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Analysis of Individual Attitudes Toward Addiction

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Abstract: Some researchers believe that addiction is a purposeful and expectant voluntary choice made by addicts after they are aware of the consequences of their behavior; on the other hand, some proponents believe that addiction is a compulsive mental illness and that addicts have almost no control over their behaviors, so people should change their attitudes towards addicts by understanding and reporting their behavior instead of demanding that they stop. In this study, two primary concerns will be addressed in order to assess the viability of this proposal: Is addiction indeed irresistible? What would happen if addiction was in fact viewed as a mental illness? After discussing various aspects of whether addiction is a compulsion or a choice, it was concluded that addicts can control their behavior even if the addictive substances are seductive and have an effect on the structure and function of the addict's brain. In addition, the negative consequences of treating addiction as a mental illness and minimizing its control, the harm to one's health, and the threat to the safety of those around one are also some reasons why this proposal is not justified.

Keywords: addiction, alcohol abuse, drug abuse, addiction as disease, addiction as chosen

1. Introduction

In contemporary society, as various social issues are brought to the surface for discussion and more cultures and ideas are accepted, people are becoming more open-minded and tolerant of many things that were considered unforgivable a long time ago. Undeniably, it has brought about many positive effects. For example, the social status and importance of women is gradually recognized and valued by society, allowing them to have their own careers and do whatever they want to do instead of being confined to their homes as they used to be; the LGBTQ2+ population are also more easily accepted, as they can be the gender they want to be or be with their loved ones without being discriminated against by society or even harmed by the law. However, there are always two sides to the coin: Higher acceptance and social tolerance may also lead to the indulgence and promotion of certain violent and criminal behaviors. For example, a topic that has been discussed in recent years: de-stigmatization of addiction [1]. Proponents of this theory argue that addiction is a disease and addictive behaviors are uncontrollable. It needs to be cured gradually by care from doctors and people around them,and that addicts cannot be forced to stop such behaviors [1]. Admittedly, it makes sense in some cases, but people also need to consider if addiction was actually defined in this way, would some addicts use the excuse like "their behavior is controlled by the disease so they need time to heal" to justify their irresistible behavior?

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A study has shown that children from families with a history of alcohol or drug abuse are more likely to experience physical, emotional and sexual abuse [2]. According to the Alle-Kiski Center of Hope, men who are frequent abusers always blame their behavior on alcoholism [3]. This means if addiction is universally recognized as an incurable illness, many abusers would attribute their violent and even delinquent behaviour on alcohol and drugs and then argue that their behaviours are caused by the sickness rather than their own willpower. Therefore, the goal of this paper is to focus on substance addictions in terms of their formation, symptoms, and society's differing perceptions of them to clarify that they are not a compulsive behavior caused by a disease, but almost a personal choice.

2. Substance Addiction

Normally, substance addiction could be defined as a person's relinquishing control over the intake of some substances in order to obtain a brief sense of well-being and pleasure, leading to repetitive behaviors and increased use, associated with desire, craving, and loss of control [4]. Despite the fact that addicts are well aware of the corresponding consequences, they continue to act compulsively, creating a vicious reward system loop [5].

2.1. Psychological Cause of Addiction

Addictive behaviors are complex behaviors, not just physical; they are also considered to be adjunctive behaviors, or subordinate behaviors catalyzed by deeper, more significant psychological and biological stimuli [4]. Factors such as life circumstances, pharmacological mechanisms, or personal control can influence the development of addiction.

Some substances, on the other hand, are believed to promote addiction in and of themselves. Recently, some scientists have identified many common classes of addictive substances, such as alcohol, caffeine, marijuana, opioids, tranquilizers, cocaine, tobacco, and even antidepressants [5].

Brain responses brought about by the living environment and the effects of addictive substances are considered to be one of the major contributors to substance addiction [1]. It is generally accepted that prolonged exposure to high stress, poor living conditions, and similar situations have a high potential to negatively affect an individual's health and vitality, which are the power source that drives all behaviors of most mammals [4]. And the use of many addictive substances will give the user the illusion of increased health and vitality [4]. Alcohol, for example, is thought to reduce anxiety and make negative emotions forgetful. Nicotine is thought to help people relieve stress; most smokers say their minds are clearer after smoking. Analgesics can relieve people's physical pain, and make people mistakenly think that the pain has disappeared and they have become healthy, so they have the motivation to perform other activities. Most of the drugs, as psychoactive substances, can make people extremely excited in a short period of time, presenting an appearance of vitality. The ability of these substances to make people feel relief from stress, the disappearance of pain and negative emotions, or mental exuberance is always the driving factor for addicts to repeatedly overuse them and then leads to addiction [4].

