

## DOPING AS ADDICTION: DISORDER AND MORAL RESPONSIBILITY

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*D'Angelo and Tamburrini (2010) invited readers to consider doping in sport as a health issue and dopers as potential addicts who need therapy rather than offenders who need punishing. The issue of addiction in sport is important and very much under researched. In this essay I explore the extent to which addiction can be justifiably used as an excuse for offending behaviour. The favoured argument is that addicts experience a craving or compulsion to use over which they have no control. I argue that there is insufficient evidence that addicts experience such compulsion. Although it seems science is unravelling some of the mysteries of addiction, it has not provided sufficient evidence that addictive consumption amounts to compulsive use. Nevertheless, it is clear that addicts do have difficulty with controlling their use and such difficulties ought to be considered in any judgements about moral responsibility. This does not mean that rules or laws including anti-doping legislation should be altered because not all those who fall foul are addicted. Moreover, accepting responsibility and punishment for the consequences of their actions (including anti-doping rules) is an important part of therapy for addicts.*

KEYWORDS addiction, moral responsibility, compulsion, doping

### Introduction

A dominant view is that doping is immoral and perpetrators deceitful, corrupt and dishonest. Motivated by greed and ambition, they employ illicit means to achieve their goals seemingly impervious to the values and obligations of fairness and honesty. They are parasitic upon the practice community and selfishly profit from the honest endeavour of their competitors. Under such description dopers are paradigmatically bad and deserve punishment. When caught individuals will often tell a very different story. Despite doping's strict liability status, offenders will offer a range of standard excuses (which may or may not be true). The defence is usually some form of the following "I didn't know I had done something wrong" - in legal terms denying that they had *mens rea*, or guilty mind. By this they might be saying that they took *something*, but didn't know that the *something* was banned; or that they had been compelled to take *something* (perhaps by a coach or corrupt regime). Their defence is that although the presence of the banned substance is indisputable, *they* are not *responsible* for its presence in their body; *they* did not intend or plan for its presence.

D'Angelo and Tamburrini (2010) invite us to reconsider this dominant cheating narrative. Using a mental health rather than a moral framework, they argue that an individual who dopes is engaging in addictive or potentially addictive behaviour over which they have "reduced or no control whatsoever" (D'Angelo and Tamburrini 2010: 700). In other words, dopers are suffering from (or at least at risk of developing) the disease of addiction and "should be handled in accordance with that characterisation" (D'Angelo and Tamburrini 2010: 700)<sup>1</sup> They argue that most failed tests reveal the presence of drugs (such as marijuana, stimulants and anabolic steroids) which produce a range of physical and mental changes which may in turn lead to addiction. Given that dependency is "the final stage of a process that begins when a person starts consuming drugs and gradually increments

her consumption through experimentation and abuse" (D'Angelo and Tamburrini 2010, 701), it is appropriate to conceive of all doping offences as potentially addictive. As such, they argue that prevention, education and therapy should usurp blame punishment and condemnation as strategies to curb the problem. Such an approach is characteristic of what Martin (2006: 3) calls a "therapeutic trend" which is "pathologizing wrongdoing" and "psychologizing virtue"<sup>2</sup>. The suspicion is that any manner of morally problematic behaviour will be considered a symptom of disorder<sup>3</sup>. Moreover the diagnosis of a personality (substance misuse) disorder will be (illegitimately?) used to *excuse* wrongdoing or to *exculpate* individuals from responsibility for their actions. After all illness implies incapacity of some kind over which an individual has no control (Parsons 1951). The key question is to what extent offenders (PED users) are in control of their drug use (which if detected will lead to a doping offence)? There are at least two key issues to be considered. The first is whether addiction is an illness or condition which undermines choice or control in morally relevant ways. The second is whether users of banned substances are in a grip of a condition (addiction) which compels (or the early manifestations thereof).

### **Punishment, blame and moral responsibility**

Honderich (2006) argues that for punishment to be justified the person who commits the offence must be an offender. In other words, they must deserve the punishment. "The culpability of an offender in his offence, we may say, depends on two things: the harm caused by his action and the extent to which he can be regarded as having been free and responsible in his action" (Honderich 1989, 31). Aristotle distinguishes between voluntary actions (and passions) and involuntary ones. Urmsen (1988, 43) argues that "intended" and "contrary to intention" are more helpful translations. For Aristotle, blame rightly attaches to intended (voluntary) actions and pardon or pity to actions contrary to intention (involuntary).

