Selections of Reality

Applying Burke's Dramatism to a Harm Reduction Policy

Järvinen, Margaretha; Miller, Gale

Published in:
International Journal of Drug Policy

DOI:
10.1016/j.drugpo.2014.02.014

Publication date:
2014

International Journal of Drug Policy 25 (2014) 879–887

Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Research paper

Selections of reality: Applying Burke's dramatism to a harm reduction program

Margaretha Järvinen[a,c,1], Gale Miller[b,*]

[a] Department of Sociology, University of Copenhagen, Øster Farimagsgade 5, Bld. 16 DK-1014 Copenhagen K, Denmark
[b] Department of Social and Cultural Sciences, Marquette University, PO 1881, Milwaukee, WI 53201-1881, USA
[c] SFI - The Danish National Center for Social Research, Herluf Trolles gade 11, 1052 Copenhagen K, Denmark

ARTICLE INFO

Article history:
Received 9 December 2013
Received in revised form 21 February 2014
Accepted 25 February 2014

Keywords:
Dramatism
Drug addiction
Ethics
Harm reduction
Governmentality
Methadone maintenance

ABSTRACT

Kenneth Burke's dramatistic perspective is applied to accounts told by staff members working in methadone maintenance treatment centres in Copenhagen, Denmark. As a harm reduction strategy, methadone maintenance is designed to reduce the costs and dangers of chronic long-term drug use by providing substitution (methadone) treatment to users. Burke's dramatistic perspective calls attention to the recurring relationships among rhetorical elements within accounts of social reality. The elements form a pentad: scene, purpose, agent, agency and acts. Our analysis examines how the ideal of governmentality is constructed by staff members to justify and criticize the operations of the Copenhagen methadone maintenance program. For Burke, social criticism involves rearranging pentadic elements to produce new meanings and justify alternative actions. We discuss how Burke's perspective might be developed by sociologists as a critical dramatism of social policies and programs.

We apply Kenneth Burke's (1969a, 1969b) dramatistic perspective to a harm reduction policy in this paper. Harm reduction has over the past 15–20 years become the dominant approach to drug problems in many Western countries (Denning, 2012; O'Hare, Newcombe, Matthews, Buning, & Drucker, 1992; Riley & O'Hare, 2000). Harm reduction involves creating safer contexts for drug use, thus reducing its negative consequences (Denning, Little, & Glickman, 2004; Kleiman, Caulkins, & Hawken, 2011; Järvinen, 2008). Examples are clean needles services, instructions on safe drug injection, heroin prescription for severely addicted opiate users, 'injection rooms' for clean drug intake – and most important: substitution treatment (with methadone or buprenorphine) for heroin addicts. Such programs represent a significant shift in contemporary orientations to personal risk and social responsibility.

Burke's (1969a) dramatism focuses on how persons' accounts of social reality orient to culturally shared narrative concerns involving definitions of situations, actors' motivated actions and the consequences of actors' actions. These concerns are arranged differently in diverse accounts. The accounts represent systems of meaning that shape 'our understanding of the world around us in ways we cannot escape' (Overington, 1977a: 140). Burke stresses both the necessity of accounts and their limitations in making sense of social issues. He explains that people

> seek for vocabularies that will be faithful *reflections* of reality. To this end they must develop vocabularies that are *selections* of reality. And every selection of reality must, in certain circumstances, function as a *deflection* of reality (Burke, 1969a: 59).

Unlike other fields, Burke's work has been largely undeveloped in sociology (Kenny, 2008). Notable exceptions include Manning's (1977, 1982) analyses of policing as dramatic action, Hopper's (1993) study of accounts about marital dissolution, Brown's (1977, 1987) rhetorical analyses of the logic of social knowledge, and Edelman's (1977, 1988) explorations of political symbolism. Particularly significant is Gusfield's (1976) study of the rhetoric of drinking and driving. Gusfield (1976: 20) examines how scientific reporting involves selective emphasis on some factors over others and how scientific rhetoric persuades 'but only by presenting an external world to the audience and allowing that external reality to do the persuading'.

The underdevelopment of the sociological implications of Burke's writings is puzzling given that his work resonates with several perspectives in interpretive sociology; including

* Corresponding author. Tel.: +1 414 964 1980.
E-mail addresses: mj@soc.ku.dk (M. Järvinen), gale.miller@marquette.edu (G. Miller).
[1] Tel.: +45 353 23274.

http://dx.doi.org/10.1016/j.drugpo.2014.02.014
0955-3959/

Geertz's (1983) approach to culture, aspects of ethnomethodology (Garfinkel, 1967), and Berger and Luckman's (1967) treatise on the social construction of reality (Kenny, 2008). Further, Burke's perspective is directly implicated in Mills' (1939, 1940) and Gerth and Mills' (1953) analyses of language, motives and social structure, and Goffman's (1959, 1961, 1963) approach to self, dramaturgy and social institutions (Genter, 2010). One purpose of this paper is to show how Burke's dramatism brings together themes in interpretive sociology and extends beyond them as a framework for developing a critical, but still interpretive, approach to social policy.

Focus and organization

Fry, Knoshnood, Power, and Sharma (2008: 1) have noticed an 'awakening' in recent years to moral questions associated with harm reduction programs. They explain that increasingly public health officials are openly aligning with social values and defining their practices as both practical and ethical responses to social issues. Fry et al. (2008: 1) explain: 'In this environment, a range of scientific, political and ethical considerations converge, many of which cannot be resolved by scientific evidence alone.' We explore these issues by dramatistically analysing the ethical claims voiced by staff members in the methadone treatment program in Copenhagen, Denmark. We analyze staff members' claims as local formulations of the ethics of methadone treatment. The claims define the boundaries within which staff members engage the ethical implications of their practices. They also form a starting point for our own dramatistic criticism of methadone treatment in Copenhagen. Dramatistic criticism seeks to expand the range of perspectives included in discussions of social issues (Burke, 1934, 1973). Such discussions are also sites for assessing ethical orientations associated with social policies and programs.

Of course, Burke's dramatism represents only one approach to the ethics of harm reduction. Pauly's (2008) application of social justice perspectives to harm reduction and Christie, Groarke, and Sweet's (2008) assessment of this policy from the standpoint of utilitarianism, deontology and virtue ethics are notable alternative approaches. Pauly makes the case for including consideration of the root causes of substance abuse and of the negative consequences of drug policies in discussions about harm reduction. Christie et al. argue for using virtue ethics to bring concern for the moral character of drug users into policy discussions. Our use of Burke's dramatism in analysing staff member accounts of a harm reduction policy involves a different type of expansion of public discussions. First, we treat staff members as practical ethicists who orient to their own moral concerns and practical experiences in assessing the ethics of harm reduction. These concerns and experiences are often overlooked in more abstract policy discussions. Second, we analyze the narrative processes through which staff members construct differing ethical assessments. Finally, Burke's dramatism is a standpoint for pointing to alternative narratives that might enhance future discussions of the ethics of harm reduction.

