

# 10 *'Incompatible knots' in harm reduction: A philosophical analysis*

Guy du Plessis

Since the introduction of the harm reduction paradigm in the 1980s, it has almost universally been presented as the 'self-evidently correct' and 'rational' approach to the problems associated with drug use (Erickson 1995; Roe 2005; Single 1995; Weatherburn 2009). It frequently pits itself against recovery-orientated paradigms, characterising them as punitive, narrow in perspective and 'rooted in punitive law enforcement models and in medical and religious paternalism' (Newcombe 1992: 1), or as undermining the freedom, dignity or positive self-image of individuals with substance use disorders (Ezard 2001; Zajdow 2005). Instead, harm reduction is often presented as a humane, value-neutral, pragmatic and scientific alternative, and is, thus, often accepted uncritically as an obvious and unqualified good (Marlatt 1998; Souleymanov & Allman 2016).

Yet, harm reduction proponents are frequently ill-informed of the epistemological and ontological assumptions that underlie their theories and interventions. When some of these assumptions are accepted as 'self-evident', harm reduction can become beleaguered with internal inconsistencies and uncertainties in its core goals (Keane 2003; Mugford 1993; Weatherburn 2009). An internally contradictory position within harm reduction theory and practice can create a 'double bind',<sup>1</sup> that results in what existential psychiatrist Ronald D Laing (1960) refers to as an 'incompatible knot'.

## *Foundational suppositions in harm reduction*

In this chapter, informed by critical hermeneutics (Gadamer 1975/1960; Ricoeur 1981), I provide a brief philosophical analysis of some of the foundational suppositions that often underlie harm reduction theories and interventions. I deliberately take on the 'strong' versions of these suppositions in order to reveal what I consider to be at stake. I will limit my focus to three theoretical orientations (or '-isms'), often advanced by harm reduction proponents, which contribute to internal inconsistencies within harm reduction theory and interventions. These are relativism, which leads to conflation of drug use and addiction as concepts and to conflation of 'drugs' in general; collectivism, which prioritises the common good over that of the individual; and determinism, which represents people with addiction as victims with limited agency. I conclude by proposing the value of an integrative and metaparadigmatic

heuristic that could possibly assist our conceptualisation of addiction and ameliorate the conceptual challenges and internal inconsistencies present in harm reduction theory and practice. The value of a comprehensive and integrative framework is that it provides a more accurate conceptualisation of drug use, addiction and its harm; this ‘right view’ lends itself to ‘right action’.

I also present the argument that addiction, as a concept, has social and human value as well as empirical merit and that harm reduction strategies should be an important link in the continuum of recovery-oriented systems of care. But, as I will show, there are problems with promoting harm reduction uniformly as an alternative, ‘better’ or ‘fix all’ intervention.

### *Relativism*

It is common for harm reduction proponents to conflate the behaviour of drug use and the condition of addiction (Davies 1997; Peralta & Jauk 2011) and to minimise the distinctions between medications commonly prescribed by the healthcare system and those (such as opioids) that are diverted into non-medical economies for their intoxicant and dependency-producing properties.<sup>2</sup> I will make a distinction between ‘categorical conflation’ and ‘continuum conflation’. Categorical conflation (which will be my focus here) can be considered as denying any categorical difference between drug use and addiction, whereas continuum conflation acknowledges some differences but assigns enough similarity to place it on an ontological continuum. I argue that both these types of conflation of drug use and addiction are serious conceptual errors that lead to deleterious consequences for the design and sustainability of harm reduction policy.