Two conditions determine whether the actions were intended. First, if the agent is "acted upon" by external forces such as a strong wind the action is not intended and is not really "action" because "nothing is contributed by the person who acts" (Aristotle 1980, 48). Aristotle (at least initially) dismisses the idea that our desires can *force* us to act. For Aristotle acting according to desire is a paradigm case of acting responsibly and we would not withhold praise on the grounds that it was one's desire to act virtuously that moved them. We should not therefore withhold blame because one's desire (say for a drug) moved one to act badly. The second condition which potentially mitigates responsibility is whether the agent knew what they were doing "so that, if one had known, one would not have done the deed" (Urmsen 1988, 46). For example, one might not know that by taking supplement *A* one is also taking banned substance *B*, but had one known they would have avoided *A*. The crucial factor is whether one could (reasonably) foresee that the action would fall under a particular description – cheating or some such.

There are two ways we might consider the addict from an Aristotelian perspective; intemperate or weak willed. Temperance is the mean disposition in relation to the pleasant feelings induced in our bodies by our senses (Urmsen 1988, 69). Intemperance might best account for addicts who delight excessively in the pleasant feelings induced by a particular substance *and* have no desire curb it. The weak willed account would suggest that addicts lack self-control (incontinent). Weakness of will occurs when our appetite and our rational wish conflict. Strong appetite can "alter our bodily condition" creating a kind of madness which drives agents to excess (Aristotle 1980, 165). The weak willed man knows that using steroids is potentially harmful, but driven by a strong appetite for

success at body building fails to act on that knowledge. Both weak willed and intemperate addicts are responsible and blameworthy. The former because intemperance is a vice and vice is blameworthy, and the latter for being excessively affected by pleasures such they cannot bring themselves to act according to the right rule (or the mean with respect to the pleasure). Punishment is both justified and prudent because it plays a key role in changing behavior (cultivating character). It is a “kind of cure” for wrong doing (Aristotle 1980, 32). Punishment also plays an important role in deterring immoral behavior such as committing doping offences. Frankfurt (1971) offers a similar insight into addiction. He believes that an addict may be willing (intemperate) or un-willing (weak willed or incontinent). Both have a desire (first order) say for a drug (or some such). Both might even share a conflicting desire not to take the drug (they know it’s bad for them), however it is only the unwilling addict who has a reflective (second order) volition *not to want* to desire the drug. The willing addict has no such second order desire. The unwilling addict:

...has conflicting first-order desires: he wants to take the drug, and he also wants to refrain from taking it. In addition to these first-order desires, however, he has a volition of the second order. He is not neutral with regard to the conflict between his desire to take the drug and his desire to refrain from taking it. It is the latter desire, and not the former, that he wants to constitute his will; it is the latter desire rather than the former that he wants to be effective... (Frankfurt 1971, 12).

This addict does not want to be an addict, however isn’t able to make the desire ‘*not to use*’ his will. Both addicts take the drug because of their first order desire. According to Frankfurt (1971, 13) it is the formation of the second order volition - to *want-not to want* to take drugs which means that:

the unwilling addict may meaningfully make the analytically puzzling statement that the force moving him to take the drug is a force other than his own, and this is not of his own free will but rather against his will that this force moves him to take it.

The unwilling addict’s will is not free because it’s not the will he wants (can’t control it) and he is “a helpless bystander to the forces that move him” (Frankfurt 1971, 16). Frankfurt considers that unwilling addicts may have a condition which enlarges the power of the appetite, undermines the strength of the will or both. Despite the conclusion above, Aristotle also observed that some individuals (which we now call addicts) seemed to manifest a range of symptoms including recidivism and imperviousness to the effects of punishment. He speculated that such individuals might indeed be in a grip of an appetite (a physical phenomenon) outside of their *control*. Consequently, if excessive appetite or desire is a product of a bodily (physical) condition/impairment which *compels* the addict to use, then both Frankfurt’s and Aristotle’s accounts could support D’Angelo and Tamburrini’s contention that addicts lack control and this should be taken into consideration when allocating blame and punishment