We develop these issues in the rest of the paper. Next, we review the practical and ethical issues noted by drug researchers about substitution as a form of harm reduction, and introduce the methods and data of our study. We then turn to Burke's dramatistic perspective on ethics and apply it to staff members' justifications and criticisms of methadone treatment in Denmark. Finally, we discuss dramatism as a critical perspective, and apply it to our findings.

Ethics and harm reduction

Harm reduction is part of a neoliberal trend stressing 'governmentality' in human service work (Foucault, 1988; Larner, 2000; Bacon & Seddon, 2013). The neoliberal strategy treats individuals as self-governing choice-makers who are capable of 'shaping their own lives through the choices they make among the forms of life available to them' (Rose, 1998: 226). Harm reduction has significantly changed how goals, performance measures and clients are defined in addiction treatment settings. Traditionally, addiction treatment has emphasized the goal of abstinence, even when it involved repeated and expensive treatments. In contrast, harm reduction treatment focuses on alleviating the consequences of illegal drug use, without necessarily reducing users' drug intake (Riley & O'Hare, 2000). Newcombe (1992: 1) explains:

> Harm reduction has its main roots in the scientific public health model, with deeper roots in humanitarianism and libertarianism. It therefore contrasts with abstentionism, which is rooted more in the punitive law enforcement model and in medical and religious paternalism.

Newcombe's statement draws attention to how science and other social values are linked in harm reduction policies. Such connections are basic to governmentality in neoliberal societies for Rose (1989). Neoliberalism involves balancing a tolerance for diverse orientations to personal conduct while privileging scientific definitions of truth and health. The technologies of governmentality operate to 'align political, social, and institutional goals with individual pleasures and desires, and with the happiness and fulfilment of the self' (Rose, 1989: 257). The sociological significance of harm reduction programs lies in how particular vocabularies and techniques are used to justify institutional interventions that are said to respect program participants' right to freely choose their life styles. This claim organizes debates on the ethics of harm reduction policies.

The connection between scientific and humanitarian values is also basic to proponents' claims that the efficacy and ethics of harm reduction policies are linked. Proponents of harm reduction depict them as effective and ethical because they treat people as autonomous subjects who act strategically to reach their own goals. Within harm reduction programs, then, ethics drive practices because participants are allowed to act in accordance with their preferred life styles (Moore & Fraser, 2006). Aceijas (2012) adds that opiate substitution programs meet the ethical standards of bioethics, while also proving to be effective in improving participants' lives.

Hathaway and Tousaw (2008) state that ethical justifications are necessary, because critics often ignore empirical evidence of harm reduction's effectiveness (Buchanan, Ford, & Singer, 2003). They also note that humanitarian appeals resonate with the public. This is perhaps why neoliberal definitions of subjecthood predominate in declarations of intent for drug substitution programs, public debates on drug addiction, health promotion materials for safe drug use – and among drug users themselves who struggle to live up to the demands of responsible self-governance (Fraser, 2004, 2006; Moore & Fraser, 2006). Finally, Gomart (2002a, 2002b, 2004) portrays substitution treatment as a 'generous constraint' and liberating alternative to traditional forms of treatment. Whereas abstinence-oriented treatment, involves a dualistic model of subjecthood – 'an individual either acts as a full rational agent or the drug acts on him/her' (Gomart, 2002b: 518) – substitution treatment mediates users' autonomy and dependence, accepting that dependence on one drug may contribute to users' freedom from other drugs.

Others, however, state that harm reduction proponents' claims overlook troubling practical and ethical issues associated with these programs. For example, Kleinig (2008) notes that harm reduction advocates' assumption that minimizing the costs of persons' risky behaviour is necessarily desirable or that all such risks are equally worrisome. He adds that proponents are inattentive to

risks resulting from harm reduction measures themselves and to ethical issues associated with the implementation of harm reduction policies at the local level. Sociological studies of substitution treatment programs have raised other practical and ethical issues. For example, Moore and Fraser (2006) point out that while substitution treatment may empower some participants, it may also obscure the unequal circumstances of drug users' lives. These circumstances may impede participants' attempts to act responsibly and rationally, the result being that they are 'further stigmatized by the perception that they are failing the test of neoliberalism' (Moore & Fraser, 2006: 3045).

Researchers also note that neoliberal policies dichotomize drug use and users by defining illegal drug use as chaotic and substitution treatment as representing order and normalcy (Fraser & Moore, 2008). Bourgois (2000: 169) explains that a heroin addict 'is defined – and often acts – as a self-destructive, irresponsible criminal', whereas a long-term methadone client 'is defined – and often acts – as a worthy, well-disciplined citizen/patient'. This is how 'dope' becomes 'medication', 'addicts' become 'patients' and 'addiction' becomes 'treatment' (Agar, 1977; Bourgois, 2000). Fraser and Valentine (2008: 47) add that, within popular discourses on substitution treatment, 'Heroin addiction operates as the "werewolf", as it were, and methadone as the mythical, almost sacred ammunition'.

Methods and data

The Copenhagen methadone treatment program expresses policy-makers' growing dissatisfaction with traditional, abstinence-oriented treatment for heroin addicts. In the past 15 years, drug-free treatment (based on different psychological or 12-step approaches) has diminished considerably in Denmark. The vast majority of opiate users are now offered long-term methadone (or buprenorphine) treatment in combination with social services (help to obtain income support, health services and housing). In 2011, around 8000 heroin users were in – more or less permanent – substitution treatment in Denmark whereas a few hundred were in drug-free treatment (The Danish National Health Board, 2011).

The aim of substitution treatment in the Danish methadone program is to stabilize clients' lives by reducing the ups and downs of intoxication and withdrawal symptoms, and by diminishing clients' need to support illegal drug use through criminal activities (City of Copenhagen, 2006). Substitution treatment should ideally improve clients' life quality by helping them maintain family relationships, enrol in education programs and seek employment. Methadone treatment is intended to 'free' participants to live socially responsible lives because they are no longer constrained by their cravings for illegal substances. The program is designed to prepare participants to live self-governing lives, while recognizing that many of them will continue to use illegal drugs. Substitution treatment is defined as a rational and humanistic approach to helping participants avoid further 'social deroute' by stabilizing their condition and making their lives less chaotic (City of Copenhagen, 2006).

The substitution treatment program in Copenhagen covers most of the city's registered heroin addicts who are enrolled at district treatment centres where they receive methadone (or buprenorphine). At the time of the interviews there were 14 outpatient centres for drug addicts in Copenhagen. Sixteen staff members from 11 different centres were interviewed. Excluded were two temporary projects and a family treatment centre. The interviewees had different professional backgrounds: six were social workers, six were social education workers, two were psychologists and two had other educations. Many interviewees had long experience with addiction treatment, with the average number of years working in this sector being seven years – the most experienced interviewee had worked with drug addicts for 24 years, the least experienced had worked in the sector for two years.

