

Subject positions within addiction treatment

Daniel Sanin

Abstract

Contrary to the common notion of a neutral relationship of experts and patients in the field of drug therapy, this article explores the various ideological premises implicated herein. With the analytical approach of Critical Psychology and its concepts, the obstacles for a subject-to-subject relationship are outlined. The concept of “daily conduct of life” helps to understand the often opposing interests of the involved subjects in concrete situations, while the concept of “restrictive/generalized action potency” is needed to highlight the “conservative” and “progressive” moments in subject’s actions.

Keywords

Critical Psychology, drug help, drug therapy, addiction, addiction treatment, addiction therapy, subjectivity, science from the standpoint of the subject, action potency, daily conduct of life

Introduction

In the following, I will provide an analysis of conditions and significances of the drug help field according to Critical Psychology. Critical Psychology written with upper case refers to Marxist psychology as science of the subject as it was developed in Germany starting in the late 1960s. There are a few basic principles on which Critical Psychology is grounded. First, humans are fundamental societal beings. They reproduce themselves through society and its structures/significances. Therefore, the need of access to or control over one’s living conditions is a fundamental one. Every human action takes place within societal conditions and thus refers to societal structures/significances. Every human action is meaningful even if the meaning is not evident. There is no concept of irrationality within Critical Psychology. Science from the standpoint

of the subject implies that the subjects are co-researchers and at no point in the investigation objects of research. There is no interpretation of human actions without the concrete humans concerned.

In my paper, I do not report on a specific subject science research project, but, rather, provide a preliminary theoretical approximation to one. Here I will provide an analysis of the conditions and significances in the drug help field based on my local and professional knowledge and experience as a clinical psychologist, which could be the first step for a thorough subject science investigation.

Medical model, psychologism, drug mythology

In general, one could assume that subject positions within addiction treatment should not be much of a problem. On one side, we have the addicted subject in need of help and, on the other, the expert subject that tries to help the former.

My hypothesis stands in opposition to the above. I say that in the vast majority of cases there is a steep hierarchy within the field of addiction. The standard relationship within addiction aid is hence a subject-to-object one. The objects – the addicts – are the target of various interventions that aim to change them, heal them. If these objects are non-compliant with the interventions, they may be not ready yet or too sick/disturbed. Usually there is little or no discussion about the treatment and consequently no participation in the development or implementation of interventions. The experts – doctors, psychologists, therapists, social workers etc. stand within a “professional distance” to the patients or clients. The gap that is thus produced varies in width. In my experience, it is biggest with doctors in in-patient treatment facilities and smallest with social workers in harm reduction projects.

This problematic constellation between experts and patients has its roots in the fragmented medical approach, the psychological reductionism (psychologism), and the broader drug mythology. The first factor means that the vast majority of doctors usually treat symptoms, not persons. If I suffer from insomnia, I will get sleeping pills; if I’m depressed, I will get an antidepressant. The psychological, social, or biographical factors are mere optional ornaments, but not relevant for the treatment. The second factor is psychologism. With this term, I address the tendency of standard –or mainstream– psychology to neglect society, both as a factor of socialization (we grow into “our” society, it is the air we breathe, the water we swim in) and context (in which society do I live, what are the dominant cultural norms, who’s in power, what are the social strata/classes, the mechanisms of oppression, segregation, stigmatization,

labelling, and so on). The third element is drug mythology. The field of drugs, addiction, and therapy is profoundly ideologically distorted. The common beliefs such as: addiction is a brain disease (U.S. Department of Health and Human Services: 3), drugs are dangerous and thus prohibited (Hart, 2013), drugs are the cause of addiction (Alexander, 2008), addiction is a lifelong disease, etc. may sometimes bear a grain of truth within, but are, in their central messages, severe distortions. Regardless of numerous scientific results that provide other – sometimes opposite results – these “mythological truths” remain hegemonic knowledge. A good example is provided by the US Surgeon General who, in his 2016 report repeats the ultimately unsustainable theory that addiction is a brain disease (Schumaker, 2016).

