THE SUBJECT OF ADDICTION

Rik Loose

Who will ever relate the whole history of narcotica? It is almost the history of 'culture', of our so-called high culture.¹

The earliest evidence of psychoactive drug use and knowledge of hallucinogenic plants dates back some 13,000 years.² Most early forms of religion used drugs in an attempt to gain divine knowledge. Drugs and drug use are an integral part of human culture. Yet, we hardly know anything about drugs, at least not the kind of knowledge that would help us to understand how drugs affect people and how people become addicted to drugs. This is most surprising in light of the vast amount of knowledge that has been accumulated in the sciences.

So, what should we expect from science concerning the effect of drugs and the pathology of addiction? Whilst science has devoted considerable time and resources to the question (for instance, the American National Institute of Drug Abuse [NIDA] allocates $600 million a year to research into drug abuse), we still do not have a satisfactory scientific basis for addiction. On the other hand, although psychoanalysis has yet to seriously and systematically address the problem of addiction, it is my contention that psychoanalysis has an unique contribution to make.

Little work has been done in psychoanalysis on addiction compared to what has been done in the sciences. Indeed, within psychoanalysis itself little has been done in comparison to the work that

¹ The text presented here is drawn from material presented in the preface and conclusion of the author’s recently published work on addiction, R. Loose. The Subject of Addiction. London, Karnac, 2002.
² F. Nietzsche, The Gay Science
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has been done on other psychopathologies. It is certainly possible to accuse psychoanalysis of not taking responsibility in this area: a fine contrast with the proclamation of the ethics of psychoanalysis, which exhorts the suffering subject to assume responsibility; and psychoanalysts themselves are certainly not excluded from that responsibility (neither in relation to their patients, nor in relation to themselves). Yet, a psychoanalytic theory on addiction that includes the subject (and his or her responsibility) is something that psychoanalysts have only recently become interested in.

Psychoanalysis might not be an obvious contender for the treatment of addiction. It is a well-known fact that most addicts do not wish to spend the time (or the money) on such a slow and painstaking process as psychoanalysis; their preferred solution to the problems of life would be something that takes immediate effect and that, therefore, doesn't require them to take responsibility. Moreover, a lot of addicts who are in need of treatment cannot afford the time of a long therapeutic process, precisely because the urgency of their need for treatment is in direct proportion to the time they have left. Psychoanalysis is, nevertheless, in an excellent position to make a contribution to a problem that so far has defied much of our understanding. By inviting people to speak about themselves, their lives, death, pleasure, pain, relationships, sex, work and family, psychoanalysis has established an unique way of collecting clinical material, a material that surely must be immediately relevant coming as it does from the horse's mouth. Also, addiction is on the increase and that fact alone justifies the necessity for a different approach. The argument is not that all addicts should undergo a 'classical analysis' for many years in order to live happily ever after with or without drug or alcohol (although it is suggested that an analysis can be enormously interesting and beneficial, especially for addicts). Instead, the argument is that aspects of the ethics, method of treatment and experience of psychoanalysis should be seriously considered and, where possible, incorporated into the treatment of addicts, irrespective of whether this treatment takes place on an individual, group, community or institutional
basis. It is extremely important to provide a theoretical foundation for this argument. People who work with addicts often express the sentiment that they don't know exactly what they are dealing with, nor indeed what they are (or should be) doing. A theory on addiction should serve as an orientation in the confrontation with a clinic of addiction.

A note on terminology is appropriate here. The focus here is on the addiction to so-called toxic substances, also known as *toxicomania*, as distinct from other addictions such as, compulsive gambling, sex addiction or the addiction to computer games. However, this focus does not imply that concepts put forward here cannot be applied to these other forms of addiction and indeed to psychopathology in general. The term *addiction* has interesting etymological connections. The word *addict* comes from the Latin *addictus*, the past principle of *addicere*, meaning to adjudge or to assign to. The former meaning refers to the making of a decision, whilst the latter refers to a bond or a binding with/to something or someone. These connections are highly relevant to the particularities of the pathology of addiction. But there is another interesting connection. Addiction, etymologically, also relates to *diction*, meaning to announce or to say. There is a strong argument for considering speech and language to be crucial for an understanding of addiction. There is a fundamental antagonism between speech or diction and addiction: *addiction is a-diction*.