### **Addiction, science and the medical model**

According to Leshner (1997, 45) addiction is a “chronic, relapsing illness, characterized by compulsive drug seeking and use”. It appears that there is an identifiable mechanistic flaw or fault at the brain level which is responsible for the subsequent problems encountered by addicts. The flaw is apparently brought on by the use of certain substances. Using certain drugs produces a hypersecretion of dopamine in the mesolimbic reward system (Smith, 2012) the activation of which

keeps drugs users using (Leshner 1997). Consequently, the addicted brain is different from the non-addicted brain:

A metaphorical switch in the brain seems to be thrown as a result of prolonged drug use. Initially, drug use is voluntary behaviour, but when that switch is thrown, the individual moves into the state of addiction characterized by compulsive drug seeking and use (Leshner 1997, 46)

There appear to be grounds for concluding that an addict's "use" or "powerful appetite" for a drug is a "mechanism" or is grounded on a "mechanism" which produces compulsion, craving and loss of control. The World Health Organization has classified addiction as a brain disease<sup>4</sup>. Leshner (1997), like D'Angelo and Tamburrini (2010) concludes that addiction is a health issue. Certain consequences are thought to follow from such a characterization. According to Foddy (2010, 26)

Among other things, we do not normally hold people morally or legally responsible for the symptoms of a disease, even when the disease is self-inflicted. When the symptoms in question are behaviours, as they are in the case of addiction, we cannot hold a diseased person responsible for enacting those behaviours.

I will return to the issue of which behaviors in particular fall under the category of symptoms below.

### **Compulsion – no control**

It does not follow, however, from the account above that addicts have no control. It is tautologous to say that an addict's brain is *doing* something different from the non-addict. For Foddy (2011, 28)

The important questions concern whether or not the biological cause of a person's behavior (whether normal or abnormal) have functional characteristics which make their actions free or compulsive.

Morse (2010, 166) similarly argues that biological causation "even abnormal biological causation is not the equivalent of compulsion" or else all behaviour would be compelled. Foddy (2010, 29) argues that when not intoxicated, there is no strong evidence that "the neural mechanisms that cause addictive behaviour among non-intoxicated addicts are less capable of supporting responsible or free action than the neural mechanics of normal behavior". Levy (2011, 92) makes a similar point arguing that addictive behaviour is not "tic-like" and craving among addicts is not sufficiently strong to undermine reactivity in terms of making choices around drugs (such as time, place and price). Addicts seem to be able to make rational choices in relation to their drug, they are able to abstain at certain periods and purportedly "mature out" (Levy 2011, 92) or quit altogether (Heyman 2013)<sup>5</sup>. Foddy and Savulescu (2006, 11) go further and argue that there is "no relevant difference at all between drug-orientated and other appetitive desires" and that the decision to take drugs is an autonomous one. Addicts act "as rational animals and not as mere automata in response to irresistible physiological or psychological impulses" (Foddy and Savulescu 2006, 15). The identification of an addictive mechanism, therefore, is not sufficient grounds for concluding that addicts can't control their behaviour around drugs. Most addicts are able to make choices, even about their proximate behavior (the behavioural symptoms of using/consuming). They can hold off from using until they are in a safe environment away from the public glare. In order to consume drugs, addicts manifest other behavioural symptoms, namely the planning, organizing and arranging required to acquire them (distal behaviour). Athletes who use PEDs (if they are to profit from their use in terms of performance) often have to make very specific and detailed calculations in terms of

supply, effective dose, and timing of use in order to maximize benefit and minimize risk of detection. It is very difficult to make the case that such behaviour is compulsive.

It is therefore doubtful that the addict's appetite for drugs is a result of a mechanism which *compels* their action in an Aristotelian sense. Compulsion doesn't necessarily follow from an identifiable biological cause and addicts are able to stop their addiction (albeit with difficulty). We ought not to absolve addicts, nor potential addicts, of day to day moral and legal responsibilities whatever their drug of choice (cocaine, alcohol, heroin or human growth hormone) on the grounds that their behaviour is pathologically compelled.