The interviews were designed to facilitate staff members' reflections on their experiences in the methadone treatment program. The interview-guide was semi-structured. It included questions worked out beforehand but allowed for new themes to be raised by both the interviewer and staff members. The interview themes focused on the treatment goals at the centres, the principles of harm reduction, practical contents of the treatment offered, and staff members' conceptions of the participants' problems and solutions to them. All interviews were conducted at the treatment centres. They were audio-recorded and transcribed in full length.

Contact was established through an e-mail (and a later phone-call) to the leaders of the centres, describing the research project, and asking them to appoint one or two staff members for participation. In two cases the leaders themselves were interviewed but most suggested another staff member, typically a person with longer experience in drug addiction treatment. All interviewees (the two leaders included) were 'front-line staff' in the sense that they had direct contact with the clients. While all of the interviewees expressed support for the goals of harm reduction, the most critical viewpoints on the program's implementation were found among three regular staff members. The critics were all women and relatively new in addiction treatment; they had worked in the sector for two, three and five years respectively. Apart from that, there were no systematic differences between them and the rest of the interviewees.

Accounts as ethical dramas

The starting point for dramatism is Burke's (1969a) claim that life is drama. This straightforward statement orients to a larger set of assumptions and claims making up Burke's perspective on language and the construction of social realities. For Burke (1969a, 1984a), the dramas of human life are inseparable from people's capacity for symbolic action, particularly their uses of language. People use language to both name aspects of their worlds and to form orienting strategies toward them. People's linguistic strategies define the structure and elements of situations, and "contain an attitude toward them" (Burke, 1973: 1). The strategies are also contexts for addressing such ethical questions as

> What should we be doing? What are we doing? What is the good life? What means are good means for pursuing the good life? (Crusius, 1999: 77)

All human accounts of reality involve ethical orientations for Burke. He adds that life involves making ethical choices under circumstances that are not fully revealed to people, and those aspects of life that are evident often appear to be inconsistent, directionless and morally ambiguous (Burke, 1984b; Rueckert, 1994). Burke's perspective includes both realist and relativist aspects (Heath, 1986). People construct social realities in making sense of their life circumstances. Once constructed, however, social realities operate as new circumstances that people manage by socially constructing additional realities. Burke offers dramatism as a strategy for examining how social realities evolve. It is a heuristic device that focuses analysts' attention on the narrative processes involved in socially constructing realities.

For Burke (1969a) accounts involve five themes that, together, form a pentad (Burke, 1969a). The pentad consists of the *scene* (the background or context); *purpose* (why agency is performed); *agency* (the means used to reach certain goals); *agent* (the performing subject); and *act* (what the agent does). The term *agent* includes personal properties that may be 'assigned a motivational

value' such as ideas, will, fear, intuition or state of mind in general (Burke, 1969a: xx). Each point of the pentad is implicated in formulations of social reality even when they are unspoken. For Burke, words *qua* words become justifications for action because of the connotations that cluster narrative themes together to form accounts (Overington, 1977b: 134).

Dramatism emphasizes the relationship between dyadic points in the pentad, called 'ratios' (Burke, 1959, 1969a). Although the five points (scene, agent, purpose, agency and act) allow for ten ratios in all, Burke singles out some as decisive in organizing rhetorical formulations of social reality. Especially important are the scene-agent and scene-act ratios which are analogous to the relationship between implicit and explicit. Scene implicitly contains all that the narrative will make explicit through the actions of the agent. Burke (1969a: 7) explains that, 'One could not deduce the details of the action from the details of the setting, but one could deduce the quality of the action from the quality of the setting.' These ratios also work in reverse, that is, depictions of acts and agents call for scenes that fit with them. Hence, there are two possible relations between scene-agent and agent-act. One possibility is that the scene calls for a 'certain kind of acts which makes for a corresponding kind of agent, thereby likening agent to scene' (Burke, 1969a: 19). Another possibility is that agents act in accordance with their purposes, and are successful in changing the scene in a desired direction (act-scene ratio) thus creating harmony between themselves and the scene (agent-scene ratio).

Particular formulations of the pentad form dramatic contexts for engaging practical issues as ethical choices (Crusius, 1999; Rueckert, 1982). Scene-agent and scene-act ratios represent logics for connecting events, people and objects into coherent orientations to social reality (Overington, 1977a). How the logics are articulated varies based on which ratio is privileged within a set of claims and which element within a ratio is emphasized. Individuals and groups selectively organize otherwise discrete events into socially meaningful patterns as they define and link elements of the pentad into accounts of social reality (Burke, 1984b). Ethical concerns are an ever present aspect of socially constructed realities because ethics are

> linked with the communicative, particularly when we consider communication in its broadest sense, not merely as the purveying of information, but also as the sharing of sympathies and purposes, the doing of acts in common (Burke, 1984b: 250).

Burke's dramatistic perspective resonates with and departs from Mills' (1940) analysis of vocabularies of motive, Goffman's (1959) dramaturgical perspective and ethnomethodologists' (Garfinkel, 1967) concern for accounts in everyday life. Both Burke and Mills treat motives as linguistic constructions that signal persons' orientations to situations and action. Unlike Mills, Burke offers the pentad as an analytic framework for comparing and contrasting diverse vocabularies of motives and the ethical orientations associated with them. Burke and Goffman share a fascination with how self and moral order are constituted in the dramatic rituals of everyday life. Goffman departs from Burke's conceptualization of life as drama in casting his perspective as a metaphor, particularly a theatrical metaphor. The theatrical metaphor points to Goffman's emphasis on scene in analysing how social realities are constructed through impression management. This is significantly different than Burke's treatment of scene as only one element in the pentad, an element that is not always privileged in accounts of reality.

Burke's dramatism resonates with the ethnomethodological approach to account-making, because both explore the practical reasoning processes used by people in making sense of their worlds. They also treat language and practical reasoning as actions that orient to the spoken and unspoken meanings associated with social contexts. For ethnomethodologists, [t]his involves viewing an utterance against a background of *who* said it, *where* and *when*, *what* was being accomplished by saying it and in light of what possible *considerations* and in virtue of what *motives* it was said. (Heritage, 1984: 139–140)

It is noteworthy that all five elements of the pentad are included in Heritage's statement. Finally, dramatism and ethnomethodology are similar in stressing the vulnerability of representations of events and issues. Ethnomethodologists emphasize the ad hoc practices that people use in protecting and repairing constructed realities. Burke departs from ethnomethodology in focusing on the challenges to accounts of reality. Specifically, Burke (1984b) explains that all claims (statements) are susceptible to correction by alternative formulations of the pentad (counterstatements). Counterstatements advance competing definitions of the facts and ethical choices at stake in situations. Once expressed, counterstatements become statements that are subject to challenge by new counterstatements.