A Freudian/Lacanian theory of addiction has to deal with complex psychoanalytic notions like the death-drive and the real (in psychoanalysis life is a question of death, and the subject a question of the real) and it might therefore perhaps come across as unnecessarily dense and difficult. However, it is important to keep in mind that addiction is an object of study which is enormously complex, but which nevertheless appears to provoke the tendency to gross over-simplifications and banal explanations for a variety of reasons. It is important to understand that tendency and to break away from it.

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3 I'm especially thinking here of the many possible applications of the concept of 'administration' which I will develop further on.
Why should psychoanalysis contribute to helping people to live a life which is grounded in the real and penetrated by its presence? How can it help people to live a life that is permeated by the real, the death-drive and by toxicomania?

Lacan emphasises that the analyst only intervenes with words and not with drugs on the body. If the real, the death-drive, and the bodily route of addiction (toxicomania) are situated outside the realm of signifiers and words, does that imply that the discourse of analysis is impotent when it comes to helping us live a life which is overwhelmed or troubled by this real? A hasty conclusion would be to say 'yes'. An alternative response, however, would be to turn the question around by rhetorically asking what the other discourses have to offer instead. It has been argued in this work that they offer a lot, but little with regards to the possibility of changing something in the relationship between the subject and the real or jouissance. At best, some of these discourses would offer knowledge as a life assurance against death. But who would put their trust in an insurance company whose only way of insuring people is by saying that it does not want to know anything about what people want to insure themselves against? Science (including human science) does not want to accept the reality and real of the death-drive.

What can the discourse of analysis offer? The analyst can offer him or herself as an object cause of desire for the analysand. That does not mean that the analyst offers knowledge. It means only that the analyst has the respons-ability to cause the desire of the analysand, and to keep this cause open for as long is necessary, by not offering the knowledge which the analysand imputes to him or her. This structure evokes and provokes the transference. It will immediately bring to the forefront the fantasmatic relationship the subject has with his object-cause-of-desire; a relationship which (at least partially) organises his or her jouissance. This is the very reason why psychoanalysis or psychoanalytic psychotherapy should contribute to the treatment of addiction. How the subject organises his or

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her *jouissance* economy - the *administration* by the addicted subject of *jouissance* and *toxicity* - is determined by his or her subjective position.\(^5\)

To further an exploration of this approach I am proposing the hypothesis that *addiction, in its various forms, is based on the mechanism of administration*. I also propose to consider the possible wider application of this concept, namely that administration can be considered as a mechanism for the symptom in general. All symptoms - and it does not matter whether they function in the real (such as the addictions) or whether they are symbolically structured - are all particular and subjective forms of administrating *jouissance*. Administration is a threefold structure with three different functions: (1) to govern or regulate; (2) to manage as a substitute; and (3) to dispense or supply. The concept of administration allows us to relate addiction to the three clinical structures of psychosis, neurosis and perversion. Addiction can also be related to Freud's clinical category of the actual neuroses via the same concept. This last category would make addiction a clinical entity which is separate from the other clinical structures and their symptoms. In psychosis addiction manages the subject as a compensation for the non-function of the signifier; addiction manages by way of a substitute (for the signifier) in this case. In neurosis and perversion addiction functions as a supplier or dispenser of a surplus-*jouissance* which was originally lost through the process of symbolic castration. In the actual neuroses addiction is a matter of regulating or governing a real *jouissance* at the level of the body.

Any effective treatment of addiction has to relate the symptom or solution to the underlying structure, whatever that may be. A differential diagnosis is possible precisely on the basis of what happens or develops in an analysis, namely the transference. The transference will eventually expose the unconscious *jouissance* economy of the subject as the cause of the addiction. The cause of addiction is not a general cause, but a cause that is specific to the subject, and this cause can only be approached ———

\(^5\) Rik, I think the text of this footnote works better in the main text. See above.
through speech in a transferential relationship. That is why a treatment that is based on the transference is an absolute prerequisite in addiction treatment. The respons-ability of the analyst is to allow the transference to unfold, or take place, around his or her position as object. Through analytic work on fantasy and other solutions such as addiction, it is possible to establish a change in the subject's economy of *jouissance*. Braunstein writes:

(...) the experience of analysis consists of the confrontation of the subject of the symptom with the impossible of *jouissance* and to offer to this impossibility the route of verbalisation in the ideal and artificial conditions which are those of the psychoanalytic encounter, those of the transference.  

