, http://www.linus-geisler.de/vortraege/0510mw_autonomie.html last checked on 30.06.2009

Glynn, John: Understanding an Addict - Part I. http://thetaximantalks.blogspot.com/2007/06/understanding-addict-part-i.html last checked on 30.06.2009

Graumann, Carl F.: Verantwortung als soziales Konstrukt. In: Zeitschrift für Sozialpsychologie, 25 (1994) N. 3, p. 184–191.

Hanninen, Vilma., Koski-Jannes, Anna: Narratives of recovery from addictive behaviours. In: Addiction 94 (1999) 12, p. 1837-1848

Herwig-Lempp, Johannes: Von der Sucht zur Selbstbestimmung. Drogenkonsumenten als Subjekte. Dortmund 1994

Hesslow, Germund: Do we need a concept of disease. In: Theoretical Medicine and Bioethics, 14 (1993) N. 1, p. 1–14.

Hofmann, Bjørn: Complexity of the Concept of Disease as Shown Through Rival Theoretical Frameworks. In: Theoretical Medicine and Bioethics, 22 (2001) N. 3, p. 211–236.

Hosser, Daniela; Windzio, Michael; Greve, Werner: Scham, Schuldgefühle und Delinquenz. In: Zeitschrift für Sozialpsychologie, 36 (2005) N. 4, p. 227–238.

Husak, Douglas N.: The Moral Relevance of Addiction. In: Substance Use & Misuse, 39 (2004) N. 3, p. 399–436.

Hyman, Steven E.: The Neurobiology of Addiction: Implications for Voluntary Control of Behavior. In: American Journal of Bioethics, 7 (2007) N. 1, p. 8–11.

Illhard, Franz J.; Koch, H.-G.: Medizinische Ethik. Ein Arbeitsbuch. Berlin 1985.

Kalant, Harold: Culture-bound concepts of addiction - still a potent influence. In: Addiction, 103 (2008) N. 12, p. 1948–1949.

Kern, Ernst: Entwicklung als Ziel von Psychotherapie. Ein salutogenetisches Modell über Veränderungen im innermoralischen Selbstbezug von Suchtkranken im Verlauf einer stationären Entwöhnungstherapie. Hamburg 1999

Kissin, Benjamin: Theory and practice in the treatment of alcoholismus. In: The biology of alcoholism, Vol. 5 (1977): Treatment and rehabilitation of the chronic alcoholic. (ed. B. Kissin and H. Begleiter) pp. 1-51. Plenum Press, New York

Kovács, József: The concept of health and disease. In: Medicine, Health Care and Philosophy, 1 (1998) N. 1, p. 31–39.

Lenk, Hans; Maring, Matthias: Verantwortung. Normatives Interpretationskonstrukt und empirische Beschreibung. In: Ethische Norm und empirische Hypothese. Ed.. von Eckensberger, Lutz H.; Gähde, Ulrich Frankfurt am Main 1993, p. 222–242.

Leshner, A. I.: Addiction is a brain disease, and it matters. In: Science, 278 (1997) N. 5335, p. 45–47.

Lindström, Lars: Managing alcoholism. Matching clients to treatment. Oxford 1992

McLaren, N.: The myth of the biopsychosocial model. In: Australian & New Zealand Journal of Psychiatry, 36 (2002):N. 5, p. 701-701.

Morse, Stephen J.: Medicine and Morals, Craving and Compulsion. In: Substance Use & Misuse, 39 (2004) N. 3, p. 437–460.

Morse, Stephen J.: Voluntary Control of Behavior and Responsibility. In: American Journal of Bioethics, 7 (2007) N. 1, p. 12–13.

Nordenfelt, L.: On the relevance and importance of the notion of disease. In: Theoretical medicine, 14 (1993) N. 1, p. 15–26.

O'Connor, Lynn E.; Berry, Jack W.; Inaba, Darryl; Weiss, Joseph and Morrison, Andrea: Shame, guilt, and depression in men and women in recovery from addiction. In Journal of Substance Abuse Treatment, 11 (1994) N. 6., p. 503-510

Palm, Jessica: The nature of and responsibility for alcohol and drug problems: views among treatment staff. In: Addiction Research & Theory, 12 (2004) N. 5, p. 413–431.

Pattison, E.Mansell/Sobell, Marc B./Sobell, Linda C.: Emerging concepts of alcohol dependence. New York 1977

Peele, Stanton: The Meaning of Addiction. Compulsive Experience and Its Interpretation. Lexington 1985 Stephan

Rawls, John: Eine Theorie der Gerechtigkeit, Frankfurt a.M. 1990.

Rinckens, Stephan: "Eine Ausrede findet sich immer!". Die subjektive Rückfallbegründung alkoholabhängiger Patienten. Bonn 2003

Rust, Alois: Ethische Aspekte. In: Suchtmedizin. Konzepte, Strategien und therapeutisches Management. Ed.. von Uchtenhagen, Ambros & Zieglgänsberger, Walter; München 2000, p.573-583

Schaler, Jeffrey A. (2000): Addiction is a choice. Chicago Ill.: Open Court.

Seneviratne, Hyranthi; Saunders, Bill: An Investigation of Alcohol Dependent Respondents' Attributions for Their Own and Others Relapses. In: Addiction Research & Theory, 8 (2000) N. 5, p. 439–453.

Toon, P. D. (1981): Defining "disease"--classification must be distinguished from evaluation. In: Journal of medical ethics, Jg. 7, N. 4, p. 197–201.

Tretter, Felix: Ökologie der Sucht. Das Beziehungsgefüge Mensch-Umwelt-Droge. Göttingen 1998

Tretter, Felix: Suchtmedizin. Stuttgart 2000

Uchtenhagen, Ambros: Suchtkonzepte. Theoretische Modelle zur Erklärung von Abhängigkeit. In: Suchtmedizin. Konzepte, Strategien und therapeutisches Management. Ed.. von Uchtenhagen, Ambros & Zieglgänsberger, Walter; München 2000, p. 193-195

Walter, Henrik: Neurophilosophie der Willensfreiheit. Vom libertarischen Illusionen zum Konzept natürlicher Autonomie. Paderborn 1999

Williams, S. J.: Parsons revisited: from the sick role to…?. In: Health 9 (2005) N. 2, p. 123–144.