This is perhaps Burke's greatest contribution to interpretive sociology. Dramatism is a framework for analysing accounts – and the ratios within them – and for developing counterstatements to them. These are related steps in doing dramatistic criticism. Dramatistic criticism differs from much of social criticism (including that of Mills and Goffman) in that it does not involve debunking other formulations of reality. Dramatistic critics recognize that all representations are incomplete and stand in need of correction through counterstatements. Within dramatistic criticism, analyses of others' statements and counterstatements are used to foster new arrangements of the pentad involving alternative orientations to issues. We develop this approach by examining staff member accounts of methadone treatment programs in Copenhagen.

Constructing the harm reduction pentad

All of the staff members affirmed the harm reduction strategy explaining that drug treatment should address the needs and wishes of participants, regardless of participants' preferences for abstinence vs. continued drug use. Except for three critics, staff members also stated that this is how the Danish methadone treatment program works. It is a coherent strategy that integrates scene, purpose and agency with agents and their acts. Staff members regarded methadone treatment as ethical because it empowers participants to pursue personally satisfying life projects. They also contrasted it with 'traditional' (abstinence-focused) treatment which they described as offering participants' no choice but to adapt to program demands (cf. Gomart, 2002a, 2002b and Moore & Fraser, 2006 for similar 'contrast'- definitions of substitution treatment).

Of all the possible ratios between the points of the pentad, we focus on the ones that were most prominent in staff members' accounts: agent-scene, purpose-agency, and agency-act. The storylines describing these ratios highlight different aspects of staff members' understandings of harm reduction and the traditional treatment scene, the purpose and contents of treatment (agency), and program participants as specific kinds of agents capable of certain acts.

Agent-scene

Interviewees portrayed program participants as distinctive agents based on the severity of their drug use and related personal characteristics, factors that rendered them largely incapable of achieving 'normal' lives. Peter, a social worker, stated:

> Drugs are a necessity for them. They need their medicine [methadone] of course, and they need their side abuse [illegal

> drugs used in addition to methadone], because without drugs they wouldn't feel normal anyway. They need their kicks now and then because otherwise they just sit at home, hiding from the rest of the world. If they became absolutely stable, with or without medicine, they couldn't stand it.

This statement underscores the correspondence between agents and scene in staff members' accounts, casting methadone treatment as ethical because it accepts participants as chronic addicts. Program participants were also portrayed as having a distinct orientation to time. Consider the following statement by Niels, a leader of one of the centres:

> Their focus in life is very much on satisfying their own needs here and now. They are not like us in that sense [. . .] they typically have a very limited time frame. They are not interested in the future in the normal sense. I have heard or read somewhere that drug users have a time frame of maximum six hours.

It is not clear whether interviewees saw participants' orientation to time as a cause, consequence or both cause and consequence of their drug dependence, but they were clear about the implications of participants' combined need for drugs and orientation to time. They explained that participants' desire for drugs overrides all other issues in their lives. As Steen, a social worker, stated, 'But even if their greatest wish is to see their children again, they aren't capable of doing it. They can't keep appointments. They can't keep promises.' Staff members also emphasized how chronic drug use saps participants of all ambitions in life. For example, Trine, a social education worker, described participants as 'old, run-down, resigned impossibles,' and recommended that they be left 'in peace with their drugs from now on and until they die.'

These depictions of chronic drug users as agents with specific needs and orientations form a background for contrasting methadone maintenance with traditional drug treatment scenes of the past. Staff members stated that traditional treatment failed to take account of the practical reality of long-term chronic drug use; the most important failure being traditional treatment's insistence that all participants adopt abstinence as their goal. They added that the unrealistic assumptions of traditional treatment justified a 'top-down system, a hierarchical system where the users had nothing to say,' a system in which abstinence was 'a dogma that all users had to surrender to, whether they wanted it or not' (Søren, social education worker).

Other staff members cast traditional treatment as unrealistic by emphasizing the severity of program participants' addictions. For example, Trine, a social education worker, described the methadone program as 'the end station,' noting that 'there is very little flow in our system' and 'there are only vacancies here when somebody dies.' This was not a negative statement but a description of the fact that opiate users are chronic addicts and want to be treated as such. Kim (a therapist with experience in multiple treatment settings) added that 'Ninety-five per cent of the opiate addicts in Denmark need long-term or permanent substitution treatment.'

These accounts display how staff members constructed two parallel storylines in justifying methadone treatment as ethical. One storyline focused on the distinctive characteristics of program participants as agents, and the second on how the scene of traditional treatment ignores participants 'true' needs and capacities. These formulations of the agent-scene ratio are also orientations to other elements of the pentad. The first storyline asserts that program participants and the scene of methadone treatment share common purposes because the act of taking methadone fosters participants' self-governance, albeit a self-governance restricted by participants' severe and long-term addictions. The second storyline casts traditional treatment as a scene for imposing program purposes on participants by insisting that they act in ways that are beyond their possibilities. Hence, traditional treatment is both unethical and ineffective.

Purpose-agency

Staff members further developed the contrast between methadone and traditional treatment in discussing the purposes and contents (agency) of these programs. Of particular note was their unwillingness to define clear treatment goals in methadone maintenance. For example, Trine, a staff member with extensive experience in addiction treatment, answered the interviewer's question about her centre's treatment goals in this way:

> Treatment goals? Well, we don't see ourselves as judges or as somebody who knows what is best for the users. Treatment goals are just beautiful words on a paper [. . .] Our users are in charge of their own life.

Interviewees explained that their scepticism about goals was related to their association of this concept with traditional addiction treatment. They added that the influence of goal-focused treatment is so strong that many clients who have been in the old system do not understand that things have changed. These clients continue to say what they have been taught in traditional treatment. Steen, a social worker, explained:

> Many of our users are a bit petite bourgeois, and that's the effect of things people have told them in the past. They want these 'normal' things because they can see that they work for the rest of us but usually they haven't formulated the goals themselves. They say so because that's what they have been told they should strive for in order to be accepted by others.

This is perhaps a reason why staff members devoted so much attention to traditional drug treatment in the interviews. They characterized it as an intrusive presence in their interactions with participants, and said they had to modify their treatment methods when participants insisted on unrealistic goals. Staff members emphasized that letting go of unrealistic goals was a vital step in helping participants recognize their 'true' needs and desires. For example, Benita, a social education worker, explained how she persuaded a participant to give up on becoming 'a better dad for his children', and then asked: 'So, why do they formulate these goals, why make this kind of treatment plan for him? It only hurts him.' She also noted the participant's 'relief' when he did not have to pursue it anymore.

Staff members emphasized the need to replace treatment goals with a focus on effectively managing participants' lives, a concern that is basic to harm reduction policies. As Søren, a social education worker, stated, 'It's all about harm reduction here, alleviating the consequences of their drug use – less prostitution, less criminality, less health problems.' He added that his work is about helping participants take 'small steps forward all the time':

> It's very often something about their teeth, that's the first item on the agenda, because they all have bad teeth. And then there are other health-related issues, like teaching them to look after their HIV if they are HIV-positive, attending to their sores, giving them meals vouchers to the drop-in centres. And we also help them clear the premises at home [. . .] small things like that, which nevertheless are very important for their quality of life.