The human subject, as speaking being, has access to the real via the signifier. However, this is problematic, because every fantasy and illusion of the subject will fight against this penetration of the real by the signifier. The real penetrates life, but not if we can help it. This penetration of the real causes pain, anxiety and trauma, whilst our illusions, fantasies and symptoms fight tooth and nail against it. Psychoanalysis allows the analysand to traverse the fantasies and break through the illusions, in the hope of being able to arrange a different relationship for the subject with the real of *jouissance*. These unconscious fantasies and illusions can be bits and pieces of knowledge built up as defences against the real drives and *jouissance* of the body; bits and pieces in the unconscious which are the effect of - in Lacan's words - 'the copulation of language (as it is with this that I support the unconscious) with our bodies'. It is via analysis, via the transference, via working-through, that the subject can work on this

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unconscious knowledge. It needs to be worked on because it is, as Lacan says, like a cancer to him.\textsuperscript{9}

This unconscious knowledge is a knowledge in the real which does not work for the subject, but rather works against him, as a death-drive. This produces symptoms as signs that something is not working in the real.\textsuperscript{10} These symptoms need to be analysed, but not by just 'making sense' of them. As with the psychoanalytic treatment of toxicomania, it is not so much the act of comprehending the sense of symptoms, but rather the act of a very elaborate working-through or a deciphering of the effects of the \textit{jouissance} of the real on the unconscious of the subject. In toxicomania, the unconscious of the subject is drenched by a \textit{jouissance} of the real of the drives, because they never became inhabited and pacified by language. This elaborate deciphering comes down to the slow process of bringing \textit{jouissance} within the realm of the signifier, in such a way that \textit{jouissance} will bow to the law of desire and can be replaced by ordinary pleasure.

The end of analysis - as Lacan suggested - is constituted by a knowing how to cope (\textit{s'avoir-y-faire}) with one's symptoms.\textsuperscript{11} Or, as Ellie Ragland put it:

Lacan gives us a new subject of lack, a new object of limit, and an injunction to live with less attachment to our symptoms because and this is crucial our masked suffering makes us harm ourselves as we harm others.\textsuperscript{12}

This harm is nowhere more obvious than in relation to toxicomania. That this harm in toxicomania can be curtailed by psychoanalysis is certain. That addicts would be prepared to take the long detour of

\textsuperscript{10} J. Lacan. op. cit. session of 10\textsuperscript{th} December 1974.
language and speech is not so certain, because to do so, they would have to give up the shortcut of drugs and alcohol via the body. And it is precisely at this point that one encounters the crux of the problem in the treatment of addiction.

It has been demonstrated that it is essential that addicts should get the chance to bring a harmful toxicity within the realm of the signifier in order to be able to come to live with the facts of who and what they are. If they do not get, or indeed, take this chance, they will sooner or later relapse into either their previous addiction, or else another form of harmful administration. This raises three questions that need a proper response if addiction treatment is to get out of its impasse: (1) Where and when should one intervene in order to be most effective in terms of treatment? (2) How does one intervene with addicts such that therapy or analysis becomes a possibility? (3) How can the intervention with addicts be conducted in such a way that the end result will lead to the likelihood of therapy or analysis, in other words, how can the demand for analysis be stimulated?

Addicts are caught between two masters and in their period of so-called 'active addiction', they have chosen the master that is the drug or alcohol. The danger of any intervention is that addicts might switch one master for another. It is very likely that they will look for an ideal to hold onto or be dictated by. Any intervention, any treatment, runs the risk of being positioned in that role by the addict. Every desire for a master is always matched by another's desire to be a master. This latter desire is, like the former, related to the desire to master the ultimate master. The addict's relationship to the death-drive, the jouissance of the real and thus, excess and transgression, often provoke a moral reaction to master the addict's behaviour, especially when he or she is faced with death.