Comparing drug use to addiction is like comparing apples and oranges. Drug use and addiction are distinct phenomena and harm reduction interventions for drug use and addiction should be fundamentally different. Making claims whether drug use is good or bad is a normative statement and stating whether someone is an addict or not (and how to treat addiction) is a descriptive or positive statement. According to ‘Hume’s law’, we cannot derive normative statements (how we ought to act) from descriptive statements (what is) because there is a fundamental difference between how we should act morally and how the world factually is (Hume 2003/1739). Addiction is not morally good or bad; it just is. It is a scientific concept; whether it is present or not is a descriptive/positive statement. Normative conflation of drug use and addiction returns us to a moral model of addiction (Pickard et al. 2015). This model applies a normative orientation to both drug use and addiction and concludes that both are moral failings and should be judged and treated accordingly (Mugford & Cohen 1988). ‘The parallel would be with theorising alcohol usage in general on the basis of what is known about institutionalised alcoholics’ (Mugford & O’Malley 1991: 27).

One of the primary reasons that many harm reduction proponents conflate drug use and addiction is because they tend to have a relativist view of drug use and addiction, influenced by strong social constructionist perspectives (Davies 1997; Dingelstad et al. 1996). ‘Strong’ social constructionism as a philosophical approach tends to suggest that ‘the natural world has a small or non-existent role in the construction of scientific knowledge’ (Collins 1981: 3). Applied here, it proposes that addiction exists as a dominant and historically produced narrative, which would cease to exist if we thought, wrote and spoke about it differently (Davies 1997). ‘Weak’ social constructionism proposes that many of the concepts and approaches to addiction are socially constructed but concedes that there is an underlying reality to some of them; it is perhaps best defined as epistemological pluralism. Proponents of strong social constructionism call addiction a ‘myth’, a phenomenon that does not really ‘exist’ outside our collective perception, and even that ‘drugs’ are social constructions (Davies 1997; Hammersley & Reid 2002). Jacques Derrida, for example, concluded that

the concept of drugs is a non-scientific concept, that it is instituted on the basis of moral or political evaluations: it carries in itself norm or prohibition, and allows no possibility of description or certification. (1995: 229)

While (as other contributors to this edited volume have discussed) the concept of ‘drug’ carries ambiguities and social meanings that impact policy, the differing chemical nature of psychoactive substances and their potential bioactive consequences on a body and psyche must be recognised and respected.

Although there is a cornucopia of perspectives on addiction, which makes a unified understanding a challenging prospect, it is nonetheless erroneous to deny the ontological reality of addiction through adopting a position of epistemic relativism (Du Plessis 2018). There are certainly ways to maintain epistemological plurality while not holding to a strictly realistic metaphysics. Adopting a form of critical or pragmatic realism (Bhaskar 1997; Harre & Moghaddam 2012) conceptualises addiction without submitting to judgemental relativism (giving equal voice or weight to multiple theories or interpretations). In the trenches of the therapist working with addicted populations, and parents who have addicted children, a radically relativist perspective of addiction has little value and purchase, and can even be harmful.

### *Collectivism*

Harm reduction proponents often profess that their approach has ‘roots in humanitarianism and libertarianism’ (Newcombe 1992: 1), which place primary emphasis on individual liberty and individualism. Yet there is also a tendency by many of them to adhere to social justice ideology (Friedman 1998; Pauly 2008), which inherently favours collectivist values and epistemology.<sup>3</sup> For example, groups

like the Harm Reduction Coalition identify as a 'movement for social justice' (Greig & Kershner 2002: 365). Social justice can be defined as a position that aims for the eradication of all forms of social oppression and inequality and, frequently, for one form or other of economic redistribution (Feagin 2001). A harm reduction approach that is informed both by the collectivist values of a social justice orientation and the individualist values of libertarianism can become internally inconsistent.