Ultimately, however, on-going methadone substitution is the pivotal treatment in the centres. At most centres, prescription of drugs is generous – typical dosages of methadone are 80–120 mg.

pr. day but some clients receive 180–200 mg. or more. Steen, a social worker, portrayed these drug-provision practices as an unspoken agreement with participants: 'Here, you get what you want from us and then we don't want any tricks.'

In sum, staff members' accounts focused on the purpose-agency ratio extend parallel stories of methadone treatment as ethical and effective, and traditional treatment as neither. Staff members explained that traditional treatment's overriding concern for abstinence (purpose) was associated with treatment practices (agency) that socialized participants to counterproductive desires and expectations. Particularly worrisome was how traditional treatment practices negatively affected the scene and practices of methadone treatment, as well as staff members' relationships with participants. Because of traditional treatment, staff members could not ethically accede to participants' expressed desires; rather, they counselled participants on what to properly expect for their lives. For staff members, their counselling response rendered their disregard of participants' desires consistent with the purposes of harm reduction. It is a step in shifting attention to participants' 'real' desires and needs, including their need for methadone.

Agency-acts

The overriding message in the interviews was that methadone treatment (agency) brings about positive acts from participants. Program participants are, according to staff members, happy about the relaxed atmosphere at the centres and feel lucky to have escaped the traditional system's 'high demands, unrealistic treatment plans, paternalistic attitudes and humiliating control measures' (Lene, social worker). Such reports confirm the incongruence between traditional treatment and the needs of chronic drug users. Traditional treatment does not work because it rests on a flawed understanding of chronic drug users' capabilities to act and on control measures that do not respect participants' right to self-determination.

While staff members agreed that the quality of participants' lives would be improved if participants actively looked for jobs, enrolled in educational programs and built social networks of non-drug users, they acknowledged that few participants did so. Rather, they defined stable participants as people who pick up their methadone at designated times; do not sell it on the streets; do not use too many drugs 'on the side' (and preferably stick to cannabis); do not raise money through illegal activities and; as far as possible, look after their health and attend to their daily duties. Staff members also acknowledged that many participants do not lead conventionally stable lives, primarily because of the chaotic effects of side abuse. While this pattern might be used to question the program's effectiveness, staff members interpreted it as an aspect of participants' life projects. Annika, a social education worker, explained:

> It's not easy to accept, but we have to realize that some of them are doing just fine out there on the drug scene. They party and they take drugs and maybe get sick and probably do not live as long as you and me. But it's their life, isn't it, and who am I to tell, they may be just as happy and content with their life as we are with ours [. . .] Their definition of what a good life looks like is not the same as ours. And I think it would be highly inappropriate if we tried to force our normative standards on them, saying for instance that their drug user network is not good for them [. . .] They don't need us to moralize.

Annika's statement clearly fits within the logic of neoliberalism (Rose, 1989). She balances a tolerance for alternative life choices with a privileging of a scientific definition of health by noting that participants' choices will likely shorten their lives. Annika also aligns institutional purposes with participants' acts in stating that, while different than those of other people, participants' life choices bring them happiness and contentment. Consistent with other staff members' accounts of participants as agents, Annika rejects attempts to impose unwanted normative standards (such as abstinence) on participants.

The combination of staff members' tolerance of participants' side abuse and lack of interest in education and employment with Annika's account might be dramatistically summarized as the following two claims. When severely addicted persons find themselves in scenes that allow self-determination, they choose acts which depart from conventional practices, but which are consistent with whom they are as agents pursuing their own life projects. And, staff members use their agency ethically in choosing medical stabilization and management of participants' practical problems to empower participants to achieve what they want.

These formulations of the agency-acts ratio complement accounts emphasizing agent-scene and purpose-agency ratios. In combination, the accounts point to the resiliency of the harm reduction pentad as a justification of methadone treatment. Indeed, it is possible to begin virtually anywhere in the pentad to reconstruct staff members' logic. But it is also possible to overstate the self-sustaining logic of the accounts. As Burke (1969b: 313) reminds us, rhetorical claims reveal 'only such reality as is capable of being revealed by this particular kind of terminology'. Thus, we also need to consider the counterstatements expressed in the interviews.

Counterstatements

While they embraced the ideals of harm reduction, three staff members challenged others' constructions of the harm reduction pentad by rejecting the claim that methadone treatment emanates from participants' needs and wishes. This shift had significant implications for how elements within the pentad relate to one another, and for assessing the ethical standing of methadone treatment as a form of self-governance. The critics' accounts reversed the agent-scene ratio by emphasizing that the scene of methadone treatment transforms participants into kinds of agents (chronic drug users) who match the agency of the program. Thus, participants who might otherwise become drug-free were trapped in a system that defines their condition as 'incurable.' Linda, a social education worker, voiced this point of view in saying:

> I am not saying that abstinence is a realistic goal for all of them. I accept that some of them probably cannot get rid of their drug problem. What I am saying is that they should be given the chance to try if that's what they want. I find it hard to accept that people who have never been in drug-free treatment aren't even offered the possibility. And I don't care if they are young or old, I think we should give it a try. 'Old' in this system doesn't mean old. The 'old' drug users here may very well be in their 30s or 40s.

While not embracing traditional treatment, Linda questions the ethics of methadone treatment by appropriating the concept of self-governance. She explains that methadone treatment is sometimes 'forced' on participants who may not want or need it; notably 'people who have never been in drug-free treatment' and 'aren't even offered the possibility' of it. Also, Linda challenges depictions of participants as chronic addicts by stressing how the system defines otherwise young people as old and hopeless. 'Old' in methadone treatment is a product of the scene and not a characteristic of the agent.

All of the critics linked questions about the kinds of agents produced in methadone treatment to concerns about its purpose

and agency. Mette, a social worker, stated that the 'real' purpose of methadone treatment was to reduce public expenditures for addiction treatment, because 'drug-free treatment is expensive and methadone treatment is extremely cheap.' Charlotte added:

> Sometimes I wonder if all this harm reduction stuff was made for other people than for the drug users. It' very easy and convenient for society to have the users toddling about here minding their own business, not being too visible – because people in general don't want to see drug users around. So I sometimes ask myself: the way the system works today, keeping the users permanently on methadone, is it good for the users? I honestly don't know.

The critics extended such questions by asking if methadone treatment is a legitimate form of treatment. For example, Mette noted that 'treatment usually means making things better but not here.' She then characterized methadone treatment as 'the same as giving up.' The critics implicitly acknowledged that the program is effective but asked, 'what is it effective at doing?' Does it respect participants' self-governing capacities or is it a distinctive form of externally imposed social control that operates through the chemical manipulation of participants' bodies? Such questions direct attention to the impact of the methadone treatment scene on agents and their acts. Linda described methadone treatment as sustaining addicted life styles that incorporate the appearance of stability through methadone with the chaos of continuing use of illegal drugs. Thus, methadone treatment might be said to foster an institutionally-preferred form of addiction.