2.2. Diagnosis of Addiction

Substance addiction could generally be diagnosed by the evaluation of a clinical psychologist and psychiatrist. The Diagnostic and Statistical Manual of Mental Disorders lists 11 diagnostic criteria that are widely used today, including: 1. taking larger amounts or longer periods of time of addictive substances than expected or prescribed; 2. having reduced or unsuccessful control over persistent cravings to use a substance; 3. spending a great deal of time and money on acquiring and using addictive substances; 4. having strong desires or impulses to use a substance; 5. repeatedly using the

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substance causes the individual to fail to fulfill the obligations of his or her role at school, home, or work; 6. continuing to use the substance when it is known to cause or aggravate precipitating or persistent social or interpersonal problems; 7. reducing, or even abandoning, most social, occupational, or recreational activities as a result of substance use 8. repeatedly using the substance when it is physically dangerous or already unhealthy. 9. not discontinuing the use of the substance when it is known that the substance may cause or aggravate relapsing or persistent physical and psychological conditions; 10. developing tolerance to these substances: 1) significant decrease in effect after using the same dose of the substance; 2) needing incremental doses of the substance to achieve the same or performance as previously or expected; 11. Developing a withdrawal reaction when stopping the use of the substance: 1) displaying a characteristic substance withdrawal syndrome; 2) continuing to take the substances in order to alleviate and avoid withdrawal symptoms [6].

Additionally, substance addiction can be categorized into three classes based on an individual's substance use in the past 12 months compared to the diagnostic criteria. Mild substance addicts will present with two to three symptom determinations, moderate substance addicts will present with four to five symptom determinations, and severe addicts will meet six or more of these symptoms [5].

3. Current Controversies

When addiction is being talked by society, the views could be broadly divided into two groups: one group sees addiction as a choice, a voluntary choice made by the addict with clear knowledge of the consequences of the behavior [7], and therefore there should be no laxity in the control of addicts. The other group of people sees addiction as a disease characterized by compulsive and relapsing substance use, where the addict has little control over his or her own behavior, even though at the outset it involves voluntary, chosen substance use [7].

3.1. Coercion and Addiction

First, proponents of the perspective that addiction is compulsive argue that addiction is a chronic relapsing disease, thus, it must be treated like any other such disease. They state that if people do not consider the hearts of heart failure patients to behave normally because their functioning has been altered by the disease, then they should not consider the brains of substance addicts to behave normally, because the brain functioning of addicts is also altered by the addictive substance [1]. Additionally, they also stated that when it was understood how genetic polymorphisms made cancers resistant to treatment, people could quickly sympathize with patients suffering from this condition, so why cannot society show the same understanding and compassion for those who are unable to quit smoking, drinking, or injecting narcotics due to genetic polymorphisms [1]?

Secondly, proponents of this view also believe that there are specific factors that can lead to addiction, such as opium, nicotine or alcohol, or even behaviors such as gambling [8]. And the reason they might be addictive is that they tend to involve simple and stereotypical actions that can bring the same, or more, rewards in the following ways [8]. Firstly, all of these addictive substances are thought to have a role in convincing the striatal dopaminergic system [8]. Making people believe that the opportunity to effectively obtain a large number of rewards is at hand, and they should focus on these opportunities and their associated cues [8]. And then stimulating the brain's regulatory systems to work in preparation for harvesting these rewards, triggers cravings, desires, and undivided attention; its signal is the phasic dopamine concentration in the nucleus accumbens [8]. Therefore, it is not that addicts want to use these addictive substances, but rather these addictive substances persuade certain systems in their brain and trigger their attention and desire for the addictive substance [8]. Their behavior is entirely due to being controlled by the dopamine mechanism [8].

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Furthermore, proponents of the view believe that the use of addictive substances also impairs the functioning of the cognitive region of the brain (prefrontal cortex), which directly contributes to difficulties in decision-making and judging the consequences of behavior, which means that addicts are likely to be unable to discern the consequences of their behavior, and instead see only the rewards of their behavior, and thus indulge in their usage in addictive substances [1,8]. Over time, continued substance use would lead to permanent anatomical and chemical changes in the brain [1].