A brief clinical interlude

This clinical fragment illustrates the dynamic between the transference and the desire of the therapist in an institution which
presents itself as what is called a 'caring community'. More often than not, caring institutions behave like an authoritarian Other or a maternal superego. This fragment concerns an alcoholic who was in analysis. He stopped drinking 15 years ago and he chose to do an analysis because he wanted to explore his life in that way. He spoke about an experience in a 'caring community', which took place a great many years ago. It was something that had traumatised him, something he never had been able to overcome.

On being admitted to the 'caring community', this man was given a guided tour through the building by the female therapist of his therapy group. She showed him traces left behind by group members who had been able 'to get in touch with their emotions'. The therapist told him: 'I want you to leave something behind as well.' He was also told that if he could do that he would be cured. He began his therapy group the next day. There was a rumour circulating that the therapist had a preference for men. He said that this rumour disappointed him for some reason (he didn't know exactly why). He immediately 'opened-up' in the group and he spoke about a particular incident. He thought he had done his best with this 'first step' in treatment. He thought he had been incredibly honest. The group reacted to what he said with, what is called, 'feedback'. One group member, whom he didn't like, said to him that he had been totally dishonest. At this point it should added that, on several occasions the therapist had encouraged him to 'express his emotions'; 'to let himself go'. She had even said that he should not 'hold back' because she was very well protected against a possible assault. Instead of complying with the hidden suggestion, he decided to attack the man who had given him 'negative feedback'. He grabbed him by the throat and 'acted-out' his aggression. He said he didn't feel particularly angry and it had even given him some pleasure. He added that he did it just because he wanted to do it. That, of course, is important because it means that it was an act in the true sense of the word: something that produces pleasure (and, therefore, something that is not unrelated to addiction). His reaction was not instinctive. The therapist told him at the end of the session that 'now he
was going to be cured'. The next day was family day (as it is called). Family members, friends and other acquaintances were present in the group. At a certain point he got extremely angry and he couldn't remember what the cause was. However, he could remember what he said: 'the group was only interested in pleasing the therapist'. He was so angry that he 'saw red'. He 'felt strange and not himself at all'. After this feeling disappeared he felt 'bad and guilty'. He spoke with the therapist and he apologised profusely. Apparently, that was sufficient, but not for long. The next day he was asked to leave the centre. He had gone too far in letting himself go and he had left behind too big a trace. It wasn't long before he was drinking again. When he apologised to the therapist she had told him that the group was in an impasse and she had been on the verge of dissolving the group.

A lot can be said about this fragment, but this will be restricted here to a number of aspects. Transference always comes as a surprise, and that is extremely problematic for institutions, especially the ones who are not prepared for it. 'Caring communities' are not prepared, at least not within their treatment philosophy, because 'why should clients get angry with us when we are trying to help and care for them?' The 'acting-out' of this man during group therapy was an act that took place in response to an institutional suggestion. It was an act committed in relation to an implicit ideal; it represented the desire to fulfil or satisfy a demand which took the form of an expectation. The transference surfaced the next day as a surprise. Precisely at that moment, a little piece of truth came to the surface as something that was unconscious and experienced as strange (he felt strange and not himself). The institution did not tolerate this piece of truth. The act (as opposed to 'acting-out') in the first group was 'dishonest' because he wanted to satisfy the desire of the therapist. The outburst the next day was spontaneous and indeed a more direct expression of the underlying truth. This truth is related to his 'dummy' from the previous day, namely the expectations that rested on his shoulder. This 'dummy' is an indication of his dependence on the master: the authority of the therapist or the institute that she represented. Something of the pathology
of the addiction manifested itself in this fragment. For example, the dependency on the master hides a not-wanting-to-know about the unconscious cause of anxiety.

Most therapeutic communities are based on a master discourse. In that sense, it is possible to say that they form a barrier against the unconscious. Every manifestation of a lack or an unconscious desire (and it makes no difference whether this concerns the pathology of the patient or the unconscious aspect of the institute itself) is 'too much' for the institution. It does not sit well with its rules. Institutions and their therapists will often show a reaction such as happened in this clinical fragment and this reaction happens when the 'too much' cannot be incorporated. This is a 'toxic' reaction with disastrous consequences for addicts; it is an institutional 'acting out'. The institution is reacting at the same level as the symptom or solution of addiction in this instance.