It is important to note that the critics' questioning of the ethics of the Danish methadone treatment program rest on the assumption that program participants are self-governing agents possessing the right to self-determination. Taken together, their statements make two general claims. The first is that the scene of methadone treatment imposes methadone use (act) on participants to achieve institutional purposes that are, at best, only loosely related to the purposes of harm reduction. An alternative claim is that the scene of methadone treatment victimizes participants by ignoring their desires and restricting their opportunities to acts that support ulterior purposes. Both claims question the ethics of methadone treatment in Copenhagen, while defining the harm reduction strategy as ethical.

Our earlier review of the literature on substitution treatment raised several other issues that might be part of more encompassing counterstatements. For example, researchers have pointed to practical constraints that limit participants' ability to realize all of the goals of harm reduction (cf. Moore & Fraser, 2006). Others might ask if this policy rests on essentialist assumptions about drug addiction and addicts (cf. Reith, 2004; Weinberg, 2013 for a critical analysis of the concept of addiction). In Denmark, methadone treatment is designed as a last resort response (Emerson, 1981; Järvinen & Miller, 2010) to addictions that cannot be effectively addressed by other means. Might this be taken as evidence that participants are incapable of self-governance? Staff members' attempts to persuade participants to adopt 'realistic' goals might be similarly interpreted. Another possibility involves defining program participants as diverse kinds of agents. This change would call for a scene allowing for multiple responses to participants' life circumstances as well as a variety of program purposes and contents.

Our purpose is not to argue for a superior stance to the harm reduction pentad but to suggest the richness of Burke's perspective for understanding what is said and might be said in discussions of social issues. For Burke (1934, 1969b: 41), public discourse is enhanced when social issues are considered in several different formulations of the pentad because rhetoric is an artful activity intended 'to form attitudes or to induce actions in other human agents.' We develop these implications of Burke's perspective in the next section.

Dramatistic criticism

For Burke (1969a), questions about the limits of dominant constructions of social issues are best addressed dramatistically. We see several possibilities for developing Burke's critical stance in staff members' assessments of the Copenhagen methadone treatment program. One starting point is with participants' acts, as they were reported by the staff members. All staff members stated that substitution treatment stabilizes participants' lives. Thus, we might ask, 'What does stabilization mean in practical behavioural terms?' This question directs attention to what program participants are willing and able to do, and to activities that they do not typically do. The staff members agreed that stabilized participants were less likely to use dirty needles or engage in crime, prostitution and other risky behaviours. They also noted that side-abuse was common among participants, that few of them sought additional education or employment and that some felt relief at not having to live up to the demands of parenthood.

A critical dramatist might next ask, 'What do these acts suggest about participants as agents?' 'Do participants freely choose not to stay in contact with their children, or not to enrol in education programs and seek jobs, or are these activities beyond their possibilities, perhaps because of their (illegal *and* legal) drug dependence?' Burke would remind us that there are no definitive answers to these questions. We note, for example, that none of the staff members clearly differentiated between freely chosen participant needs and desires, and those that were affected by forces beyond participants' control. It is one thing to say that the treatment system should respect participants' continuous need for (legal and illegal) drugs; it is another to claim that participants prefer life on drugs to more conventional life styles. At what point do the debilitating effects of long-term drug use render participants' incapable of self-governance?

The questions that we raise here might be interpreted as grounds for rejecting substitution treatment as a social policy, and perhaps as a justification for abstinence-focused treatment. But such a conclusion does not necessarily follow from our questions. For us, a more interesting next step, and one that is truer to the impulse of Burke's work, is to ask, 'Are there other rhetorical grounds that might be used to explain the operations of the Copenhagen methadone treatment program?' This question invites people to look at the program from a different standpoint, one that is not bound by the limitations of the language of self-governance voiced by both proponents and critics of the Copenhagen methadone treatment program.

Burke offers two guidelines for aspiring dramatistic critics. The first is to focus on aspects of dominant accounts that are portrayed as beyond doubt (Burke, 1968). The second is to develop alternative formulations of social issues within the comedic frame. For Burke (1984a), the comedic frame is not so much about humour as it is a strategy for humanizing people and their actions. It casts people as both agents who shape their social worlds and who are shaped by practical circumstances. Burke (1984a: 43) describes the comedic frame as humane because it dramatizes the quirks and foibles of people living their lives: "It takes up the slack between the momentousness of the situation and the feebleness of those in the situation." And, as Crusius (1999) notes, comedy is a standpoint for criticizing without demonizing.

The comedic frame is a distinctive context for examining staff members' accounts. We see two interpretations as particularly useful. Both begin with the agent-scene ratio but they define the ratio differently and involve differing orientations to other elements of

the pentad. The first counterstatement casts the harm reduction policy as the organizing agent of the scene of methadone treatment. The policy acts as an agent in defining the purposes of the program and authorizing the provision of resources to staff members charged with implementing it. In organizing the scene of methadone treatment, the harm reduction policy establishes an institutional context within which staff members and participants may act and are held accountable for their actions.

This formulation of the pentad complements the literature on people processing in street-level bureaucracies (Lipsky, 1980; Prottas, 1979). This literature documents how human service professionals reconfigure abstract social policies as they apply them to the practical circumstances of their work with clients. Studies of street-level bureaucracies sensitize us to how staff members' accounts are local constructions that define self-governance in ways that reconcile the abstract ideals of harm reduction with the staff members' practical interests. Of particular note is staff members' construction of program participants as distinctive agents having uniform capacities for ethical judgement. We have seen how staff members use this social construction to justify their efforts to instruct participants on their 'true' needs and desires, including participants' need for continuing methadone treatment.

So viewed, neoliberal ideals are resources that staff members use in addressing the going concerns of everyday life in methadone treatment centres (Hughes, 1971). These concerns might include managing the flow of participants through the centres, helping participants to manage their lives to reduce the demands they make on social welfare, medical, and other institutions, and reducing public awareness of and negative responses to having chronic and severe drug users in their midst. We might represent this counterstatement dramatistically by saying that staff members use institutional means (especially methadone provision) to address practical purposes about potentially undesired participant acts in the multiple scenes of participants' lives.

The second counterstatement draws on interviews with participants in the Copenhagen methadone treatment program (Järvinen & Miller, 2010). Participants stressed how their options were constrained by staff member expectations and demands, as well as by their continuing use of legal and illegal drugs. While participants' assessments varied, many of them voiced ambivalence about their goals and ability to achieve them. For example, participants who stated that they had requested abstinence-focused treatment without getting it frequently added that this goal might be unrealistic given their long-term drug dependence. Participants were also ambivalent about their desire to participate in their families and to hold jobs.

Participants' accounts form a context for assessing staff members' accounts of the ethics of harm reduction. They problematize the staff members' emphasis on self-governance by questioning participants' capacities to act. The accounts also question portrayals of participants as pursuing freely chosen life styles. The challenge applies equally to the accounts of proponents and critics of methadone treatment. Participants' accounts might also be interpreted as challenges to any policies that assume that long-term drug users are fully capable or incapable of self-governance. Participants' accounts place methadone treatment within the context of addiction. They assert: Addicts are agents of uncertain and limited agency who orient to multiple and sometimes incompatible purposes and act in scenes involving differing opportunities and constraints for exercising whatever personal agency they possess.