Bruce Alexander conducted a series of experiments (1988), known as the Rat Park Experiments, where he tried to “produce” addiction in rats who were placed not in the usual single cages, but in an expansive cage where they were together and could interact with each other, play, hide, etc. It was not possible to reproduce even one result of the single cage experiments. Even rats who got addicted in the single cage all but stopped with their addictive behavior when put in the park (where the drug was freely available).

In addition to the fact that there is no proof for chronic brain alteration in “addicts,” Alexander’s findings emphasize the utter importance of context in addictive dynamics.

Knowledge and power

The story of the Rat Park Experiments is also a good illustration of Kuhn’s theory of knowledge production (1970). In a nutshell, Kuhn points out that knowledge is not produced as a part of steady scientific progress where we come closer to truth step by step (as suggested by theorists such as Popper), but rather as fitting in a broader established body of knowledge shared by a dominant collective within a discipline. The state of the art proclaimed by this collective is challenged when another collective gains influence and power or when its representatives leave the field (by death or retirement). But when an individual tries to establish insights that contradict the dominant truths s_he will encounter difficulties in doing so. This may include even sanctions. In the case of Bruce Alexander, no main journal accepted his Rat Park paper. Furthermore, his university cut the funds for continuing his research (Slater, 2004: 154)

The Rat Park Experiments are still widely unknown, although Hari (2015) has made quite some efforts lately to change that with his successful and broadly received book.

Restricted and generalized action potency

The puzzling question is thus why some findings – although indisputable – are so fiercely fought against. The answer may lie in the degree of threat they are posing to the established body of knowledge and its concrete and practical structures.

In Critical Psychology, there is a central category, which in English is sometimes called agency or action potency (Tolman, 1994). Action potency refers to the fact that for humans as, first of all, societal beings it is crucial to have control over the means for the reproduction of their existence within the conduct of daily life. Daily life occurs not within genetic, hormonal, or other biological frameworks, but within complex societal contexts, with their rules, mechanism, tools, relationships and so on. I have to conduct and reproduce my life in direct or indirect cooperation with others. In such complex societies as the capitalist western ones, the cooperation sometimes disappears from our conscious perception and is also actively pulled out from direct reach. As a human, I have a choice of acting within the established rules or trying to change the rules, the framework. This abstract “dual possibility” of human action (Holzkamp, 1991: 50pp.) is concretized within capitalism into (1) restrictive action potency – which means securing my agency without touching the framework and hence contributing to the segregating, exploiting etc. status quo – and (2) generalized action potency: I act with the goal of changing the circumstances into more including or just ones.

Getting back to our Rat Park example, we can now understand Alexander’s experiments as a form of generalized action potency, an attempt to change the established framework. The circumstances of addicted behavior seemed to play a central role here. However, he had no – or not enough – supporters. His opponents on the other side saw their spheres of authority in danger and decided –consciously or unconsciously – to fight his research. Similarly, his superiors seemingly perceived their position in danger if they stood with their scholar, so they gave in to the pressure and sacrificed him for their own sake.

Restrictive and generalized action potency are just a tool to analyze a situation regarding to the practical circumstances that may favor some actions and disadvantage others. The specific reasons behind an action can only be guessed; alternatively, they have to be identified in collaboration with the person. Consequently, in Critical Psychology there are no interviewees, probands, participants etc., but co-researchers (cf. Tolman, 1994).

Action potency within drug treatment

What are the consequences for positions subjects are relegated in the context of addiction treatment? First of all, we have to look at the specific arrangement that is constitutive for the treatment center. In the following I base my analysis on my knowledge of the drug treatment system in Vienna, Austria.

As in many other places, Viennese drug facilities can be assigned to three categories: basic/low-level (harm reduction), mid-level (outpatient centers), and high-level (inpatient centers). Since all drug help institutions follow the medical model, there is a (sometimes implicit) professional hierarchy that places doctors at the top. In low-level institutions, the prevalent psycho-social professionals are social workers; in mid-level facilities, the number of psychologists and psychotherapists increases; and in high-level ones, it does so even more, although there are still some social workers. While in basic centers, classic harm reduction treatment prevails (syringe exchange, opiate substitution, etc.), in mid-level centers, there is also (pharmacological) psychiatric treatment.