Several detrimental consequences can result when harm reduction policies are geared towards collectivist instead of individualist aims. The influence of social justice activists has moved the aim of harm reduction away from helping the individual towards that of the 'common good'. Mugford (1993) points to the self-contradictory nature of harm reduction's adherence to its utilitarianism (informed by collectivist values, through which draconian anti-drug strategies have been defended) and its liberal values (based on humanistic and libertarian perspectives, the protection of civil liberties and human rights). Miller's (2001) view is that the primary impulse of many harm reduction programmes has not been out of concern for the individual drug user, but rather for the benefit or protection of the general public and the reduction of healthcare costs. Indeed, for some harm reduction organisations and activist groups, syringe exchange is merely a means to an end, a political activity and not a value-neutral healthcare intervention, even though it is often proclaimed by harm reduction supporters that one of the major strengths of harm reduction is its value-neutral standpoint on drug use and drug users (Newcombe 1992; Riley et al. 1999). Therefore, the incorporation of social justice ideology (or any political ideology) into the harm reduction paradigm contradicts the professed value-free neutrality of harm reduction. In extreme cases, harm reduction threatens to become a 'holy cause', a kind of mirror to the moral righteousness behind the politics driving the 'war against drugs'. As Eric Hoffer, author of *The True Believer*, reminds us:

The burning conviction that we have a holy duty toward others is often a way of attaching our drowning selves to a passing raft. What looks like giving a hand is often a holding on for dear life. Take away our holy duties and you leave our lives puny and meaningless. There is no doubt that in exchanging a self-centred for a selfless life we gain enormously in self-esteem. The vanity of the selfless, even those who practice utmost humility, is boundless.<sup>4</sup> (1951: 23)

The bias of an overly collectivist approach to addiction is also exemplified in research, where nearly all attention has focused on indicators of change that are observable and socially desirable, such as abstaining from drugs, avoiding criminal activity and obtaining gainful employment. It frequently neglects other, more functional, indicators, such as quality of life and satisfaction with treatment, that bear more importance to drug users themselves (Fischer et al. 2001). And, perhaps most crucially, rarely have studies explored the congruence of these outcomes with the perspectives of drug users (Fischer et al. 2001). The currently available

instruments, such as the generic Nottingham Health Profile, were developed for and by professionals without input from drug users or their families and caregivers (Fischer et al. 2001). Their viewpoints are notably missing from the literature. According to Saleebey (1996: 301) oppressed or marginalised populations typically have '[their] stories buried under the forces of ignorance and stereotype'. In the context of this chapter, I would argue that drug users often have 'their stories buried under the forces of ignorance and stereotype' of collectivist thinking.

The largely uncritical acceptance of a social justice ideology by harm reduction proponents and the influence of social justice activists who choose harm reduction as a platform to promote their ideological aims will continue to have a deleterious effect. Social justice activism is a political project; harm reduction approaches should not be driven by collectivist political agendas, and we do not need more 'true believers' (see Strang 1993). Instead, we require the perspectives of people who identify as addicts, empirical research, clinical experience, concern for drug users as individuals and pragmatic health aims. Strang notes that

the true champion of harm reduction is neither for nor against increased civil rights for users ... neither for nor against the legalisation or decriminalisation of drug use ... except insofar as one or other of these choices influences the nature and extent of harms consequent upon the drug use. (1993: 3–4)

### *Determinism*

Due to its libertarian foundations, harm reduction proponents purport to acknowledge the existence and value of human agency. However, due to the influence of social justice ideology, many also tend to ascribe to a radically deterministic view of addiction, based on the premise that social pathologies are addiction's 'root cause'. The pitfall here is when social factors, which of course contribute to patterns of drug use, are considered determinate. Ironically, 'overgeneralization from the [social] deficit model is the fundamental political and theoretical error which underlies prohibitionist strategies' (Mugford & O'Malley 1991: 28).

Social justice proponents often conceptualise society with over-simplified dichotomies of power and status, such as 'oppressor/privileged' and 'oppressed/non-privileged', and present a socially deterministic framework, where drug use has been identified as a symptom of gender oppression (Travis 2009), as a reaction to internalised homophobia (Bobbe 2002) and so forth (Ettorre 2007). It introduces a new moralism by suggesting that problematic drug use might be a 'rational' response to (in some cases generalised) social victimhood. Robert Peralta and Daniela Jauk (2011: 890), for example, postulate that various forms of 'social inequality ... are often sources of substance use and abuse and their noxious corollaries'. Apart from presenting a radically deterministic position, such statements once again conflate

drug use and addiction. Social justice proponents often epistemologically prioritise 'social inequality', in which the individual drug user is the hapless victim of an unfair, deficient or exploitative world. But, as Mugford and O'Malley state:

such a [social] deficit model must be considered against the fact that the fastest growth in drug use arose [in many parts of the world] in the affluent 60s and 70s ... It was the privileged in search of pleasure, not the underprivileged in search of escape who provided the impetus for the development of large-scale cocaine trade. (1991: 24)