These 'comedic' counterstatements point to the usefulness of dramatism in engaging social issues. The pentad is a heuristic device for enlarging policy deliberations. It is a standpoint for asking, 'What is de-emphasized and ignored by typical formulations of social issues?'

Conclusion

Our analysis of staff members' accounts of the Copenhagen methadone treatment program is one use of the dramatistic perspective in examining social policies as rhetorical constructions. Staff members—like participants—are well positioned to speak to ethical issues associated with methadone treatment and other harm reduction programs. Their practical ethical assessments orient both to the general purposes of social policies and to the practical contexts in which they are implemented, thus, their voices are vital to discussions about harm reduction policies. The dramatistic perspective is a useful way of organizing staff members' concerns and those of others who are usually left out of policy discussions.

While there are many ways of developing a dramatistic perspective on ethics in addiction treatment, we believe that a particularly promising route involves comparative studies of diverse harm reduction approaches. Such analyses promise to extend our understanding of how the ideals of harm reduction are defined and contested in diverse institutional sites. They might also provide a fuller picture of the multiple rhetorical grounds that are used by advocates and critics of harm reduction in defining people as capable or incapable of self-governance. For example, future research might compare methadone prescription programs with programs using other drugs, such as the newly implemented (2010) heroin prescription program in Copenhagen. This is a small-scale program intended for the most severely addicted opiate users who do not function well in methadone treatment. The program may be said to represent a solution to some of the inconsistencies in the pentad of harm reduction.

The most debated ethical issue in discussions of methadone treatment has always been the argument that participants *need* illegal drugs alongside their substitution treatment. With heroin included in a legal prescription system, and administered under controlled clinical conditions, there is no need for side abuse. At least this is a major assumption of the heroin prescription policy. Not unexpectedly, there are counterstatements and, again, the debate focuses on the scene-agent ratio. Is heroin prescription really what the opiate users want and need or is it a new step in a development that gradually does away with therapeutic treatment and 'gives up' on users? Is heroin prescription ethical in the sense that it enhances opiate users' self-governance or is it a measure that traps them in a position as outsiders in society? These questions point to the value of comparative dramatistic analysis of methadone treatment and heroin prescription.

A second strand of development is comparative studies of staff members' ethical assessments of methadone treatment in other countries. The majority statements about the Copenhagen methadone program are characterized by a very specific construction of the agents in the harm reduction pentad: participants are both regarded as unconditionally free and entrepreneurial and as chronically dependent (on drugs and the drug treatment system). In consequence, their preferred treatment goals are seen as genuine as long as they match the purpose of harm reduction (stabilization) but as false and imposed by other people if they match the purpose of traditional treatment (abstinence). An obvious possibility would be to compare the harm reduction pentad in Copenhagen with methadone maintenance programs that are less defeatist when it comes to depicting drug users' future possibilities.

The research possibilities that we have discussed here are intended to encourage further research on the ethics of harm reduction using the dramatistic perspective. Comparative studies would probably show alternative ways of understanding the ratios in harm reduction pentads and hence alternative ways of discussing the ethics involved in harm reduction. Comparative research may also point to the rhetorical nature of our analysis. Our study is itself a

vocabulary that reflects, and deflects the complexities of social reality. It also stands in need of correction through counterstatements emergent from other research.

Acknowledgement

The authors want to thank the Danish Council for Independent Research for supporting the study.

Conflict of interest statement

Neither of the authors has a potential conflict interest (financial, personal or other) that render this paper ethically inappropriate.