The (implicit) hierarchy in mid- and high-level institutions, which places the medical element higher, has its roots in the medical model of addiction, in which the three objectifying factors mentioned above – the western medical approach, psychologism, and drug mythology – merge to different extents.

The medical superposition is backed by the standard classification systems of diseases, the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual (DSM), where physical withdrawal symptoms and out-of-control cravings are described as core symptoms of “dependence syndrome” (the “correct” term for “addiction”). The drug starts a dynamic that, at a certain point, gets very physical and seems to change something in the body. Nowadays even classical psychological disorders are phenomena of the body, they all are diseases of the brain, at least that is what biological psychiatry claims (although biological psychiatry is challenged more and more it is still hegemonic, alas). And since at the root of “addiction” lies a pharmacological agent – that involves psychological factors as well, but they’re not causal – this disease has to be treated with other pharmacological agents.

In the world of biological psychiatry and the medical model, “addiction” is also chronic. In the case of opioid dependency, substitution therapy is therefore the treatment of choice. The illegalized opioid (heroin, e.g.) is replaced by a legalized one (methadone, e.g.). Opioid substitution therapy has a whole range of beneficial effects – the user does not have to rely on the black market, the quality is guaranteed, one is regularly seen by doctors, and so on (Kermode et al., 2011) – but also a bunch of negative ones. In theory, on substitution therapy, one can conduct a “normal” life, but in reality, it’s not that easy. In Austria, if you’re

unemployed, you have to get your drug daily at the pharmacy. If you're employed, you get it for the whole week. If you want to go on holidays, you have to discuss your plans with your doctor, who can give you a special vacation prescription. This prescription – like every other substitution receipt that is longer than three days – has to be approved by a public health officer. It happens regularly that the public health officer rejects take-home permits or holiday prescription. The substitution patient thus relies on three authorities: the prescribing doctor, the public health officer, and the pharmacist. Every element in this chain can interfere with the patient's autonomy, and can compromise his/her integrity – for instance, by stigmatizing or discriminating behavior/attitudes. If a person has to get his/her substitution drug daily, the pharmacist has to make sure that the dosage is taken right away. Some take this duty very seriously and perform visual control of the mouth cavity. This control practice is carried out within the regular service hours and regardless of the presence of other customers. Many describe this practice as very unpleasant and humiliating (Tiapal & Sanin, 2016).

Since in the medical model “addiction” is an autonomous dynamic, the person cannot be trusted. One of the defining symptoms of “addiction” states that the substance becomes more and more important, so that, little by little, all other interests and duties are neglected. Another one says that the behavior is maintained even as the harm that it causes is evident. A person who is subject to such a dynamic will thus do everything to obtain the drug of choice: lie, cheat, blackmail, steal, threaten, etc. It is almost as if the person was possessed: it is “addiction” that speaks through her/him (Sanin 2015).

The helping professional now has the duty to act against the primary will of the person just to serve them better in the long run. Objectifying the person becomes functional for strengthening her/his subjectivity in the end. This self-understanding as a helping professional, who sometimes has to act against a person to serve her/him better in the end needs the distorting mechanisms of the medical model to function. Without them this fragile arrangement collapses and another possible reality becomes intelligible.

To elaborate on this hypothesis I shall operate in the following with the Critical Psychology concept of “conduct of life” (Bader & Weber, 2016).

“Conduct of life” in Critical Psychology

Since the evolutionary principle has been replaced by the historical-societal one as the core of processes of change or progress for humankind, it is not biological or genetic mechanisms, or basic learning schemes that shape human behavior,