### **Reduced control**

The primary explanation for the addict's consumption given above is that they are moved by a compulsion to use which overpowers their rational wish to abstain (not being able to react to reasons that they hold and understand, Fischer and Ravizza 1998). Levy (2011) believes an addict's problem; however is an inability to control their mental life. A loss of control over their mental will lead an agent to believe (and therefore act upon) a lie ("I really need this, I can't do without it, I'll only have the one, it wasn't that bad last time, I won't get caught"), or in Aristotle's terms – act in ignorance (or madness). Such an act, according to Levy (2011) cannot easily be explained by a loss in reactivity (because the reasons [albeit bad ones] *did* move them to action – "I do really need this – so I'll take it). For Levy, the addict knows, or judges that taking the drug is wrong or harmful in general, but at a given moment changes their mind and judges that taking it is the rational thing to do. The action, according to Levy (2011) is a result of a "judgment shift" or a change of mind *in that moment*. Levy (2011) believes that the concept (theory) of ego-depletion can help explain why the judgement shift which characterizes the addict's behaviour comes about. Research shows that self-control is a depletable resource.

On the ego-depletion hypothesis, self-control is a limited resource: an agent's ability to control himself is a function of the state of that resource, and the state of that resource is, in turn, a function of the number and demandingness of self-control tasks in which that agent has recently engaged (Levy 201, 99).

When agents have had to exercise self-control and the resource is depleted, they are more likely to succumb to temptation. In response to temptation individuals whose resources are depleted are more likely to believe or listen to arguments in favour of giving in. This is because generating or retrieving such arguments takes less effort. Levy (2011, 102) argues that temptations:

...automatically generate arguments in their favour. They might even be said to *constitute* arguments in their favor: for typical temptations, the major argument in their favor is that consumption of the tempting good is pleasurable.

Moreover, Levy argues that we typically experience weakness of will with regards to goods we have decided to resist which are familiar to us. Levy believes that the ego-depletion hypothesis explains many of the behaviours associated with addiction. Addicts consume and desire a substance (or engage in behaviour) which has a powerful mood altering effect for them so it provides strong reasons for them to do so. Short term abstention is comparatively easy (athletes addicted to alcohol are able to abstain for long periods of time when necessary, and doping athletes are able to regulate their use in order to avoid detection by the anti-doping authorities). Longer term abstinence is more difficult because the effort required depletes self-control resources.

Addicts are very susceptible to familiar cues or triggers and are therefore more successful at giving up when they are able to change the environment. Leshner (1997) argues that although addiction is a brain disease, the social context is important. Cues trigger the desire for consumption which in turn requires addicts to draw on their self-control resources. Levy (2011, 103) argues that “if the temptation is persistent – if, for instance, the cue, or similar cues, remain salient to the agent – self control reserves will fall until judgment shift occurs, and with it consumption”. D’Angelo and Tamburrini (2010) argue that a ban (which removes the PED user from their support system) is potentially detrimental to their well being. According to Levy (2011) removing a drug user (athlete or otherwise) from the milieu in which drugs (behaviour) are prevalent is potentially beneficial because it removes temptation.

Even though on this account, addicts are choosing the behaviour, it is very difficult for them not to. The difficulty is a consequence of certain features about her which sets her apart from non-addicts. These features include the various changes in the brain brought about by her drug use, her genetic or hereditary predisposition and the other social/psychological correlates for addiction (see below). These factors (which don’t amount to compulsion or lack of control) make it very difficult for the addict to make the right choice when it comes to their drug of choice. Levy (2011, 106) argues that “Given how she is, when she experiences her failure of mental control, there is nothing she can reasonably be expected to do to prevent the failure”. Levy (2010, 108) acknowledges that if excuses on such grounds are allowed, then excuses might proliferate, but argues that “we can not allow the fact that we do not like its conclusion to prevent us following an argument where it leads”. In other words, a genuine addict is not compelled mechanistically to use, but for various reasons they find it more difficult (if not almost impossible) not to use. For Levy, this increased difficulty is morally relevant.