Social inequality and pathology '[are] associated with certain kinds of psychotropic drug use in the present period, but it is neither a necessary nor sufficient condition for such use' (Mugford & O'Malley 1991: 24). The truth is that addiction and drug use are 'great equalisers' and cut across all boundaries and identities of class, gender, sexuality, race, culture and religion (Amodeo & Jones 1997).

Bruce Alexander (2008) presents a 'social deficiency model' in his dislocation theory of addiction, where he posits the globalisation of free-market capitalism as the primary etiological factor of addiction on a population level. This is a highly contestable position. While he pushes hard against the physiologically reductionist 'brain disease model' of addiction (represented, for example, by Volkow et al. 2002), he proves himself equally reductionist, reducing the numerous etiological factors of addiction to primarily socioeconomic factors. Alexander is not alone among harm reduction proponents in his critique of biological determinism of the 'brain disease' school (Leshner 1997). Yet, ironically, harm reduction advocacy 'has also extended the "disease" model of addiction, labelling drug users as permanently disabled by their dependence on drugs' (Roe 2005: 247). While building on the early twentieth-century trope of 'enslavement', a deterministic formulation of harm reduction does not provide an emancipatory option for addicts. Instead, it disempowers them and 'can be seen as a move from a problematic "curative" model, through prohibition and treatment, to an equally problematic "palliative" model' (Roe 2005: 248).

In the initial formalisation of harm reduction, it was conceptualised as a needed partner to treatment and prevention. But, due to the influence of activists and 'true believers', it has metamorphosed into a worldview geared to legalisation and 'normalisation' of drug use (Mangham 2008). This is where I strongly disagree with Shaun Shelly (Chapter 9). Nobody would deny that socioeconomic factors influence an individual's behaviour. But when we adopt a deterministic view of human existence, we risk conceptualising individuals as being without agency or without the resilience to overcome obstacles, and thus doing injustice to human nature and the individuals we purport to help.

A socially deterministic view of addiction implies that individuals have little or no free will, are psychologically homogenous, and are at the mercy of their environment. Taken to its logical conclusion, a socially deterministic view would

mean that the entire sociopolitical structure of our world must be changed to effect change on an individual level.<sup>5</sup> There is no doubt that drug users and addicts are often viewed as outsiders and are historically and currently marginalised to varying degrees (see various chapters in this edited volume). But it is misguided to assume this is primarily due to ‘oppressive’ forces inherent in society, as a social justice view would suggest. One could as easily argue that for the addict their ‘marginalisation’ is self-chosen and ‘embraced’ and, as long as ‘society is judging his behavior as an attack on civic unity, he will always remain homo oeconomicus while playing out his societal role as the negative hero’ (Zoja 1989: 15).

Most crucially, by adopting a socially determined view, the consequent solutions will be equally socially determined and at odds with many of our basic human rights. A socially deterministic view of recovery or harm reduction has obvious appeal to governments and pharmaceutical corporations. Personal responsibility and agency have no market value, but victims can be sold many ‘external solutions’ to their ‘problem’, whether through social engineering or pharmaceutical interventions. I find it ironic that although many harm reduction proponents are often critical of ‘Big Pharma’ and the ‘medical-industrial complex’, most of their solutions are pharmacological and medical, such as opioid substitution therapy (OST) and needle exchange programmes for intravenous drug users to reduce the transmission risk of HIV and hepatitis B and C (Single 1995). Harm reduction should not be understood as a paradigm that provides a palliative band-aid for a group of helpless victims at the mercy of their environment, but rather as a choice, among many, for drug users and addicts, as individuals with agency.

