13

Proposals for the Treatment of Users of Alcohol and Other Drugs: A Psychoanalytic Reading

Cynara Teixeira Ribeiro[1,2,3] and Andréa Hortélio Fernandes[4,5]
[1]*Pontifícia Universidade Católica de São Paulo (PUC/SP)*
[2]*Universidade Federal da Bahia (UFBA)*
[3]*Universidade Federal Rural do Semi-Arido (UFERSA)*
[4]*Université de Paris VII*
[5]*Universidade Federal da Bahia*
[4]*France*
[1,2,3,5]*Brazil*

1. Introduction

Currently, the harmful use of alcohol and other drugs is recognized as a serious public health problem in many countries (WHO, 2002). However, it has not always been so. The reason is because, for quite a long time, the prevention and treatment related to the use of psychoactive substances were neglected in the context of public health policies, and delegated to other institutions such as justice and public safety. This fact gave rise to initiatives of total character attention[1] and to therapeutic practices that aimed mainly at the abstention from psychoactive consumption. Hence, traditionally, the great majority of treatments offered to users of alcohol and other drugs was based on the abstinence proposal (Marlatt; Larimer & Witkiewitz, 2012).

Nevertheless, a worldwide discussion about the difficulties that alcohol and other drug addicts have to drastically stop consuming such substances identified the need for the development of other treatment models as an alternative to the abstinence proposal (Brasil, 2005; Paes, 2006). As a consequence, many countries all over the world adopted the approach of harm reduction as the official strategy for prevention, treatment and education of people who use psychoactive substances in a harmful way (Brasil, 2001).

Another existing perspective in the treatment of alcohol and other drug users is the psychoanalysis proposal (Director, 2005; Laxenaire, 2010; Loose, 2000; Valentine & Fraser, 2008). Its main specificity lies in recognizing the different ways in which the subject relates to the toxic substances and consequently, understanding that drug use is anchored in the subjective dimension. Besides, psychoanalysis points to the fact that certain types of relationship to drugs can provide a kind of paradoxical and deadly satisfaction, called

[1] The term "initiatives of total character attention" is a mention to the term "total institutions", coined by Erving Goffmann (1985/2001).

jouissance (enjoyment)[2] (Lacan, 1969/1992; Laxenaire, 2010; Melman, 2000; Olievenstein, 2002), which is articulated to the unconscious and the death drive.

Thus, taking into consideration the abstinence proposal, the damage reduction proposal and the psychoanalytic proposal, this chapter will discuss the particular features of each one of these treatment models. Besides, it will also analyze the controversial and convergent points that exist among them, paying special attention to the debate between psychoanalysis and harm reduction. Finally, the chapter will briefly consider how the treatments of drug users can be optimized, as the result of the 'approximation' between these proposals.

2. The treatment proposals of drug use

In order to start a discussion on the treatments offered to users of alcohol and other drugs, first it is necessary to emphasize the historical character of the phenomenon of psychoactive substance use. As several authors have pointed out, the human practice of drug consumption is universal and ancient. In fact, in nearly all civilizations and human societies, the consumption of drugs capable to promote changes in what are considered as the human beings' states of consciousness has been a resource of great social and subjective importance (Mcrae, 2001; Seibel & Toscano Jr., 2001; Carneiro, 2006).

Although this consumption was historically widespread, it is important to highlight that, until a certain moment in history, it was restricted to small groups and happened in connection to collective ceremonies and sacred rituals, according to socially shared norms and conventions, which gave a predominantly symbolic value to the use of these substances. For instance, some ancient people believed that the consumption of certain substances made it possible for the spiritual representatives of certain groups to incorporate supposedly supernatural powers. This association between psychoactive substances consumption and religion lasted for quite a long time, including the medieval period, when the use of drugs was condemned because it was considered a hedonistic and sinful behavior.

However, this conception was strongly challenged from the seventeenth century on, with the development of medical studies, when certain vegetal products that have psychoactive effect started to be valued as a source of energy, stamina, humor and temper balance. As examples, we can mention the opium, originated from the poppy, which was for a long time prescribed as a painkiller, antitussive and antidiarrheal medication, and the marijuana, prescribed as a general sedative, for the specific treatment of rheumatism, neurosis, insomnia, headaches, diarrhea, seizures and anorexia as well as in the therapy of tetanus and cholera (Carneiro, 2006).