### **Doping as addiction**

According to Flanagan (2011) addiction is a complex phenomenon which cannot be explained solely in terms of neuroscience, evolutionary biology, sociology, psychology or philosophy alone (although all have important insights). There is an important phenomenological aspect which provides important insight into “what is it like to be an addict” (Flanagan 2011, 269). Flanagan (2011), who was addicted to alcohol and benzodiazepines, says he was someone who developed a *need* for:

...molecules such as these (although without having any desire for the molecules they are, or as we philosophers say, not for the molecules under that description, but for the molecules for what they do) more than all the things that wise persons have ever thought have existential importance

In other words, the alcohol and drugs, because of their psychoactive properties, did something for him; they calmed his soul and produced some sort of safe feeling. This *need* for a substance (even when the addict might not *want* the substance) is a central phenomenological aspect of addiction says Flanagan. It is the psychoactive property/effect which the addict becomes addicted to (the drugs stimulate dopamine secretion in the mesolimbic reward pathway [Smith 2012, 2]). At first glance certain PEDs such as steroids don’t fit the bill because they don’t share the psychoactive (mood altering) properties associated with other drugs (they are not addictive<sup>6</sup>). They are (normally) taken because they contribute effectively to increased muscle mass and body size. These effects are pursued in order to improve athletic performance (among other things), although most steroid abuse is associated with recreational body building. Nevertheless evidence by Kanayama et al.

(2008), Kanayama et al. (2010) and Skarberg et al. (2009) suggest that dependency is a feature of a significant minority of users of Anabolic Steroids<sup>7</sup>.

According to Grant et al. (2010, 233) there are a number of behaviours beside the ingestion of psychoactive drugs which produce certain rewards (particular phenomenological feelings mentioned by Flanagan) which can lead to dependency. Individuals will continue with the (reward inducing) behaviour despite negative consequences. Such behaviours include gambling, overeating, sex, pornography, self-harming, internet use, exercise and perhaps even winning (or its obsessive pursuit). Perhaps the steroid or EPO user is obsessed with, dependent upon, or addicted to the feelings associated with being big, strong or fit. It is not the direct psychoactive effect of the molecules themselves which provide the phenomenological feeling described by Flanagan, but the feelings associated with being admired, successful, powerful or “big”.

Although we understand the expression addicted to processes such as sport or exercise, it is not clear whether these are actual addictions (as opposed to obsessions or compulsions)<sup>8</sup>. According to Pope et al (2005, 295) muscle dysmorphia is a personality disorder (a form of body dysmorphic disorder) characterised by a pathological preoccupation with muscularity (as opposed to a focus on being thin, or beautiful or having large breasts or some such). Those with muscle dysmorphia may experience “impaired social and occupational functioning, and abuse of anabolic steroids and other substances” (Pope et al. 1997, 549). Whether it is legitimate to refer to this disorder as “process addiction” or “behavioural addiction” is a matter of current debate in the field of addiction studies and diagnostics. According to Smith (2012, 1) DSM –V proposes a new category of Addictions and Related Disorders which would include behavioural addictions because certain behaviours also cause dopamine release in the brain similar to psychoactive drugs. Put simply the behaviour becomes addictive because it is the most effective means for releasing dopamine<sup>9</sup>. Grant et al. (2010) argue that behavioural addictions resemble substance addictions in many ways including detrimental consequences, irrational use, compulsive use, genetic predisposition and comorbidity with other addictions and personality disorders. Based on current evidence however, they conclude that only pathological gambling warrants being re-classified as a non-substance addiction. This does not mean that other candidates like obsessive training or exercise are ruled out; it just means there is insufficient evidence to grant them the status at the moment.

Whether steroid use/abuse is best classified as (or indicates potential) substance addiction, process addiction, personality disorder or vice is a complex issue. Nevertheless D’Angelo and Tamburrini’s talk of addiction in the context of certain performance enhancing drugs seems plausible<sup>10</sup>. There is a further difficulty however. Although addiction is brought on by the use of a substance, it doesn’t appear to be the case that use, even overuse, will automatically lead to addiction (as suggested by D’Angelo and Tamburrini). According to Morse (2011, 176), most people who use “potentially addicting substances do not become addicts, but between 15% and 17% do”. Smith (2012, 2) similarly argues that large numbers of people will be “exposed to psychoactive drugs, but only a certain percentage, primarily the at-risk population will progress to addictive disease”. Increasingly, it is believed that addiction, or the chances of becoming addicted, runs in families. Establishing the precise nature of the hereditary relationships however is complex and difficult, particularly when looking for connections between genetic/genomic variations and psychological diseases such as addiction (Volkow and Muenke 2012, 773). A genetic marker for addiction does not necessarily lead to addiction, but is one of the risk factors. Levy (2004) argues that “There is nothing inevitable about innate propensities: they remain responsive to cultural and social factors”. Addiction is also