### *Concluding thoughts: Untangling the ‘incompatible knots’*

Many harm reduction commentators have argued that the ‘clarification of its defining characteristics and principles was crucial to its successful incorporation into policy and research’ (Keane 2003: 227). This article presented the argument that harm reductionists must look more carefully at the suppositions that underpin their advocacy, and that an uncritical acceptance of the ‘defining characteristics and principles’ of harm reduction can lead to internal inconsistencies, and consequently the harm reduction movement will continue to be beset by conceptual confusion, lack of efficacy and ideological conflicts. It was pointed out that the ‘incompatible knots’ often found in harm reduction theory and interventions can be ameliorated by a critical review of its foundational premises.

Moreover, harm reduction proponents should not present their approach in opposition to recovery-orientated approaches, especially since they are embraced by many, and self-help groups like 12-step programmes are easily accessible and freely available across all socioeconomic axes.<sup>6</sup> The conceptual schism between harm reduction and recovery-orientated approaches, where these approaches are often discussed in either/or terms within the context of strategic drug policy (Ezard 2001; Zajdow 2005), is a

false dilemma. Instead, harm reduction should be an important link in the continuum of recovery-oriented systems of care.<sup>7</sup> But when harm reduction is promoted as a 'better' or 'stand-alone' approach, it can do more harm than good.

In conclusion, I propose that an integrative metaparadigmatic heuristic, through the application of a critical or pragmatic realism (Bhaskar 1997; Harre & Moghaddam 2012) and integral pluralism (Wilber 1995), could help to address the conceptual challenges by untangling some of the 'incompatible knots' in harm reduction theory and practice. In short, this metaparadigmatic heuristic points out that various explanatory views (models and theories) 'co-arise' depending on methodology (methodological pluralism), which 'enacts' a particular reality of drug use, addiction and its harm (ontological pluralism and complexity), while being mediated by the worldview of the subject applying the method (epistemological pluralism) (see Du Plessis 2012; 2014; 2018). The notion of enactment points out that reality is not to be discovered as a 'pre-given' truth, but rather that we co-create or 'co-enact' reality as we use various paradigms to explore it (Wilber 1995). This is not to be confused with a social constructionist position or epistemic relativism. From the above point of view some of the 'incompatible knots' in harm reduction theory are a result of epistemological and ontological reductionism.

The '-isms' of relativism, collectivism and determinism each have an element of truth, but when given epistemological priority over other points of views, dissolve into a reductionist worldview. When we understand that the constructs of drug use, addiction and its harm can be enacted through various epistemological positions, we can appreciate a plurality of positions, without having to revert to relativism and deny its ontological reality. When the socioeconomic and cultural factors are given epistemological priority over individual factors, a deterministic and reductionist view of human nature results. Both perspectives (individual and collective) prioritise certain domains of our human 'being-in-the-world'. Neither of these domains should be given epistemological and ontological priority, otherwise there is the risk of reductionism and creating a battleground of '-isms'. An existential perspective would point out that drug users are always situated 'within-the-world' (Boss 1983; Heidegger 1962/1927). But being-in-the-world is not the same as being-a-victim-in-the-world. A socially deterministic view of harm reduction and recovery provides little emancipatory value and hope for the individual. In contrast, a non-deterministic and resiliency-orientated view of harm reduction and recovery<sup>8</sup> would propose that although we are in-the-world, we have the capacity to overcome the limitations of our 'thrownness'. The latter position is congruent with the experience of millions of individuals in recovery from addiction.