Furthermore, with the isolation of the active principles of the psychoactive substances in the eighteenth century, trade was established and certain products started to be available to the general population. Simultaneously, there was the weakening of the socio-cultural regulation strategies for the use of these substances, as well as the rise of a number of social issues that contributed to the large dissemination of drugs consumption, both for therapeutic and recreational ends. This dissemination, in turn, revealed the capacity of these substances to cause physical and psychological dependence in some users.

[2] 'Jouissance' means 'pleasure' or 'enjoyment', but the terms in English lack the sexual connotation that the word has in French. Hence, in consonance with the majority of the English translations of Lacan's works, the original term was adopted in this text.

Thereafter, the phenomenon of drug use was regarded both as a social and health problem, leading many scholars to devote themselves to the systematic investigation of the several types of addiction originated from the consumption of psychoactive substances. Consequently, especially from the nineteenth century on, the use of drugs has become the object of study in the field of psychiatry and started to be considered a psychopathology, and as such, it needed to be treated (Conte, 2000). This was the context in which several treatments for drug dependence appeared, which, in a first moment, focused mainly on the detoxification and/or the isolation of drug users.

In a review of the existing treatments, it is noticeable that the field of drug addiction presents a great variety of offers. These offers can be classified as: medicamental treatments, with or without internment (especially through pharmacological interventions aimed at detoxification); non-medicamental treatments with internment (in therapeutic communities, recovery program farms, etc); non-medicamental treatments through the engagement in mutual help groups (such as Alcoholics Anonymous and Narcotics Anonymous, based on the Minnesota Method, also known as the Twelve-Step Model); cognitive-behavioral therapies (with emphasis on counseling techniques, motivational interviewing, relapse prevention and skill training); psychoanalysis (through individual and/or group psychotherapy care) and more recently, harm reduction (which provides services of drop-in, needle exchange, target delivery of healthcare, outreach and drug consumption rooms) (Stevens, Hallam & Trace, 2006).

According to Queiroz (2001), except for psychoanalysis and harm reduction, the other treatments are predominantely grounded in the principle of abstinence. Hence, as previously mentioned, in the scope of drug addiction treatments at least three different proposals can be identified: abstinence, harm reduction and psychoanalysis.

3. The proposal of treatments that aim at abstinence

Considering that drug abuse treatments appeared mainly due to the recognition of drug addiction as a psychopathology by the psychiatry field, it is not difficult to understand why these treatments have been developed based on assumptions originated from psychiatry. Being a branch of medicine, initially psychiatry incorporated the hegemonic biomedical model and its strong emphasis on the organic and biological aspects of both physical and mental diseases (Pratta & Santos, 2009; Rothshild, 2010). Thus, due to the strong influence of the biomedical model on the psychiatry field, especially during the nineteenth and twentieth century, in many countries the treatments for drug use were led to adopt the same logic implemented in the therapies of other psychopathologies.

Therefore, traditionally, these treatments had as their main feature the hospitalocentric model, with predominantly pharmacological therapies aiming at healing, which in general, in the case of psychoactive substance users, was considered equivalent to the abstention of drug use (Faria & Schneider, 2009; Rothschild, 2010; Valentine & Fraser, 2008). Although this fact was more evident in some countries, such as the USA, who have lived under the aegis of a real 'war on drugs', in a way it did have, and still has, effects upon how certain organizations around the world deal with the drug addiction phenomenon[3] (Marlatt,

[3] An example of the influence of the prohibitionist concept on worldwide agencies were the three International Conventions organized by the UN Commission of Narcotic Drugs, that aimed at

Larimer & Witkiewitz, 2012). The concept underlying this type of this viewpoint about drug use was that drug addiction would be a neurochemical dysfunction caused by the use of drugs (Freda, 1989/1993; Khantzian, 1995; Olievenstein, 2002).

In the mid-nineteenth century, a moral model of religious or spiritualist origin was added to this classic psychiatric view of psychopathology and treatment (Marlatt & Witkiewitz, 2010). This model proposed that drug use was the result of character deviation, and rehabilitation, correlated to abstinence, was of divine nature (Faria & Schneider, 2009; Stevens, Hallam & Trace, 2006). This moral model is still adopted by some therapeutic communities and by a great part of the self-help groups, which propose that chemical dependence is an incurable physical, mental and spiritual disease.

In fact, according to Bastos (2009), there are still remaining practices of these ideas of morality in current treatment for drug users. Such practices determine that drug use treatments inserted into this logic take the strand of reward and punishment, to mould the drug users' behavior into the one desired by the public health service, that usually is the abstinent behavior. This way, it is noticeable that both treatments, the one originated from the classic psychiatry and the one originated from the moral model, have as their common objective to make the user abandon the use of drugs and reach the goal of abstinence.