correlated with many other social or environmental factors including parent's consumption of drugs and alcohol, peer and group norms, advertising and masculinity (De Visser and Smith, 2007; Ellickson et al., 2005; Kuntsche et al., 2006; Martino et al., 2006; Mullen et al., 2007; Spijkerman et al., 2007; Talbott et al., 2008; White and Jackson, 2004). The pattern of steroid and behaviour addiction matches that of other addictions. Not all steroid users (or users of other banned substances) become addicts but a minority do<sup>11</sup>. This minority also seem to be at risk of cross-addiction with opioids and alcohol (Skarberg et al 2009) and other "drugs to enhance physical appearance or performance" (Kanayama et al., 2009, 111). In layman's terms the addictive personality or predisposition to addiction or disorder is borne out in steroid abuse as with other substance and process addictions.

It is of course difficult to decide which of those individuals who are taking PEDs are actually prone to, or in the grip of a personality disorder or addiction. It seems that individuals like Mike Tyson and Marco Pantani were addicts. They used PEDs, recreational drugs, alcohol and other processes like sex in excessive and detrimental ways<sup>12</sup>. Is Lance Armstrong addicted to EPO? Perhaps he was addicted to winning and the power and prestige that came with it, or perhaps he had some other kind of personality disorder (e.g. Narcissistic personality disorder) – who knows? Whatever the circumstances of any given individual found to be taking PED, two key issues stand. First we ought not to conclude that every PED user is an addict or potential addict (not all alcohol users are addicts or potential addicts). Second, we ought not to conclude that a PED user (addict, disordered or otherwise) is unable (mechanistically/biologically) to refrain from taking it, although it might be difficult for reasons already mentioned.

### **Responsibility, treatment and prevention**

I have argued that addicts are not behaving compulsively in the sense that would render their actions involuntary or contrary to intention. Nevertheless it is clear that addicts find it very difficult not to keep using once they have become addicted and we should bear this in mind in our moral evaluations (Levy 2011). Before we accept that user's proximal behaviour (the actual ingestion of the drug or engagement with the behaviour) is not (fully) responsible we may ask three further questions:

1. Does the addict carry any responsibility for becoming the sort of person who *now* has difficulty controlling their behaviour or mental life?
2. Is the addict responsible for distal behaviour connected to their addiction such as breaking doping regulations?
3. Ought they to seek help to rid themselves of their addiction?

In relation to question 1) I don't think any general conclusions can be drawn here. An addict might have knowingly and deliberately taken a substance despite being aware of the risks in order to fulfil a rational wish (to win, to fit in, to improve). It would be far fetched to think that in the current climate an individual would not know about PEDs and the rules surrounding them. A decision to take them would therefore have to be evaluated against this background<sup>13</sup>. On the other hand, she may have been encouraged, manipulated or coerced to take the substance by a coach, team mate or partner (potential mitigation). She may have a genetic predisposition to become addicted which she didn't know about. As we have seen, addiction is correlated with a number of other social and psychological factors including other personality disorders and life experiences like abuse or a



troubled childhood (Pickard 2011b). We can only hope to form a reasonable diagnosis and judgment about responsibility for any given individual on a case by case basis, and even then there is no guarantee of agreement.

In relation to 2), if an individual has become addicted to a substance or process, they might still be held responsible for committing offences, i.e. competing in sport where their use is banned. They may not be able to desist from taking the drug, but all the evidence points to a clear ability among addicts (at least when not under the influence of their drug) to make rational decisions. A body builder who is dependent on steroids or human growth hormones will be able to choose not to compete in “clean” competitions or train at “clean” gyms. If she does try to surreptitiously enter “clean” arenas, then her decision to do so seems self-evidently blameworthy and little to do with the proximal effect of the drug on her system. We do not absolve alcoholics from laws about driving nor illicit drug users from laws regarding possession.