3.2. Choice and Addiction

Dr. Gene M. Heyman states in his book *Addiction: A Disorder of Choice* that it is incorrect to think of addiction as an illness and a compulsive behaviour that is uncontrollable [9]. Heyman shows that, like all choices, addiction is influenced by preferences and goals [9].

3.2.1. Addictions and Mental Disorders

There is a view that addictive behavior is the result of the addict's personal decision-making process and can be influenced by their willpower, but this does not exclude the current medical diagnosis of addiction as a mental disorder [7]. However, mental disorders could be influenced by psychotherapy, which means that the expected outcome of psychotherapy is to empower victims of mental disorders to have the ability to voluntarily influence their symptoms [7]. Alternatively, if addiction is a mental disorder, addictive behavior can be managed by psychotherapy, and psychotherapy involves the individual addict's willpower and voluntariness, then people do not have a very strong and obvious reason to view addictive symptoms as an involuntary decision-making outcome.

3.2.2. Cause and Effect of Addiction

Some proponents of addictive-compulsive theories believe that the altered physiological state that accompanies the symptoms of addiction is the primary cause of addicts' actions, and that the addict's thoughts are merely the result of passive [10]. This may be due to a common misconception: when thoughts, actions, and physiological changes occur simultaneously, the physiological change is the thing that happens first, thus influencing people's thoughts and motivating them to take action [10]. So as mentioned earlier, they believe that addicts' excessive preoccupation with addictive substances may be caused by the systems in their brain being affected. However, those proponents ignore the theoretical fact that thoughts, desires, values, and other mental phenomena can also reside in bodily functions and physiological changes [10]. For example, assume that a man has a pretty nice brother, but one day his brother died to save him. In this case, he could be said to have suffered unbearable sadness, pain, and even guilt; he cries about it a lot and tries to avoid those negative emotions by drinking. At the same time, this man's body changes in response to his emotions and behavior. It is obvious that if he lets himself indulge in these negative emotions, he will become dehydrated, trigger hypoglycemia and stomach problems and his intracerebral systems will change as a result of drinking [10]. Hereby it would be misleading to say that the changes in his body make him feel sadness, pain, and guilt and engage in the behaviors of crying and drinking. Likewise, it would be patently illogical to assume that addicts think and act on the idea of drinking, smoking, or taking drugs because of shifting levels of dopamine production in the nucleus accumbens.

3.2.3. Addictions and Compulsions

Some scholars have attempted to classify addiction as a form of obsessive-compulsive disorder (OCD), because it exhibits numbers of similar characteristics to OCD, and define the symptoms of

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addiction as a form of involuntary behavior [7]. However, whether or not this viewpoint is accurate depends on how compulsive behaviour is defined.

Proponents of this view generally believe that coercion results in the loss of free choice and tend to conceptualize such coercion as interpersonal coercion-related, i.e., a person being compelled by another to act against his or her will, more like a coercive act involving an element of compulsion [7]. In interpersonal relationships, the coercive factor is another person, an irresistible desire [7]. However, is this idea in line with the features of obsessive behaviour that are utilized as diagnostic indicators in clinical practice? And is it true that compulsive behavior in clinical practice results from an irresistible desire?

The irresistible desire could be defined as if a person is unable to resist the desire to take that action at that moment in time, this desire is irresistible to this person at this moment [7]. There are different interpretations of what implies "unable", which generally fall into two broad categories. The first group advocates desire-centered explanations, which attempt to explain the powerlessness of people with OCD by the abnormal intensity of the desires that lead to compulsive behavior [7]. They think that it is because these desires are so strong that there are no other goals that could really counteract and divert patients' attention. The second category is the control-centered proposition, which attempts to explain that this sense of powerlessness develops as a result of a loss of the individual's normal rational self-control [7]. In summary, desire-centered explanations explain compulsions as desires and overwhelming forces oriented toward addictive substances like drugs, while control-centered explanations explain them as a breakdown of typical self-control. However, are they able to properly explain the obsessive behaviours linked to clinical OCD patients?