### Notes

- 1 Psychologically, a ‘double bind’ (see Bateson 1972) gives rise to the experience of cognitive dissonance, where the individual often relies on misperception, rejection or refutation of the contradiction to restore psychological consonance (Harmon-Jones 2002).
- 2 For the purposes of this chapter I will use the term ‘drug use’ to make a distinction (and avoid conflation) between ‘substance use’ and ‘substance use disorders’. The term ‘addiction’ normally refers to a broad category of behaviour; this chapter will limit its discussion to substance use disorders as defined in the fifth edition of *Diagnostic and Statistical Manual of Mental Disorders* (APA 2013).
- 3 Individualism is a cultural value that prioritises the interests of the individual over the state or social groups, whereas collectivism prioritises the interests of group or state over the individual (Schwartz 1990).
- 4 Like Hoffer (1951), Karl Popper noted we should be wary of the professed ‘selflessness’ of proponents of collectivist ideologies like social justice: ‘Collectivism is not opposed to egoism, nor is it identical with altruism or unselfishness. A collectivist can be a group-egoist. He can selfishly defend the interest of his own group, in contradistinction to all other groups. Collective egoism or group egoism (e.g. national egoism or class egoism) is a very common thing. That such a thing exists shows clearly enough that collectivism as such is not opposed to selfishness’ (Popper et al. 2008: 65).

This ‘collectivist egoism’ is very prominent among social justice-oriented harm reduction proponents. It often manifests in dogmatism, and ‘insulates itself against criticism, regards non-believers as a threat, and refuses to examine evidence coming from outside the closed circle of gratifying ideas’ (Rodger Scruton, personal communication, 5 August 2018).

- 5 This is a dangerous point of view, as clearly articulated by Popper in his book *The Poverty of Historicism* (2002).
- 6 Many harm reduction proponents are critical of 12-step programmes, despite the clear benefits that many have found and its ubiquitous and ‘grassroots’ approach that makes it available regardless of socioeconomic background. Unfortunately, it is often the case that those ‘who write disparagingly of the organisation do so without the benefit of attending AA meetings or familiarising themselves with its working on more than a passing, superficial, or purely analytical level. They fail to understand the subtleties of the AA programme and often erroneously attribute qualities and characteristics to the organisation that are one-dimensional and misleading’ (Flores 1997: 249).
- 7 Ray Baker states that in recovery-orientated systems of care ‘the locus of control or responsibility shifts from the doctor or therapist to the patient or consumer, from passive victim of disease complying with expert directives to motivated survivor adhering to a self-directed recovery plan guided by the advice of the knowledgeable professional. Families and social groups are included in recovery planning and engagement with recovering peers within mutual aid recovery groups is encouraged’ (2016: 9).
- 8 See, for example, integrated recovery meta-therapy, Du Plessis 2018.