In relation to 3) attitudes to this question will depend on how we see addiction more generally. For some, this is a moot question – addiction is a choice and addicts make bad choices – there is no problem to solve<sup>14</sup>. They see addiction as a vice, pure and simple – a matter of self-control, addicts are deluded wantons. Even if there is a growing acceptance that alcoholism is an illness, there is a reluctance to extend that characterisation to other potential addictions or personality disorders<sup>15</sup>. Notwithstanding such issues, determining at which point occasional use becomes habitual, which in turn becomes abuse then addiction, will be different in each individual. Diagnosis of addiction and other forms of personality disorder is difficult because addicts may hide or deny their addiction and often lie about their use. Moreover the culture in which such addicts exist might serve to normalise behaviour further decreasing the likelihood of admission.

D’Angelo and Tamburrini (2010) advocate person tailored counselling and treatment if necessary for athletes who fail dope tests. A test failure however is neither a necessary nor a sufficient condition of problematic (potentially addictive) use. If an individual is genuinely (notwithstanding diagnostic difficulties) suffering from, or at risk of developing, an addiction or other disorder, then trying to help them with therapy is a laudable goal, but neither seeking nor receiving help guarantees recovery (Pearce and Pickard 2010). Moreover if therapy is warranted, it shouldn’t be an alternative to punishment. Pickard (2011b, 213) argues that taking responsibility for their actions is therapeutically important for addicts. It is not therapeutically useful to conceive that addicts could not do other than use and thereby let them “off the hook”. It is important that they “face aspects of their personalities and behavior that are harmful to self and to others, and to take responsibility for them” (Pickard 2011b, 220). This includes behaving appropriately relative to conventions and rules and accepting the consequences for failing to do so. If the consequence of being caught using PEDs is a two year ban (or more if not the first offence) then addicts should take responsibility and be held to account. In the therapeutic context the aim is to find out why the addict behaves as she does and this requires compassion and empathy. It also means withholding blame that may result in counterproductive feelings of guilt and shame. PED policy, however, should not be tailored to fit the therapeutic needs of a minority who might be addicted.

## **Conclusion**

My aim in this paper was to evaluate D’Angelo and Tamburrini’s (2010) claim that doping in sport should be considered as an addiction (or potential addiction) characterised by drug use over which

the agent has little or no control. As such, treatment not harsh punishment should be the proper course of action. I have argued that it's not legitimate to characterise all PED users as addicts or potential addicts. I have also argued that despite the empirical evidence that addiction is characterised by changes to the brain, it does not follow that addicts can't control or change behaviour. Nevertheless, it is clear that some individuals do have significant difficulties in controlling their behaviour and seem impervious to compelling reasons not to use drugs (they may have some form of personality disorder or substance or process addiction). In such cases, treatment or therapy is crucial, but this does not mean that they ought not to be held accountable. In fact it is therapeutically important that they are held to account (and perhaps taken out of the environment where using is a temptation) Anti doping regulations should not be guided by the possibility that a small minority of users are (or at risk of becoming addicted). If an individual who is caught cheating is a potential addict, then punishing them without some form of treatment is futile (if the goal is their rehabilitation). But this says nothing about the length of the ban they should face because punishment has other institutional goals such as restoring justice or as a deterrent (Honderich 1989).

**ACKNOWLEDGEMENTS** My thanks to John Russell and two anonymous reviewers for their comments and recommendations and to Nicholas Dixon and others at the IAPS 2013 conference for their valuable suggestions.

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<sup>1</sup> The DSM does not use the term addiction, but rather refers to Substance-related and addictive disorders. I will continue to use the term addiction in the paper.

<sup>2</sup> The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) is largely responsible for defining or creating specific disorders. It has important cultural, medical and legal impact "...in shaping attitudes, standardising reimbursement for services by psychotherapists, and guiding the funding of research" (Martin 2006: 8). Despite, or perhaps because of its powerful influence, the DSM can be problematic. Prior to 1973, homosexuality was included in the DSM and the way the DSM defines disorders

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makes expansion easy. Martin (2006: 23) argues that “At least in some instances, psychiatrists create, via their authoritative definitions, the illness they then cure”. Later in the paper, the status of “process addictions” on the DSM is discussed.

