

Comparison Between Addiction And Diabetes

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Introduction

Addiction and diabetes are different diseases, but comparing them can correct a common misunderstanding about chronic illness. Both conditions involve biological vulnerability, environmental influences, behavior, recurring risk, and the need for long-term management. Neither can be explained adequately by saying that a person simply made a bad choice. At the same time, the comparison has limits. Diabetes is a group of metabolic disorders involving blood glucose regulation, while addiction—clinically described as a [substance use](#) disorder—affects reward, motivation, learning, stress, and behavioral control. Their causes, symptoms, treatments, and immediate risks are not interchangeable. (National Institute on Drug Abuse; National Institute of Diabetes and Digestive and Kidney Diseases)

The most useful comparison is therefore not that addiction and diabetes are “the same,” but that both challenge the false division between diseases caused entirely by biology and problems caused entirely by behavior. Human health develops through interaction among genes, physiology, social conditions, exposure, decisions, and access to care. This essay compares the two conditions while preserving personal responsibility, rejecting stigma, and explaining why relapse or loss of control should lead to better treatment rather than moral condemnation.

Understanding Diabetes

Diabetes occurs when blood glucose remains too high because the body does not produce enough insulin, cannot use insulin effectively, or both. Type 1 diabetes is an autoimmune disease in which the immune system destroys insulin-producing beta cells. People with type 1 diabetes require insulin to survive. Type 2 diabetes is more common and involves insulin resistance together with progressive impairment in insulin production. Gestational diabetes develops during pregnancy and increases later risk for type 2 diabetes. (American Diabetes Association; Centers for Disease Control and Prevention)

The Centers for Disease Control and Prevention estimates that tens of millions of people in the United States live with diabetes and that many adults have prediabetes. The burden includes heart disease, kidney disease, nerve injury, vision loss, and lower-extremity complications, although good management can greatly reduce these risks. Treatment may include nutrition planning, physical activity, glucose monitoring, oral or injectable medicine, insulin, blood-pressure and lipid control, smoking cessation, education, and regular screening for complications.

Type 2 diabetes is associated with factors such as family history, age, prior gestational diabetes, social environment, physical activity, sleep, food access, and body composition. It is inaccurate to say that diabetes is simply caused by “a lack of exercise and unhealthy food choices.” Many people develop the disease despite substantial effort, and social conditions can make prevention and management difficult. Type 1 diabetes is not caused by lifestyle choices at all.

Understanding Addiction

Substance use disorder is characterized by a problematic pattern of alcohol or drug use that leads to impairment or distress. Symptoms may include unsuccessful efforts to reduce use, craving, hazardous use, continued use despite harm, tolerance, withdrawal, and neglect of major roles. Severity varies. Some people recover after brief intervention, while others experience a persistent or recurring condition requiring medication, counseling, social support, and repeated episodes of care. (National Institute on Drug Abuse)

The National Institute on Drug Abuse explains that addiction is a medical disorder that affects the brain and changes behavior. Repeated exposure can alter circuits involved in reward, stress, memory, judgment, and self-control. This does not eliminate agency, but it means that the capacity to choose is affected by the disorder itself. The initial use of a substance may be voluntary, prescribed, socially encouraged, coerced, or connected to trauma or pain; the later compulsive pattern cannot be understood simply by referring back to the first decision.

Risk is influenced by genetics, age of first exposure, mental health, trauma, family environment, availability, drug potency, poverty, isolation, and peer networks. Protective factors include supportive relationships, stable housing, meaningful work, access to treatment, and early prevention. No single factor determines the outcome. Many people who use a substance do not develop addiction, just as many people with diabetes risk factors do not develop diabetes.

Shared Features of Chronic Disease

Both conditions can persist over time and require continuing management. A short course of treatment may stabilize a crisis without eliminating future vulnerability. People with diabetes continue monitoring glucose and other risk factors even when they feel well. People recovering from addiction may continue medication, counseling, peer support, or relapse-prevention planning after stopping substance use. Success is better measured by improved health and function than by the absence of any future difficulty.

Both diseases also involve recurrence. Blood glucose may worsen when medication, illness, stress, sleep, diet, or access to care changes. Substance use may recur during stress, exposure to cues, untreated pain, mental illness, or loss of support. Recurrence does not mean treatment was pointless. In chronic care, a setback signals that the plan should be reviewed and intensified. Medicine does not

deny care to a patient whose blood pressure rises again; the same logic should apply to a person whose substance use returns.

Self-management matters in both. Patients make daily decisions about medication, food, activity, appointments, and risk. Yet self-management is not solitary management. Clinicians, family members, insurers, pharmacies, employers, and communities influence whether the recommended behavior is possible. A person cannot follow a plan for a medicine that is unaffordable or unavailable.