Desire-centered explanations fall into two kinds of versions: non-normative and normative versions. The non-normative version of the explanation states that, the incapacity of the OCD patient to control cravings owing to his or her abnormal physical strength is perceived as the patient's powerlessness, resulting in physical actions when the sufferer is forced to directly carry out the compulsive behavior; the sufferer did not choose or decide to make these actions [7]. Situations that could be analogous to this view might be a police officer subduing a thief, a robber grabbing the master's hand to open a safe, or a terrorist holding a hostage captive; people with OCD are physically unable to restrain their compulsive behavior in a similar way. Thus, compulsive behavior is involuntary and unintentional [7]. However, this explanation conflicts with the obsessive behaviour expressed in clinical cases. In clinical situations, compulsive behaviours appear to be the result of deliberate active decisions made to momentarily lessen the discomfort or anxiety caused by the compulsion [7]. In substance addiction, addicts use drugs, alcohol, or cigarettes also to temporarily reduce their own pain. In typical cases of OCD, patients clearly demonstrate that they are intentionally engaging in compulsive behaviors and believe that failure to do so will result in catastrophic consequences [7,11]. Those clearly demonstrate the presence of purpose, planning and personal control in OCD behavior.

Under the normative version of the explanation, the powerlessness of the person subjected to coercion is due to the fact that the desire forces this person to choose to perform the coercive behavior [7]. It asserts that coercion causes a person to make concessions by threatening or causing excessive psychological or bodily pain, like kidnappers who threatens their victims' family through grievous bodily harm or psychological pressure to ask for money [7]. However, this explanation is also not consistent with the clinical symptoms of OCD. Because although it is clear that OCD sufferers experience distress in their attempts to restrain compulsive behaviors, there is minimal proof that these distresses might escalate to the point of unbearable psychological or bodily suffering [7]. Desire-centered hypotheses therefore failed to adequately account for the typical OCD behaviours detailed in the clinical documents.

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Self-control-focused explanations for the powerlessness of people with OCD are due to the loss of conventional self-control [7]. This view suggests that the loss of self-control is likely to be due to a lack of sensitivity to countervailing reasons, which means that in these people's perception, some sort of counterfactual is correct, so they would not resist and exercise self-control over these desires that appear to be seductive to the casual observer [7]. However, the success of one form of treatment for obsessive-compulsive disorder, response prevention therapy, demonstrates that this explanation is not successful in describing obsessive-compulsive behavior in the clinical setting [7]. It will be exceedingly challenging for a person with OCD to lessen the urge to participate in obsessive behaviour, regardless of the amount of effort that is put forward, assuming that compulsive behaviour entails a full loss of normal self-control. Therefore, people with OCD should be retaining their basic self-control.

In conclusion, the compulsive behaviors believed by the proponents of the view that addictive behaviors are a form of obsessive-compulsive disorder (OCD) cannot actually link to the compulsive behaviors described in clinical literature because they are not caused by irresistible desires [7]. Obsessive-compulsive behaviors resulting from OCD can in many cases involve voluntary, intentional, and decision-making that can be controlled by the person with OCD [7]. Therefore, if those people consider addiction to be a kind of OCD, then it is not brought on by compulsive cravings.

3.2.4. Addiction and Pleasure Acquisition

In the middle of the 20th century, the idea that addiction is a compulsive neurological condition first gained traction, partly in response to prior moral models that believed addiction as a sin or evil. [12]. This view rejects the part of the moral model that views addiction as a choice and refuses to condemn the possibility that addicts will choose to use drugs once they become addicted because they believe that addicts do not have any choice [12]. So they believe that moral condemnation should not be directed at the addict, but at the addictive substance and the pleasure derived from it [12].

Many times, proponents of illness models highlight that addicts continue to take drugs even after they are no longer enjoyable [12]. However, studies that have been conducted in the past do not seem to support this view [12]. In a retrospective clinical examination of 40 inpatients receiving treatment for cocaine dependency, it was discovered that 100% of them claimed to still experience continuous bliss, and only 27.5% reported that the acquisition was slightly diminished but still present [13]. In summary, the existence of an addiction still allows addicts to derive pleasure from those substances, and current scientific evidence could not prove that addiction removes those pleasures properly. So why are advocates of addiction as a compulsive neurobiological disorder so eager to emphasize that addiction could eradicate the pleasures that addictive substances provide?