The addicted subject attempts to reach the object of the drive with a drug in order to obtain an ideal level of pleasure or jouissance. The institution attempts to moor a subject who has gone adrift, by putting the law and the object onto the same place. That attempt is exactly the same as trying to unite the ego-ideal with the object. For instance, the clinical fragment illustrates that everything has to fit into the expectations, ideals and rules of the institution. When something disturbs the equilibrium of the institution, when something happens that transgresses its rules, ideals and expectations, the unity is broken (the therapist had been on the verge of dissolving the group because it did not function anymore). The expulsion of the man was an attempt to reunite the group; a sacrificial offering to the ideal, in order to bring the group together. The unification of the ideal and the object (in an institution) creates an institutional hypnosis.

To give addicts a chance, it is absolutely essential that, from the very initial stages of intervening, they be given the chance to explore their subjective relationship to jouissance. Institutions have to conduct a clinic that includes the subject and not just focus on the addiction. It is therefore essential that the object and the ideal be kept as far apart from each other
as possible. A treatment centre for addictions has to create a *space* between object and ideal. That is the precise definition of a therapeutic space in a treatment centre. Only this kind of space leaves room for a confrontation between the subject and the lack or desire of the Other. Institutions should function as a lacking Other. But if they function as an authoritarian father or a caring mother (or vice versa), that is, if they function without a lack, they have turned their ideals into objects of desire.

Any institution or treatment centre functions, to a greater or lesser extent, on the basis of elements of a master discourse. No centre or institution can function without ideals, without a signifier that unites them. However, in the case of a treatment centre for addiction, it is crucial that the law, which represents these elements or ideals, is not a cruel law. A cruel law is a law which forces the ideal onto the subject. This implies a law which demands that the subject enjoys in a perverse way. To install a law that is not cruel is not an easy thing to do. Today's consumer culture has managed extremely well to bring the law and the object together in a cruel unit. Our institutions represent that culture. That is why it is an absolute imperative that exceptions are made to - and within - those units. The problem is that while our culture enforces the law of *jouissance*, it has a great need for strong prohibitions at the same time and this precisely in order to curtail the 'too much' of *jouissance*. One of the strongest prohibitions is the one which makes the law itself an object of enjoyment. Quite often this characterises the ideology and methods of addiction treatment. As asserted earlier, a detoxification of drugs is relatively easy via a reintoxification with the law. This was called a collective hypnosis.

'Addicts are victims'. This is a statement one often hears. It is not the kind of statement that tallies well with the ethics of psychoanalysis. However, if one accepts that addicts are victims, then so too are the institutions that deal with addiction. These institutions have the impossible task of marrying the ideal of the consumer society - to enjoy as much as possible - to the installation of a law, because a very strong prohibition is needed to call a halt to the evoked *jouissance*. How can this be translated into the daily reality of addiction treatment? 'Do as I do';
'Follow the programme!'; 'Forget the past!'; 'Meet your needs!'; 'Get in touch with your emotions and you'll get better!'. 'Forget the past' is something that one hears a lot in the world of addiction treatment. This is very interesting because the only a-historic aspect of the subject is precisely *jouissance*. This imperative of addiction treatment indicates a choice for *jouissance* and not a choice for creating a distance from *jouissance* through a symbolisation of the past. The imperative 'to get in touch with your feelings' is a classic example of the impossible and cruel order to enjoy. Treatment centres and institutions have accepted the impossible task of uniting the law with the object of *jouissance* because it is an attempt at preventing the disastrous consequences of the ideal of consumer society. The impossibility of this task is so frustrating that it often results in aggressive behaviour (such as happened in the clinical fragment).