<sup>3</sup> Martin (2006, chapter 11) examines the arguments for whether “bigots are sick?”

<sup>4</sup> The disease conception, as mentioned is not new. AA referred Alcoholism as a disease in 1939 and it appeared in the DSM in 1968.

<sup>5</sup> The claims made by Hyman (2013) that most addicts quit by themselves are controversial to say the least. Dawson et al (2006) found that for many alcoholics formal treatment and 12 step recovery programmes were necessary for recovery. A recent report by White (2012) which reviewed 415 scientific studies of recovery outcomes (in different populations and in different countries) found that around 50% of people who once met the criteria for substance misuse disorders no longer did so. The report paints a far more complex picture of addiction and recovery than the one offered here.

<sup>6</sup> I recognise that there is a long list of PEDs which are banned by WADA – some may have psychoactive properties and users may become addicted to these directly just as with cocaine or heroin.

<sup>7</sup> Recent figures in the UK show that there has been a dramatic rise in steroid users visiting needle exchanges which suggests the problem of steroid abuse is on the increase (at least in the UK)

<http://www.independent.co.uk/life-style/health-and-families/health-news/nice-needle-exchanges-should-supply-safe-equipment-to-under18-steroid-users-9247087.html> accessed 9th of April 2014. van Amsterdam et al (2010) argue that the dependence liability of anabolic steroids are very low.

<sup>8</sup> –See Grant et al. (2010) for an extended discussion about how “obsessive disorders” are distinguished from “impulsive control disorders” and whether certain behavioural “addictions” meet the DSM criteria for either/or both and/or whether they meet the criteria for substance

<sup>9</sup> This is too simplistic, but for an extended discussion of the comparison between addiction to psychoactive substances and addiction to behaviour see Smith (2012)

<sup>10</sup> There are lots of other PEDs on WADA’s banned list. Whether the claim is equally plausible in each case is beyond the scope of this paper and doesn’t affect my overall argument.

<sup>11</sup> In some cases there is co-morbidity with other issues such as low self-confidence, abuse, childhood disorder commonly associated with addiction (Pickard 2011a and van Amsterdam et al 2010).

<sup>12</sup> Tyson (2013) describes how he had a false penis made in order to circumvent doping control because he was a routine user of cocaine and marijuana before fights. According to a biography by Rendell (2006) the cyclist Marco Pantani was a regular user of performance enhancing substances like EPO and of cocaine.

<sup>13</sup> Currently in the UK there is a preponderance of “legal highs”. They are substances which have similar psychoactive effects as illegal drugs. An individual who knowingly took a legal high might be judged differently to one who knowingly took heroin – the latter is likely to be acting in spite of well known facts about heroin and its taboo status in our culture. The former might be excused for thinking that the legal high was not dangerous (acting in [reasonable] ignorance).

<sup>14</sup> This seems to be a view espoused by Peter Hitchin in a recent British Television debate with the American actor Matthew Perry. Hitchin intimated that addiction is a myth and addicts are in a grip of a deception not in the grip of a disease [http://www.huffingtonpost.co.uk/2013/12/17/newsnight-matthew-perry\\_n\\_4457258.html](http://www.huffingtonpost.co.uk/2013/12/17/newsnight-matthew-perry_n_4457258.html) accessed 28/03/2014.

<sup>15</sup> In the UK, the National Institute for Health and Care Excellence (Nice) advised doctors not to blame obese patients <http://www.telegraph.co.uk/health/healthnews/10382775/Dont-blame-obese-patients-for-being-fat-doctors-told.html> accessed 28/06/2014 and there has been controversy about the possibility that the European Union may define obesity as a disability <http://www.bbc.co.uk/news/world-europe-27809242> accessed 28/06/2014. The debate is characterised by what Martin (2006, 6) calls the problematic morality-therapy dichotomy. One is either sick (suffering from an illness) or bad (exhibiting a range of vices like sloth and gluttony).