The response may be that since addicts experience pleasure from taking addictive substances, it is reasonable to assume that they do it for pleasure. This would refute the idea that their use is compulsive because it appears to be goal-driven [12]. Another possibility is based on another element of the moral model that addicts may be morally condemned even if they are not using for pleasure and gaining pleasure is just a fact [12]. Therefore, in order to avoid moral condemnation, proponents of the disease perspective emphasize that addicts do not derive pleasure from drugs. However, even though eradicating the stigma associated with addiction is critical to those addicted who are forced into exposure to the substance, eradication is unlikely to be lasting if it is achieved through unreasonable and even false claims.

As hard as it is to imagine, for many users, both addicted and non-addicted, addictive drugs are a reliable source of pleasure [12]. For example, opioids could provide short-term pain relief; amphetamines could increase energy and cognitive ability for a period of time, and MDMA could help enhance social connections [12]. As mentioned above, these substances are of great value to people because they can help people gain vitality which is an important driver to achieve many

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valuable goals. Thus, addiction is goal-directed behavior: people choose to take those substances, and their intended worth is why people consume them [12].

As mentioned earlier, there is no sufficient scientific evidence to support the assertion that "once the addictive transition occurs, the drug no longer provides any pleasure." And it also proves that the addict's access to the addictive substance is purposeful and anticipatory, rather than a pathological compulsion.

4. Possible Consequences of Viewing Addiction as a Mental Illness

Imagine what would happen if society showed the same understanding and compassion for those who are "forced" to refuse to quit smoking, alcohol or drugs as it does for patients with other mental illnesses [1]. A reasonable guess is that family and friends of addicts may be reluctant to control their use because of compassion. And some people who have violent and hurtful behaviors due to excessive use of addictive substances are also likely to use the mental illness of addiction as an excuse to reduce the punishment they are about to receive.

4.1. Addictive Substances and Physical Health

It is well known that excessive and uncontrolled use of any substance, no matter what it is, would cause a range of effects on the body, and most of them are negative, especially addictive substances. Although they could always provide momentary pleasure and vigor, if used uncontrolled, it might cause a host of serious side effects and complications [4,12]. The article will use alcohol, medicine, and drugs as examples.

Firstly, according to research, alcohol is linked to more than 60 different diseases, accounts for 4% of the global burden of disease, and one of the leading causes of death and disability worldwide [14]. Alcohol's effect on liver function is one of them: chronic alcohol abuse might lead to alcoholic liver disease (ALD), including fatty liver, steatohepatitis, hepatic fibrosis and cirrhosis, and even progression to hepatocellular carcinoma [15]. Among them, severe acute alcoholic hepatitis (AH) has a mortality rate of up to 50% [16]. In addition, alcohol abuse also causes lung disease: ARDS is a severe form of lung injury accompanied by physiologic changes including severe hypoxemia, increased lung dead space, and decreased lung compliance [17]. Nearly 50% of persons with ARDS in the United States have a history of alcohol misuse; the mortality rate for those with ARDS is already up to 40%, and for those who abuse alcohol, it will increase by another 25% [17].

Secondly, medication abuse could induce many side effects, including depression, anxiety, sleep disorders, behavioral disorders, physical and mental disabilities, gastrointestinal bleeding, pharmacological nephrotoxicity, and metabolic syndrome. One of the most common ones is medication overuse headache (MOH) [18]. This is a secondary headache with frequent attacks in headache patients after long-term overuse of analgesics, and is the headache type with the highest incidence after migraine and tension-type headache [18]. According to statistics, approximately 63 million patients worldwide suffer from MOH due to medication abuse [18]. Although MOH is not a life-threatening disease, it will lead to severe disability and reduced quality of life, and even manifest high suicidal ideation and risk [18].

Finally, the mortality rate among people addicted to injecting drugs is seven times that of their peers in the general population. in the United States, illicit drug use leads to approximately 20,000 deaths annually, with causes overdose-induced suicides or homicides, tetanus, pneumonia, hepatitis, and endocarditis [19]. By the 1980s, HIV became the leading cause of death among injecting drug addicts: drug users contracted HIV through needle sharing or sex-for-drugs and spread it to social networks [19]. Otherwise, long-term cocaine use can lead to myocarditis, ventricular hypertrophy, dilated cardiomyopathy, heart failure, and even kidney failure [20].