References

Aceijas, C. (2012). The ethics in substitution treatment and harm reduction: An analytical review. *Public Health Review*, *34*(1), 1–12.
Agar, M. (1977). Going through the changes: Methadone in New York City. *Human Organization*, *36*(3), 291–295.
Bacon, M., & Seddon, T. (2013). The contractual governance of drug users in treatment. *International Journal of Drug Policy*, *24*(5), 379–384.
Berger, P. L., & Luckmann, T. (1967). *The social construction of reality: A treatise in the sociology of knowledge*. Garden City, NY: Doubleday & Company, Inc.
Bourgois, P. (2000). Disciplining addictions: The bio-politics of methadone and heroin in the United States. *Culture, Medicine and Psychiatry*, *24*(2), 165–195.
Brown, R. H. (1977). *A poetic for sociology: Toward a logic for the human sciences*. Cambridge: Cambridge University Press.
Brown, R. H. (1987). *Society as text: Essays on rhetoric, reason and reality*. Chicago: University of Chicago Press.
Buchanan, B., Ford, S., & Singer, M. (2003). Empirical science meets moral panic: An analysis of the politics of needle exchange. *Journal of Public Health Policy*, *24*(3-4), 427–444.
Burke, K. (1934). The meaning of C.K. Ogden. *The New Republic*, *78*, 328–331.
Burke, K. (1959). *Attitudes toward history*. Berkeley: University of California Press.
Burke, K. (1968). *Counter-statement*. Berkeley: University of California Press.
Burke, K. (1969a). *A grammar of motives*. Berkeley: University of California Press.
Burke, K. (1969b). *A rhetoric of motives*. Berkeley: University of California Press.
Burke, K. (1973). *The philosophy of literary form: Studies in symbolic action*. Berkeley: University of California Press.
Burke, K. (1984a). *Attitudes toward history*. Berkeley: University of California Press.
Burke, K. (1984b). *Permanence and change: An anatomy of purpose*. Berkeley: University of California Press.
Christie, T., Groarke, L., & Sweet, W. (2008). Virtue ethics as an alternative to deontological and consequential reasoning in the harm reduction debate. *International Journal of Drug Policy*, *19*(1), 52–58.
City of Copenhagen. (2006). *Sektorplan for Københavns Kommunes indsats over for stofmisbrug 2006–20*. Københavns Kommune: København.
Crusius, T. W. (1999). *Kenneth Burke and the conversation after philosophy*. Carbondale, IL: Southern Illinois University Press.
Denning, P. (2012). *Practicing harm reduction psychotherapy: An alternative approach to addictions*. New York: The Guilford Press.
Denning, P., Little, J., & Glickman, A. (2004). *Over the influence: The harm reduction guide for managing drugs and alcohol*. New York: Guilford.
Edelman, M. (1977). *The symbolic uses of politics*. Urbana, IL: University of Illinois Press.
Edelman, M. (1988). *Constructing the political spectacle*. Chicago: University of Chicago Press.
Emerson, R. M. (1981). On last resorts. *American Journal of Sociology*, *87*(1), 1–22.
Foucault, M. (1988). Technologies of the self. In L. H. Martin, H. Gutman, & P. H. Hutton (Eds.), *Technologies of the self: A seminar with Michel Foucault* (pp. 16–49). Amherst: University of Massachusetts Press.
Fraser, S. (2004). It's your life!: Injecting drug users, individual responsibility and Hepatitis C prevention. *Health*, *8*(2), 199–221.
Fraser, S. (2006). The chronotype of the queue: Methadone maintenance treatment and the production of time, space and subjects. *International Journal of Drug Policy*, *17*(3), 192–202.
Fraser, S., & Moore, D. (2008). Dazzled by unity? Order and chaos in public discourse on illicit drug use. *Social Science & Medicine*, *66*(3), 740–752.
Fraser, S., & Valentine, K. (2008). *Substance and substitution. Methadone subjects in liberal society*. Hampshire: Palgrave MacMillan.
Fry, C. L., Knoshnood, K., Power, R., & Sharma, M. (2008). Harm reduction ethics: Acknowledging the values and beliefs behind our actions. *International Journal of Drug Policy*, *19*(1), 1–3.
Garfinkel, H. (1967). *Studies in ethnomethodology*. Englewood Cliffs, NJ: Prentice-Hall, Inc.
Geertz, C. (1983). *Local knowledge: Further essays in interpretive anthropology*. New York: Basic Books, Inc., Publishers.
Genter, R. (2010). *Late Modernism: Art, Culture, and Politics in Cold War America*. Philadelphia: University of Pennsylvania Press.
Gerth, H., & Mills, C. W. (1953). *Character and social structure: The psychology of social institutions*. New York: Harcourt, Brace & World, Inc.
Goffman, E. (1959). *The presentation of self in everyday life*. Garden City, NY: Doubleday& Company.
Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates*. Garden City, NY: Doubleday & Company, Inc.
Goffman, E. (1963). *Stigma notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall, Inc.
Gomart, E. (2002a). Six effects in search of a substance. *Social Studies of Science*, *32*(1), 93–135.
Gomart, E. (2002b). Towards generous constraint: Freedom and coercion in a French addiction treatment. *Sociology of Health and Illness*, *24*(5), 517–549.
Gomart, E. (2004). Surprised by methadone: In praise of drug substitution treatment in a French clinic. *Body & Society*, *10*(2), 85–110.
Gusfield, J. (1976). The literary rhetoric of science: Comedy and pathos in drinking driver research. *American Sociological Review*, *41*(1), 16–34.
Hathaway, A. E., & Tousaw, K. I. (2008). Harm reduction headway and continuing resistance: Insights from safe injection in the city of Vancouver. *International Journal of Drug Policy*, *19*(1), 11–16.
Heath, R. L. (1986). *Realism and relativism: A perspective on Kenneth Burke*. Macon. GA: Mercer University Press.
Heritage, J. (1984). *Garfinkel and ethnomethodology*. Cambridge: Polity Press.
Hopper, J. (1993). The rhetoric of motives in divorce. *Journal of Marriage and the Family*, *55*(4), 801–813.
Hughes, E. C. (1971). Going concerns: The study of American institutions. In E. C. Hughes (Ed.), *The sociological eye: Selected papers* (pp. 52–64). Chicago: Aldine Atherton.
Järvinen, M. (2008). Approaches to methadone treatment: Harm reduction in theory and practice. *Sociology of Health and Illness*, *30*(7), 975–991.
Järvinen, M., & Miller, G. (2010). Methadone maintenance as last resort: A social phenomenology of a drug policy. *Sociological Forum*, *25*(4), 804–823.
Kenny, R. W. (2008). The glamour of motives: Applications of Kenneth Burke within the sociological field. *KB Journal*, *4*(2), 1–32.
Kleiman, M. A. R., Caulkins, J. P., & Hawken, A. (2011). *Drugs and drug policy: What everyone needs to know*. New York: Oxford University Press.
Kleinig, J. (2008). The ethics of harm reduction. *Substance Use and Abuse*, *43*(1), 1–16.
Larner, W. (2000). Neo-liberalism, policy, ideology, governmentality. *Studies in Political Economy*, *63*(Autumn), 5–25.
Lipsky, M. (1980). *Street-level bureaucracy: Dilemmas of the individual in public services*. New York: Russell Sage Foundation.
Manning, P. K. (1977). *Police work: The social organization of policing*. Cambridge, MA: The MIT Press.
Manning, P. K. (1982). Technological dramas and the police: Statement and counterstatement in organizational analysis. *Criminology*, *30*(3), 327–346.
Mills, C. W. (1939). Language, logic and culture. *American Sociological Review*, *4*(5), 670–680.
Mills, C. W. (1940). Situated actions and vocabularies of motive. *American Sociological Review*, *5*(6), 904–913.
Moore, D., & Fraser, S. (2006). Putting at risk what we know: Reflecting on the drug-using subject in harm reduction and its political implications. *Social Science and Medicine*, *62*(12), 3035–3047.
National Health Board. (2011). *Narkotikasituationen i Danmark*. Copenhagen: Sundhedsstyrelsen.
Newcombe, R. (1992). The reduction of drug-related harm. A conceptual framework from theory, practice and research. In P. A. O'Hare, R. Newcombe, A. Matthews, E. C. Buning, & E. Drucker (Eds.), *The reduction of drug-related harm* (pp. 1–14). London: Routledge.
O'Hare, P. A., Newcombe, R., Matthews, A., Buning, E. C., & Drucker, E. (Eds.). (1992). *The reduction of drug-related harm*. London: Routledge.
Overington, M. A. (1977a). Kenneth Burke as social theorist. *Sociological Inquiry*, *47*(2), 133–141.
Overington, M. A. (1977b). Kenneth Burke and the method of dramatism. *Theory and Society*, *4*(1), 131–156.
Pauly, B. (2008). Harm reduction through a social justice lens. *International Journal of Drug Policy*, *19*(1), 4–10.
Prottas, J. M. (1979). *People-processing: The street-level bureaucrat in public service bureaucracies*. Lexington, MA: D.C. Heath and Company.
Reith, G. (2004). Consumption and its discontents. Addiction, identity and the problem of freedom. *British Journal of Sociology*, *55*(2), 283–300.
Riley, D., & O'Hare, P. (2000). Harm reduction: History, definition and practice. In J. A. Inciardi, & L. D. Harrison (Eds.), *Harm reduction: National and international perspectives* (pp. 1–26). Thousand Oaks, CA: Sage Publications.
Rose, N. (1989). *Governing the soul: The shaping of the private self*. London: Routledge.
Rose, N. (1998). *Inventing our selves: Psychology, power and personhood*. New York: Cambridge University Press.
Rueckert, W. H. (1982). *Kenneth Burke and the Drama of human relations*. Berkeley: University of California Press.
Rueckert, W. H. (1994). *Encounters with Kenneth Burke*. Urbana: University of Illinois Press.
Weinberg, D. (2013). Post-humanism, addiction and the loss of self-control: Reflections on the missing core in addiction science'. *International Journal of Drug Policy*, *24*(5), 173–181.