In a general way one can say that addicts are dominated by a maternal superego which commands that he or she enjoy outside the phallic function or the symbolic law. Addiction is, as was already noted by Freud, a way of pacifying the superego. But the superego is (as is no surprise) egoistic. The more it is promised, the more it wants from the subject. This was Freud's original discovery in *Civilization and its Discontents*. Addiction can never be a solution for this discontent. Considered from the point of view of its relationship to culture, addiction always centres around an impossible dynamic between two solutions that exclude one another. It is an attempt to enjoy as commanded by the perverse superego, and it is an attempt to disarm this superego by drowning it in a sea of toxicity. Heroin culture reflects this impossible dynamic. Groups of heroin addicts often form a sub-culture in reaction to a dominant culture which commands that people enjoy in the way it wants them to. The effect of heroin and the effect of heroin culture obfuscate and disarm, by their very action, the effect of the command of culture. Heroin addicts install (in their own particular way) an ideal and this ideal is the exact mirror image of the ideal of dominant culture. (It is important to remind the reader at this stage that what is being talked about is addiction as a social bond. One should not lose sight of the fact
that behind the manifest uniformity of addiction one encounters the complexities of the subject and addressing those should be the ultimate aim in treatment). Society is up in arms about this alternative culture. The war against drugs is a desperate attempt to fabricate a failing father function as a way out of the obvious impasse. It is especially in the context of this desperate attempt that psychoanalysis has to assume responsibility. Both society and addicts have to pave a way towards desire. This implies the necessity of a symbolic pact, not the command to enjoy.

An intervention can be done such that it leads to the possibility of an interrogation of the administration of jouissance by the subject. This requires that in the 'intervention set-up' room is created between the ideal (or law) and the object. Another requirement is that therapists (and other clinicians) are prepared for the fact that the solution they offer is not 100% foolproof. If one demands from one's clients that they be duped, one has to allow for being duped oneself. Not every addict will recover. That is a fact. And anyone who does not accept that fact should not be allowed anywhere near an addict.

However, once one is prepared to be duped, there is still a crucial question to be answered: when does one intervene in order to move most effectively from the specific effects of drugs and alcohol to the cause of addiction via the medium of articulation? An intervention should start with the initial point of transference, namely the demand of the subject of addiction, which is a demand that relates to, or will be particular to, the subjective position of the subject. Why should one start there? The specific effects of drugs (also those that lead to addiction) are determined by unconscious 'knowledge in the real', but these effects are filtered through and co-determined by the subjective structure of the subject (his or her position). To put this into other words: the only restrictions on the effects

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13 The pre-oedipal differences regarding jouissance (of the Other) are the result of interactions with particular others and their fantasy structures. Lacan relates these differences to what he calls a 'knowledge in the real'. This seems to indicate a knowledge (like traces) that is deeply unconscious, but which, nevertheless, has a determining effect.
of variations in unconscious 'knowledge in the real' (which also cause variations in drug and alcohol effects) are the limits set by the subjective structure of the subject. That implies that the limit on variations in ways of dealing with jouissance is set by the different mechanisms of administration. Hence, it is possible to say the following: the effects of drugs and alcohol depend on unconscious 'knowledge in the real', but they are shaped and restricted by the structure of the subject via the mechanism of administration. One should start an intervention with the demand, because that is the point where something of the real cause of addiction reverberates in language; that is the point where unconscious 'knowledge in the real' makes itself felt linguistically, albeit in extremely veiled terms. The demand, also in the form of a complaint or an accusation, is the translation of the real into the language of the patient via the code of the mechanism of administration. The language of addicted patients is often defensive because translating the real is extremely painful. This requires a long working-through process in the causes for addiction: (1) the cause of the constitution of the subject in language which installs a lack which the subject of addiction wants to undo, and (2) the unconscious 'knowledge in the real' as an effect of the cut of the signifier in the real which causes subject-specific effects of drugs and alcohol which can 'hook' the subject. It is in the interplay between these two symbolically determined causes that addiction finds its cause. For instance, it is not sufficient to say that addicts cannot stand lacking anything. The complex interplay of causes is one of the reasons why addiction is such a complex pathology and why it is difficult to treat.

The treatment of the subject of addiction implies a therapeutic movement from the demand to establish a change in the unconscious 'knowledge in the real' with the hope for a change in the future regarding the effects of drugs and the effects of life. To say that the treatment should

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on the subject. This knowledge concerns the very first encounters between the infant and (linguistic) otherness. For a further exploration of this concept, and its relationship to knowledge within the human and modern sciences, the reader is referred to the Subject of Addiction, especially pp. 198-200.
start with the language of the demand is coherent with the hypothesis put forward that addiction is symbolically determined. The real complications arise from the problem that, despite the one source of determination (the symbolic order or the signifier), there are always ultimately at least two causes.