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4.2. Substance Addiction and Violence

In addition to the physical harm caused by substance addiction, it is also important to consider the injurious and unlawful behaviors of addictive episodes. This is because it involves not only an increase in violent behavior due to uncontrollable addictive behaviors, but it may also result in the inability of the harmed person to protect his or her basic rights.

Domestic violence has always been an issue of great concern to society. In the United States, about 24 people are victims of intimate partner rape, physical violence or stalking ever minute, about 12 million people in a year [21]. And according to a paper by the American Society of Addiction Medicine (ASAM), different studies have found that between 40% and 60% of reported incidents of domestic violence involve substance abuse, and more than 20% of male offenders report having consumed alcohol prior to the violence behaviours [22]. Moreover, drug users may lose control of their behaviors and cause violence, injury, and other illegal and criminal behaviors due to mental disorders after using drugs [23]. Drugs may also lead to extreme self-injury, suicide, and even homicide behaviors without awareness of the drug user [23]. Compared to non-drug users, drug users tend to be more aroused, more eager to let off steam, or more relaxed and euphoric, with a higher sex drive [23].

Additionally, if substance addiction is considered a mental illness that triggers violent behavior, when an alcoholic, drug user, or drug addict acts impulsively and violently because they choose to use the substance, but they learned that their behavior could be explained by saying that their behavior was controlled by a mental illness called addiction and that it took time to heal, will they use this as an excuse to shirk the punishment they deserve? It is well known that the laws of many countries state that when a mentally ill person who has completely lost the ability to recognize or control his or her behaviour commits a crime, the punishment will be lightened or mitigated, or even do not have to take criminal responsibility. The law of the United Kingdom stipulates that if the offender exhibits the main category and performance characteristics (or a combination of mental impairment or disease) consistent with the mental disorder at the time of the crime, the guilt can be mitigated [24]. Imagine, if this happened, how would the national crime rate be affected?

5. Conclusion

The topic of whether addiction is a personal choice or a disease compulsion has long been debated by society. Proponents of the disease model argue that it is the addictive substance's inherent ability to persuade the dopamine-producing system in the brain that makes it easier for the user to focus on the addictive substance and not be distracted from it. Furthermore, many addicts strongly state that they do not want to use the addictive substances before using it, and they do not derive pleasure from them. Therefore, addictive behaviors are forced, and society should not morally condemn or forcefully regulate addicts, but rather accept and tolerate them and understand their uncontrolled behaviors.

However, proponents of the choice model do not see it that way. They argue that the idea that addiction is a form of compulsive behavior that is beyond self-control is false, and justify this claim in several different ways. Firstly, they show that even if addiction is viewed as a mental disorder, it does not show that addiction is a compulsive behavior, because mental disorders can be managed through psychotherapy. Secondly, they also state that thoughts or desires can also cause changes in the body's functioning and trigger a series of behaviors. It is obviously illogical to assume that addicts have thoughts and actions about drinking, smoking, or taking drugs because of changes in dopamine production levels in the nucleus accumbens. Thirdly, due to the research of addiction and OCD, they found that OCD-induced compulsions always involve voluntary, deliberate, and controllable decision-making. Therefore, if addiction is defined as a type of obsessive-compulsive disorder, it is

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not irresistible. Finally, proponents also claim that substance users will still obtain happiness after the addiction, and the use of those substances are still purposeful and expected.

Additionally, the consequences of treating addiction as a mental illness and deregulating addictive products and behaviours also demonstrate the irrationality of the argument that addiction is a mental illness. Such as the negative effects of alcoholism, substance abuse and drug use on the human body, and even the stimulation of mortality, make it difficult to recognize that society should deregulate the behaviors of addicts and addictive substances, especially drugs. The personal harm is so serious, not to mention the violent or hurtful incidents caused by the mental stimulation of addictive substances.

So far, it seems that the query at the beginning of the article could be answered: precisely, it is true that the addictive substances in substance addiction have a certain temptation for the users, but it is not completely impossible for the users to resist, and the addicts' acquisition of the addictive substances is purposeful and expected. Whatever, addicts still act based on their own choices rather than pathologizing compulsion. Therefore, it is unreasonable to think that addictive behavior is a behavior that is completely beyond the control of the addict himself, and to relax the control addicts.

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