but reasons. (I'll get back to this.) Society is not an aggregate of individuals, as mainstream (social) psychology might suggest (if the term "society" is even used), but the foremost frame of reference. All of our thoughts and actions take place within a societal framework, with innumerable connections and cross-references. In Critical Psychology this complexity is analyzed with different concepts. A central point is that no action can be fully understood without societal references. All such explanations are either psychologisms or individualisms, with psychologism referring to the reduction of complex causes into the psyche with concepts such as personality, traits, genes, etc.; and individualism meaning that the societal ties are severed, which results in such ideas as "life is what you make of it," "everyone is the architect of her_his fortune" and so on. But Critical Psychology is also critical towards sociologism. This term targets approaches that aim to explain human behavior through conditions and circumstances. Individuals are not "produced" by their circumstances. This condition-grounded approach is opposed by Critical Psychology with a reason-centered one. Human behavior always has its reasons, even when the acting person isn't aware of it herself. Reasons are thus not to be understood as conscious decisions but rather as a sometimes complex combination of feelings, perceptions, thoughts, both conscious and unconscious. These reasons can only be analyzed by the subject itself. Researchers, counsellors, etc. can help in this process, but in Critical Psychology the subject is a co-researcher, not a study object. The subject's actions take place within her_his daily conduct of life. Within objective societal conditions, which are perceived not in their objectivity but as significance, the subject extracts some aspects as premises for her_his *actions*. Let me try to explain this better with an example: We live in a complex capitalist society run by the principles of representative democracy (*objective condition*). I may see this as the result of a historical process of struggles for power; another one sees this as the actual point of a natural progress of humankind; a third person interprets it as mere decadence and sees the ancient rural past as the peak of humanity, etc. (*significance*). In our society one has to work to get access – through money – to take part in "normal" social life. Which kind of career I choose – if I have the luxury to choose – depends again on my view of society and the part I can play in it. If I have a critical stance, maybe an anti-capitalist one, I may choose a career that aims to change something (ecology, e.g.) or tries to soothe the devastations produced by this system (social worker, psychologist, etc.). If I agree with the system and want to make money I might pursue a career in the financial field (*premises*).

This analytical scheme – conditions, significance, premises, action – can be applied to any human behavior/action. The specific human condition, the core difference to other species, is that humans shape their world completely. Humans

don't have an "environment", they have their own world, created by them. This fact tends to be forgotten and the perception of an environment can therefore emerge. Humans fully create their living conditions (as society). Therefore, the ability to control one's own living conditions is a core need (Holzkamp, 1991: 58pp.).

With regard to action potency, this leads us to the concept of double possibility: with every action one can decide to (try to) change the conditions in which the action shall take place or leave them as they are. Under the general conditions of capitalist dominance, though, this double possibility becomes a lot trickier. The concept of restrictive/generalized action potency allows us to analyze human actions under "hostile" conditions. Humans can reproduce themselves only through cooperation. Western capitalist society is based on competition, however. Cooperation takes place only as long as it serves the goals of the participating subjects. At the moment when cooperation interferes with the individual goals it will be replaced with competition. Critical Psychology thus differentiates between intersubjective relationships, where the subject's reasons are made transparent, and instrumental ones, where one's reasons are kept hidden and the interactions with others are maintained only as long as it serves one's purposes. Our society is hence characterized not by cooperation and solidarity, but competition and instrumentality. All the conditions and relationships I depend on can dissolve or be withdrawn. So, every time I want to change something about the conditions, I have to fear losing the partial control I had in the first place. If, for example, I want to change something at work, and this change could possibly interfere with the interests of my employer, I may lose my job. So, to keep the partial and restricted control given to me, I may act according to the declared or assumed rules of the employer. This kind of action is classified as restrictive action potency, since I try only to secure my own (partial and conceded) access to the conditions in which I'm placing my actions, even at the cost of oppressing others. Generalized action potency, on the other hand, would apply to an action that aims to more (collective) control over conditions and is beneficial for me and others as well. Our daily conduct of life consists of innumerable actions of varying complexity. Since our whole existence is societally mediated, every thought, emotion, or action involves societal categories and concepts, of which we are usually unaware. In the case of a concrete problem, a difficult decision I have to make, e.g., the involvement of concepts and structures becomes more apparent. In the case of restrictive action potency, I act against my own higher interests: I reproduce the conditions of exploitation and oppression. I may profit from such a situation for a certain amount of time, but it is always possible that the degree of control I have over a situation and the conditions diminishes or vanishes. It would be in my very

interest to conduct my daily life under conditions of which I am – together with others – a direct participant/contributor. My self-enmity in restricted action potency becomes unconscious, since I cannot consciously act against my interests.