Biology, Behavior, and Responsibility

The original essay suggested that both diseases become evident through a series of “life choices.” This framing is incomplete and can become harmful. Behavior influences many health conditions, but behavior itself is shaped by biology and environment. Addiction can reduce inhibitory control; depression can reduce motivation; withdrawal can produce intense distress; and unstable housing can make regular treatment difficult. Similarly, diabetes management can be undermined by food insecurity, shift work, medicine cost, disability, or limited access to primary care.

A medical explanation does not mean that actions have no consequences. People with diabetes remain responsible for participating in care to the extent they are able, and people with substance use disorders remain accountable for harm they cause. The question is how responsibility should be used. Shame and exclusion usually make treatment harder. Accountability is more constructive when it includes clear boundaries, protection of others, access to evidence-based care, and support for safer decisions.

Treatment Similarities

Effective care for both conditions begins with assessment rather than assumptions. Clinicians evaluate severity, complications, coexisting illness, medicines, social needs, and patient goals. Treatment is individualized and adjusted over time. Education is essential because patients need to understand the disease, warning signs, medicine effects, and when to seek urgent care. (Substance Abuse and Mental Health Services Administration; American Diabetes Association)

Medication can be central. Insulin and other glucose-lowering medicines treat diabetes. Medications such as methadone, buprenorphine, and naltrexone can treat opioid use disorder, while other medicines are available for alcohol and tobacco dependence. Medication for addiction is sometimes unfairly described as replacing one drug with another. In reality, properly prescribed treatment can reduce withdrawal, craving, overdose risk, and illicit use while supporting stability.

Behavioral support is also important. Diabetes education may address meal planning, activity, glucose monitoring, sleep, and problem solving. Addiction treatment may include cognitive behavioral therapy, contingency management, motivational approaches, family therapy, and recovery support.

In both cases, respectful communication and shared decision-making improve engagement.

Important Differences

The analogy must not erase important distinctions. Type 1 diabetes is an autoimmune disorder with no behavioral initiation. Addiction requires exposure to a substance or behavior, even though later progression is not fully voluntary. Diabetes is not generally associated with intoxication, impaired driving, illegal markets, or immediate behavioral danger to others. Substance use may create acute overdose risk, violence exposure, infection, legal involvement, and family disruption.

Stigma also differs. People with diabetes may encounter blame, especially regarding weight, but addiction carries intense moral and legal stigma. Patients may be denied pain treatment, employment, housing, or respectful healthcare. Criminalization can separate people from treatment and increase overdose risk after release because tolerance falls. At the same time, communities must address drug-related harms and protect children, drivers, coworkers, and other vulnerable people. Compassion and safety are not opposites.

Relapse, Remission, and Outcomes

The language of relapse should be used carefully. In addiction treatment, recurrence of use is common but not inevitable. Some people achieve stable remission without repeated recurrence, while others require multiple treatment episodes. A single episode does not erase months or years of progress. Clinicians assess frequency, amount, route of use, overdose risk, and return of diagnostic symptoms rather than defining every lapse as complete failure.

Diabetes also has variable courses. Type 2 diabetes can sometimes enter remission after substantial weight loss, metabolic surgery, or intensive lifestyle change, but remission requires continued monitoring because glucose may rise again. Type 1 diabetes is not cured by diet or exercise. The comparison therefore supports realistic expectations: treatment controls risk and improves life, but the course depends on disease type, severity, resources, and individual response.

Prevention and Public Policy

Prevention for diabetes includes access to healthy food, safe activity, prenatal care, screening, and evidence-based programs for people at high risk. Prevention for addiction includes delaying first use, reducing childhood adversity, safe prescribing, mental-health care, education, and limiting exposure to highly dangerous products. Messages based only on fear or individual willpower are insufficient.

Policy should also reduce barriers to treatment. Insurance coverage, transportation, confidentiality, trained clinicians, and integration with primary care are important for both conditions. Harm-reduction

measures such as naloxone, sterile equipment, and drug checking can prevent death while people are not yet ready or able to stop. These measures do not replace treatment; they keep people alive long enough to benefit from it.

Conclusion

Addiction and diabetes can both be chronic, recurring, and influenced by genetic, biological, behavioral, environmental, and social factors. Both benefit from early identification, medication when appropriate, education, continuing support, and adjustment when control worsens. The comparison helps explain why recurrence should prompt clinical review rather than humiliation. (National Institute on Drug Abuse; American Diabetes Association)

However, the two diseases are not identical. Their mechanisms, exposures, acute risks, social consequences, and treatments differ. A balanced approach recognizes agency without reducing disease to choice, and recognizes biology without denying accountability. People living with either condition deserve accurate information, effective treatment, and the opportunity to recover health and function.

References

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