## References

- Alexander BK (2008) *The globalisation of addiction: A study in poverty of the spirit*. Oxford: Oxford University Press
- Amodeo M & Jones LK (1997) Viewing alcohol and other drug use cross-culturally: A cultural framework for clinical practice. *Families in Society: The Journal of Contemporary Human Services* 78(3): 240–254
- APA (American Psychiatric Association) (2013) *Diagnostic and statistical manual of mental disorders* (DSM-5). Arlington: American Psychiatric Association
- Baker R (2016) Recovery medicine: Lessons for healthcare from the addiction recovery movement. Paper prepared as part of a submission to the British Columbia Government Select Standing Committee on Health, July. <https://www.leg.bc.ca/content/CommitteeDocuments/40th-parliament/5th-session/health/Submissions/20160712-DrRayBaker.pdf> (accessed 13 August 2019)
- Bateson G (1972) *Steps to an ecology of mind: Collected essays in anthropology, psychiatry, evolution, and epistemology*. Chicago: University of Chicago Press
- Bhaskar R (1997) *A realist theory of science* (2nd edition). London: Verso
- Bobbe J (2002) Treatment with lesbian alcoholics: Healing shame and internalized homophobia for ongoing sobriety. *Health & Social Work* 27: 218–222
- Boss M (1983) *The existential foundations of medicine and psychology*. New York: Jason Aronson
- Collins HM (1981) Stages in the empirical program of relativism: Introduction. *Social Studies of Science* 11(1): 3–10
- Davies J (1997) *The myth of addiction*. Amsterdam: Harwood Academic Publishers
- Derrida J (1995) *Points: Interviews, 1974–1994*. California: Stanford University Press
- Dingelstad D, Gosden R, Martin B & Vakas N (1996) The social construction of drug debates. *Social Science and Medicine* 43(12): 1829–1838
- Du Plessis GP (2012) Toward an integral model of addiction: By means of integral methodological pluralism as a metatheoretical and integrative conceptual framework. *Journal of Integral Theory and Practice* 7(3): 1–24
- Du Plessis GP (2014) An integral ontology of addiction: A multiple object existing as a continuum of ontological complexity. *Journal of Integral Theory and Practice* 9(1): 38–54
- Du Plessis GP (2018) *An integral foundation of addiction and its treatment: Beyond the biopsychosocial model*. Tuscan, AZ: Integral Publishers
- Erickson PG (1995) Harm reduction: What it is and is not. *Drug and Alcohol Review* 14(3): 283–285
- Ettorre E (2007) *Revisioning women and drug use: Gender power and the body*. New York: Palgrave
- Ezard N (2001) Public health, human rights and the harm reduction paradigm: From risk reduction to vulnerability reduction. *International Journal of Drug Policy* 12: 207–219
- Feagin JR (2001) Social justice and sociology: Agendas for the twenty-first century: Presidential address. *American Sociological Review* 66(1): 1–20

- Fischer B, Rehm J & Kim G (2001) Whose quality of life is it, really? *British Medical Journal* 322: 1357–1360
- Flores PJ (1997) *Group psychotherapy with addicted populations*. Binghamton, NY: The Haworth Press
- Friedman SR (1998) The political economy of drug-user scapegoating – and the philosophy and politics of resistance. *Drugs: Education, Prevention, and Policy* 5(1): 15–32
- Gadamer HG (1975/1960) *Truth and method*. New York: The Crossroad Publishing Co
- Greig A & Kershner S (2002) Harm reduction in the USA: A movement toward social justice. In B Shepard & R Hayduk (Eds) *CT UP to the WTO: Urban protest and community building in the era of globalization*. New York: Verso
- Hammersley R & Reid M (2002) Why the pervasive addiction myth is still believed. *Addiction Research and Theory* 10: 7–30
- Harmon-Jones E (2002) A cognitive dissonance theory perspective on persuasion. In J Price Dillard & M Pfau (Eds) *The persuasion handbook: Developments in theory and practice*. Thousand Oaks, California: Sage Publications
- Harre R & Moghaddam FM (2012) *Psychology for the third millennium: Integrating cultural and neuroscience perspectives* (New York edition). Thousand Oaks, California: Sage Publications
- Heidegger M (1962/1927) *Being and time* (trans. J Macquarrie & E Robinson). New York: Harper
- Hoffer E (1951) *The true believer*. New York: Harper & Row
- Hume D (2003/1739) *A treatise of human nature*. New York: Dover Publications
- Keane H (2003) Critiques of harm reduction, morality and the promise of human rights. *Integrational Journal of Drug Policy* 14: 227–232
- Laing RD (1960) *The divided self: An existential study in sanity and madness*. Harmondsworth: Vintage Book Editions
- Leshner AI (1997) Addiction is a brain disease, and it matters. *Science* 278(5335): 45–47
- Mangham CR (2008) Mingling activism with policy influence: Harm reduction ideology and the politicisation of Canadian drug policy. *Journal of Global Drug Policy and Practice* 1(41). [https://www.researchgate.net/publication/265317928\\_Mingling\\_Activism\\_with\\_Policy\\_Influence\\_Harm\\_Reduction\\_Ideology\\_and\\_the\\_Politicisation\\_of\\_Canadian\\_Drug\\_Policy](https://www.researchgate.net/publication/265317928_Mingling_Activism_with_Policy_Influence_Harm_Reduction_Ideology_and_the_Politicisation_of_Canadian_Drug_Policy) (accessed 18 February 2018)
- Marlatt GA (1998) *Harm reduction: Pragmatic strategies for managing harm-risk behaviors*. New York: The Guilford Press
- Miller P (2001) A critical review of the harm minimization ideology in Australia. *Critical Public Health* 11(2): 167–178
- Mugford S (1993) Harm reduction: Does it lead where its proponents imagine? In N Heather (Ed.) *Psychoactive drugs and harm reduction: From faith to science*. London: Whurr Publishers
- Mugford S & Cohen P (1988) Pathology, pleasure, profit and the state: Toward an integrated theory of drug use. Paper presented to the 1988 Annual Conference of the Australian and New Zealand Society of Criminology, University of Sydney, 22 August