“Conduct of daily life” in the drug treatment field

Let us now explore two models of conduct of life, one of an addict searching help in a drug counselling center, and the other of a counsellor working there. I'll pick some typical details of the clients I work with: male, unemployed, without final degrees, living off welfare, in opioid substitution treatment, drug use patterns oscillating between stable and polytoxic (using various substances simultaneously). A typical day consists of getting up early (many suffer from sleep disorders) and getting ready for the pharmacy, where they get their daily dose of substitution. Maybe they take their dog for a walk before they have to leave. Many have dogs or cats, and those are often the dearest relationship to them. After the pharmacy, if they don't have an errand to run (work agency, doctor, social service or the like) they go home and watch TV. Sometimes, in the afternoon, they meet friends, who are mostly also in the substitution program. Often they smoke hemp together. It is to some extent quite a dull life, from which they suffer themselves. On the other hand, they see – quite realistically – not many options for a change. We are dealing with vulnerable, fragile subjects here, with a sometimes terribly troubled past, prison experience, experience of neglect, abuse, exploitation, and, maybe most of all, stigma. Society wants them to integrate themselves into “normal” lives and, at the same time, offers almost no possibility for achieving this goal.

So, this prototypic person I'm thinking of here just tries to get along. Often they are quite isolated because they try to avoid “the scene” or other people who consume wildly, and many times most of the old friends are dead. Since they have a lot of experience in being rejected and stigmatized, also in their daily errands (at the general practitioner, the pharmacy, offices, etc.), they try to lead quiet lives. This approach keeps them out of trouble most of the time, but at the price of loneliness, emptiness, and boredom. The only peaks may be a bit of weed, some alcohol, or sometimes an extra dose of the substitution drug. This fragile routine is highly dependent on the “cooperation” of others. Since the general attitude towards addicts is defined by skepticism, caution, and suspicion, this routine is in constant danger: the medical officer wants to change the take-home arrangement, the prescribing doctor doesn't want to prescribe the usual dosage any longer, the work agency case manager assigns a useless course, etc.

Any change in the conditions of this daily conduct of life is highly threatening for the subject and s_he will try whatever possible to prevent changes to her_his disadvantage, including omitting information, lying, cheating, being aggressive, threatening, and the like. From the perspective of the subject, these behaviors make perfect sense: they are measures to keep restricted control over the conduct of daily life, if necessary against the interests of others.

These ‘others,’ in our example, would be the drug center professionals. To examine a prototypic conduct of life here, we first need to look at the logic of drug help facilities and institutions in society. The “drug problem” is in its core a moral issue. It is not about harmful substances, it is not about a “disease” called addiction, it is about class and lifestyle, it’s about the *dispositif* (Agamben, 2009) that defines, monitors, and regulates what is good, acceptable, etc. Blaming the destructive sides of certain addicted lifestyles to personality traits or drugs is a scapegoating strategy. With *dispositif* I mean – following Foucault – a complex of ideas, institutions, and individual practice that defines and handles certain topics. In the case of drugs the ideas are prescriptive: drugs are illegal because they are dangerous; citizens need to be protected from them; in the case of illegal drug use, users must be assessed if they have criminal motives or are driven by sickness (addiction); children, youth, and adults need to learn that drugs are dangerous; sick individuals must have treatment, and so on. The corresponding institutions are thus drug laws, special police units, school prevention programs, public campaigns, drug help facilities, etc.

This *dispositif* shapes the reality of the subjects. All pieces fit into each other and make the material world manageable and provide sense and meaning (but only as long as it is not questioned). If I’m conducting my daily life within and according to the *dispositif*, the roles are clear: on one side, there are the (addicted) drug users (I can see them as deviant, sick, victims etc.) that need interventions (help, corrections, assistance, support, therapy, medication), and on the other, there are the professionals (doctors, psychologists, social workers) who have an objective and science-based view of the problem, who can identify the problems and best interventions, and who try to nudge the former to embrace what (I say) is best for them. If I identify more with a humanistic approach, I may emphasize more the victim side of the biography and may try to involve the other in decisions about interventions. But even a humanistic approach just reproduces the societal problems if these are not reflected (cf. Sanin, 2016).