Finally, if treatment should start with the demand, then what is required to create a demand in addicts for therapy or analysis? The answer is simple: everything and anything that works. And it is clear what works and what doesn't work. What works is the lure of an ideal. What works is anything that incarnates the essence of addiction. What works is the scientific real of methadone. What works is the imaginary identification of therapy groups and self help groups. What works is the symbolic position of the master. Is it justified or ethical to use that lure? The answer has to be that it is. These are the only tools available unless, of course, one is prepared to incarcerate addicts or commit them to a hospital. Unfortunately, there are far too many people around who would be prepared to do just that. To lure addicts is both justified and ethical on the basis of a distinction that has to be made. One has to separate the position of agent provocateur from the way the agent is going to function. The agent should never function as lure or ideal. Making this distinction is perfectly coherent with the ethics of analysis: it is the lure of a promise that brings an analysand to an analyst and it is the function (as object of transference) that creates the possibility of an analysis. This is perfectly applicable to the treatment of addicts. Every initial encounter with addiction is an encounter that involves symbolic elements (especially, for instance methadone exchange programmes, but also doctors, family members, work, etc.) and that leaves room for a symbolic way out. Often that room is tiny, but it is a matter of knowing that it exists and indeed to seize the moment (carpe momentum) and act with words.

For most chronic addicts, the imaginary identification of a therapeutic community might be the only viable start of a recovery. There are a number of therapeutic communities that incorporate a Lacanian ethics in their way of working (for instance, Enaden in Belgium and
Communauté Zéro in Italy). However, a lot of therapeutic communities that treat addicts are based on a moral reaction to the problem of addiction. The majority of these types of treatment originate in North America (Synanon and Daytop) and they unite the law with the object in a way that leaves no room for the subject. Alcoholics Anonymous and Narcotics Anonymous also originated in the U.S.A., but they do not come from a moral tradition, and they are not a therapeutic instrument or facility. There is also an European tradition in therapeutic communities. Maxwell Jones is the father of what is called the Democratic Therapeutic Community. He started a community in Northfield Hospital during the Second World War. He had analytic training but did not consider analytic ideas to be of importance for his therapeutic work in communities. Harold Bridger trained analytically in the Tavistock Clinic in London. Bridger was inclined to incorporate psychoanalytic ideas into his way of working with patients in communities. He also worked with groups in the Northfield Hospital and he became a close associate of Wilfred Bion.14 These European therapeutic communities have their roots in psychoanalytic thinking. The therapeutic intervention of these types of communities includes the subject. However, this is not made explicit because the English psychoanalytic tradition never developed a theory of the subject. But that certainly does not mean that there was no room for the voice of the subject. It is precisely the idea of a 'transitional space' in the therapeutic community that leaves room for the subject. The transitional space is a concept that relates to Winnicott's transitional object. This object has a function for the subject in the encounter with the Other. The transitional space is a space that leaves room for the subject in the therapeutic community for such an encounter with the Other.

The direction of the treatment of addicts is a matter of managing the transference in such a way that via speech within the transference the

14 For an excellent overview of the traditions and history of the therapeutic communities the reader is referred to an article by Eric Broekaer Geschiedenis, Filosofie en Grondstellingen van de Therapeutische Gemeenschap, De Nieuwe Therapeutische Gemeenschap Leuven/ Apeldoorn, Garant, 1996, pp. 9-32.
particular effects of drugs and alcohol on the subject can be influenced via an effect on the 'knowledge in the real'. The therapist creates the possibility for analytical work of the subject. In other words, the universal function of the therapist/analyst creates the possibility for the production of the very particular in the subject. However, classical analysis is often not a viable option in addiction treatment. That does not mean that addicts cannot 'recover' through an analysis. It is possible when the analyst is able to replace the drug or alcohol as an object of transference. This is not possible in every case, and as indicated before, in chronic cases it is even extremely unlikely. In that case, all and everything is permitted, as long as the intervention contains the opening of a psychoanalytic ethics. This is an opening for the speaking subject.

Address for correspondence:  
DBS School of Arts  
6-9 Balfe Street  
Dublin 2  
Ireland

email: rloose@dbs.edu