In this sense, one may say that abstinence consists of a treatment proposal that is influenced by these two models, in that both establish the total abstention of consumption as the easiest way to avoid drug users to lose control in face of psychoactive substances. As a consequence, many countries that adopt abstinence based treatments (for examples, USA, Japan, Singapore, Malaysia, and others) favoring the therapeutic models based on the isolation of users (Alves, 2009; Pratta & Santos, 2009). It is worth mentioning that this preference for treatments with internment reveals the influence of the asylum model in mental health, which has been sharply questioned by the anti-psychiatry movement[4] (Marchant, 2010).

Among other reasons, this preference comes from the belief that inpatient care allows for better surveillance and control of the users, which would assure the abstention of drug consumption, at least while under treatment. However, one of the main criticisms to treatments in closed institutions lies in the fact that the patient's isolation from society creates an artificial environment which characteristics cannot be reproduced outside the institution's walls. Hence, once the treatment ends, the patient's reintegration to the family and social environment tends to be disturbing, favoring the occurrence of numerous relapses (Alves, 2009; Brasil, 2005; Marlatt; Larimer & Witkiewitz, 2012; Rothschild, 2010).

This idea of making users' access to psychoactive substances difficult is justified by the basic assumption that grounds the abstinence treatment proposal, which is that the drug makes the drug addict (Freda, 1989/1993). According to this viewpoint, drugs are seen as having a

implementing a common program to combat drugs in all its member states (Alves, 2009). In 1998, this same Organization devised an action plan, ratified in 2003, whose title was "A drug free world: We can do it," establishing the year 2008 as the deadline to reach this goal in several countries.

[4] It is important to emphasize that, in some countries such as France and Switzerland, due to the influence of psychoanalysis, historically the psychiatric treatments were not so subordinated to the biomedical model. However, a steady increase of an organicist perspective in mental health has been perceived lately, even in these countries (Decker, 2008).

supposedly intrinsic power of getting subjects addicted to them. Thus, the idea conveyed is that anyone who uses drugs will compulsorily become, sooner or later, a drug addict. This is considered especially true in regard to those drugs viewed as more powerful, such as cocaine, heroin and crack. But in a way, this is a belief that is extended to the remaining psychoactive substances – mainly in cases in which the consumption of these drugs goes beyond the socially established standards. However, this viewpoint ends up favoring the pharmacological aspect of drugs, and ignoring the individual, subjective, social and cultural aspects implied by the phenomenon of drug abuse and addiction.

Thus, in the perspective of treatments that aim uniquely and exclusively at abstinence, drug abuse is generally considered as a problem that concerns the disease, not the subject (Dufour, 2004; Olievenstein, 2002; Passos & Souza, 2011). By doing this, it is not taken into consideration the possibility that the use of drugs represents a way the subject found to deal with his/her conflicts and with the pain of existing, that is, the discontent that, in some measure, affects all human begins (Freud, 1930/1996)[5].

Therefore, in the abstinence proposal, it is assumed that the only means to prevent or treat drug addiction would be the non-use of drugs. This is one of the reasons why many drug addicts that are treated by the abstinence proposal say that they are permanently in recovery, regardless how long ago the last drug use was, and affirm that they are 'clean just for today'. The explanation for this type of discourse is based on the fact that relapses are seen as a great threat in the horizon of those who undergo this model of treatment. And since relapses are considered the total treatment failure, abstinence is thus placed as the objective to be pursued daily and for the whole life.

This conception favors the idea that once a drug addict, forever a drug addict. As a consequence, the abstinence proposal ends up promoting an imaginary collage of drug users to the signifiers 'addict', 'toxicomaniac', 'sick', etc. In turn, this collage makes it difficult for the user to get out of the subjective position of dependence on psychoactive substances. This is because the former user who structures his/her life around the abstinence from drugs continues to delegate to the drug a central role in his/her life, and to live under the aegis of an imperative: it is as if he/she had simply replaced the statement "I have to consume" for "I have to *not* consume", thus remaining in the same subjective position of being subjected to toxic substances. In this case, the patient, whether using drugs or not, continues to use the resource to the toxic as a subterfuge to avoid confronting his/her psychic issues, so that his/her submission to the external imperative of abstinence ends up exempting him/her from the need to make his/her own choices and be responsible for them (Rothschild, 2010).