I will now draw a prototypic conduct of life of a drug help professional, again a mixture of personal experience and personal observations. I have gone through a long educational career, studied medicine, clinical psychology, or clinical social work, have specialized maybe in psychotherapy, psychiatry, or the like. If I’m a psychologist or social worker, I may be happy to have an

(underpaid, but) decent job. (As a doctor the pressure of keeping a job by all means is less. In my education and practice, I learned how to identify and classify certain behaviors/problems and how they should be dealt with. My work provides certain instruments I should use and some duties I have to fulfill (questionnaires for specific data, e.g.). My work also provides me with a professional role and corresponding “rules of conduct” (cf. Bourdieu, 1987): what is professional/unprofessional (emotional distance, clinical glance, etc.). My work also gives me a position within society (doctor, psychologist), maybe even with some prestige, and it provides me with money (for selling my workforce), so I can participate in capitalist society (buy, own, consume). All these aspects arrange my reality, put things and people in their places, and provide (restricted) control over my living conditions. Since I try to fit in the general order – although I might aspire to change something in my direct environment, like working hours, precise duties, target groups, procedures, e. g. – I automatically reproduce the bigger structural inequalities. My workplace relies on specific drug laws, on the medical model that assigns certain individuals to treatment, and on societal mechanisms of sanctions and stigmatization.

My actions and routines are also woven into the whole of actions and routines of my colleagues. I follow rules and protocols. Only within this framework can I find or conquer individual “freedom,” develop “my style” in doing what has to be done. I also have to develop and maintain my position with regard to my colleagues in a mixture of cooperation and competition.

The interaction with clients/patients should run smoothly as long as their interests don't interfere with mine. But when they do so, I'm confronted with the “double possibility” of human agency: do I change the conditions of the situation I'm in or do I just act within them? The likelihood of choosing the first option is influenced by my own motivation (“Why should I do it?”) and the possible risks I face by changing the conditions (troubles with my co-workers, boss, the law, my reputation, etc.). So, if I opt for the restrictive option and hence act according to the established rules and within the conceded framework, I simultaneously opt against the interests of the other, in this case the client. In failing to address (and attempting to change) the unjust structures I abstain from trying to improve my own conditions, too, thus I am acting against my greater interests. This self-enmity is suppressed and made unconscious.

The failure to address the other's interests is usually attributed to general norms or laws (“I'm sorry, my hands are tied”) or directly to the client (“s_he's too unstable for a take-home prescription,” “s_he's not trustworthy enough for medication switch,” “s_he's too unrealistic to be assigned for reduction treatment,” etc.). Often these judgments about the other's realism may even be justified or accurate, nonetheless, I'm directly interfering in the other's daily

conduct of life in negating her_his needs in this moment. With the view of oneself as the healthy professional and the other as the sick client, I'm also occulting the underlying structures of power. In the concrete societal situation, I'm actively participating in putting the addicted person in his_her place. The person's structural dependence is seen as necessary part of the relationship health professional–sick person. As long as the broader societal framework (conditions and significance) remains unquestioned and unaddressed, it seems “natural” or “inherently logical” to explain or justify actions with “professional standards” or the “patient's condition.”

Concluding thoughts

The conditions “suggest” or “impose” certain actions, thoughts, or logic and “disadvantage” or even “penalize” others. The conditions as basis for human actions (mediated through significances, premises, and reasons) are naturalized and often simply neglected or “forgotten.” The actions of individuals hence appear not grounded within societal significances, but as expressions of “personality,” “traits,” “disorder,” “illness,” “disability,” etc.

This individualization has to be addressed, analyzed, and reconstructed to facilitate a subject-to-subject relationship in an intersubjective mode, thus transcending the instrumentality that characterizes the vast majority of interactions in our competitive and individualistic society. But before, and most of all, we have to reflect on our own involvement in the dominant structures and our benefit from it. We must investigate against our mechanisms of repression, since we have to deny our involvement in and complicity with the interests of the ruling class, and hence our self-enmity in acting against our own broader interests.

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Daniel Sanin, Critical Psychologist, Clinical and Health Psychologist, works part-time in an addiction treatment center in Vienna, Austria, and teaches Critical Psychology in workshops and seminars as a freelancer. Contact: critpsych@gmail.com, www.danielsanin.at.