- Mugford S & O'Malley P (1991) Heroin policy and deficit models: The limits of left realism. *Crime, Law and Social Change* 15(1): 19–36
- Newcombe R (1992) The reduction of drug-related harm. In P O'Hare, R Newcombe, A Matthews, EC Buning & E Drucker (Eds) *The reduction of drug-related harm*. London: Routledge
- Pauly B (2008) Harm reduction through a social justice lens. *International Journal of Drug Policy* 19: 4–10
- Peralta RL & Jauk D (2011) A brief feminist review and critique of the sociology of alcohol-use and substance-abuse treatment approaches. *Sociology Compass* 5(10): 882–897
- Pickard H, Ahmed SH & Foddy B (2015) Alternative models of addiction. *Frontiers in Psychiatry* 6, Article ID 20. <http://dx.doi.org/10.3389/fpsy.2015.00020>
- Popper, KR (2002) *The poverty of historicism*. London: Routledge & Kegan Paul
- Popper KR, Shearmur J & Turner PN (2008) *After the Open Society: Selected social and political writings*. London and New York: Routledge
- Ricœur P (1981) *Hermeneutics and the human sciences*. Cambridge: Cambridge University Press
- Riley D, Sawka E, Conley P, Hewitt D, Mitic W et al. (1999) Harm reduction: Concepts and practice. A policy discussion paper. *Substance Use and Misuse* 34(1): 9–24
- Roe G (2005) Harm reduction as paradigm: Is better than bad good enough? The origins of harm reduction. *Critical Public Health* 15(3): 243–250
- Saleebey D (1996) The strengths perspective in social work practice: Extensions and cautions. *Social Work* 41: 296–305
- Schwartz SH (1990) Individualism–collectivism: Critique and proposed refinements. *Journal of Cross-Cultural Psychology* 21: 139–157
- Single E (1995) Defining harm reduction. *Drug and Alcohol Review* 14: 287–290
- Souleymanov R & Allman D (2016) Articulating connections between the harm-reduction paradigm and the marginalisation of people who use illicit drugs. *British Journal of Social Work* 46(5): 1429–1445
- Strang J (1993) Drug use and harm reduction: Responding to the challenge. In N Heather (Ed.) *Psychoactive drugs and harm reduction: From faith to science*. London: Whurr Publishers
- Travis T (2009) *The language of the heart: A cultural history of the recovery movement from Alcoholics Anonymous to Oprah Winfrey*. Chapel Hill: University of North Carolina Press
- Volkow ND, Fowler JS & Wang GJ (2002) Role of dopamine in drug reinforcement and addiction in humans: Results from imaging studies. *Behavioral Pharmacology* 13: 355–366
- Weatherburn D (2009) Dilemmas in harm minimization. *Addiction* 104(3): 335–339
- Wilber K (1995) *Sex, ecology and spirituality: The spirit of evolution*. Boston, MA: Shambhala
- Zajdow G (2005) What are we scared of? The absence of sociology in current debates about drug treatments and policies. *Journal of Sociology* 41(2): 185–199
- Zoja L (1989) *Drugs, addiction and initiation: The modern search for ritual*. Boston, MA: Sigo