Another criticism to drug treatments that aim exclusively at abstinence is the fact that they don't generally consider the different modalities of drug use and consequently, the fact that

[5] The concept that drug use is tied to a subjective need of the user was strongly advocated by Khantzian (1995), who, from the perspective of ego psychology, proposed that the intoxication practices were a type of self-medication which the subject used in an attempt to better deal with his torments. However, the association between the use of certain substances and the existence of specific psychological problems, proposed by this author, did not resist empirical tests and clinical experience. On the other hand, the hypothesis of self-medication ended up contributing to the spread of the adoption of the psychoanalytical approach in the treatment of drug users, which will be explained in more detail in following sessions.

not every drug user becomes what is considered a drug addict. This view ignores that most users of drugs do so for recreational or occasional purposes, but never come to a dependency relationship with them (Araújo, 2007; Nery Filho & Torres, 2002; Rezende, 2000; Stevens, Hallam & Trace, 2006)[6].

Nevertheless, the differences among the types of drug consumption are acknowledged in several fields of knowledge. In this respect, the UNESCO, for example, distinguishes four types of drug users: the experimenter, who tries one or several types of drugs, but limits this contact to the first experience; the occasional user, who occasionally uses one or several drugs, but is not a drug dependent; the habitual user, that frequently uses drugs, but still functions socially; and the dependent user (also called a drug addict or toxicomaniac), who lives by and for the drugs, and has his/her social bonds severely hampered or even broken by them (Rezende, 2000). Hence, the definition of drug addiction does not include the modalities of drug use in which the subject, although he/she uses the drug, does not place it at the center and as a destructive element in his/her life, and manages to preserve the social ties.

As a result of the various criticisms to the abstinence proposal, many authors have considered that, given the impossibility or great difficulty to maintain abstinence and eradicate drugs, the most interesting posture to be adopted is to try to manage the effects of drug use and minimize the damage caused by it, as proposed by the harm reduction strategy (Rezende, 1999; Queiroz, 2001; Pratta & Santos, 2009). And in fact, although the zero-tolerance policy to drug use still prevails in some countries, many other, especially in the European Union, adopt the harm reduction approach in the prevention and treatment of drug addiction as well as in the problem arising from it (Marlatt & Witkiewitz, 2010; OEDT, 2011).

4. The proposal of the harm reduction strategy

Harm reduction[7] is currently defined as a public health strategy that targets at reducing the damage caused to the individuals' health and controlling the possible adverse consequences that result from the adoption of risk practices (Marlatt; Larimer & Witkiewitz, 2012). In the specific context of alcohol and other drugs, harm reduction implies a set of interventions with the purpose of preventing the negative consequences of the consumption of psychoactive substances, without the requirement of immediate and automatic abstinence.

Among these interventions, it is worth of notice the distribution of syringes, needles and pipes, the presentation of educational lectures and the referral of users that are outside the health services to specialized institutions. Besides, the harm reduction approach is also dedicated to teach the patient the supposedly most efficient way to deal with the variety of risk factors that lead to the abuse of psychoactive substances, in order to help the patient to reach the goal he/she established for him/her, be it the total abstinence or moderate consumption. Hence, harm reduction presents an alternative perspective to treatments based on the abstinence logic, when it considers possible to prevent the negative effects of drug addiction without its compulsory interruption.

[6] According to the report published by the UM in 2007, approximately 200 million people use drugs worldwide, and only one-eighth of these have dependence problems. The remaining are occasional users (Araújo, 2007).

[7] In some places, the term harm reduction is replaced by risk reduction, and these two terms are often used as synonymous, although they are not.

The harm reduction approach, as a general guideline for action, was originated in England in 1926, through the development of the Rolleston Report (Stevens, Hallam & Trace, 2006). A ministerial committee chaired by the UK Ministry of Health established that the most adequate treatment for certain patients would be the maintenance of the use of certain substances, thereby regulating the right of British doctors to prescribe opiates to addicts of this type of drug. In the same Report, it was established that the criterion adopted for this prescription should be the need, after several failed attempts at abstinence, to manage the syndrome caused by the abstention of certain substances, besides the observation that the patient would not be able to lead a normal and productive life without a minimal dose of the drug administered regularly (Brasil, 2001).

This procedure was known as substitution treatment, and until today is one of the harm reduction strategies used (Marlatt & Witkiewitz, 2010; Stevens, Hallam & Trace, 2006). It consists of changing the substance which the user is dependent on for another substance that will offer lower risk. The most common strategy is the substitution of heroin by methadone, a synthetic opioid agonist with long half-life, which is consumed orally, helps to relieve some of the heroin withdrawal symptoms, causes less organic and psychological damage and is considered a substance with lower addictive power. Although this model of treatment appeared in a context different from the current, it is still in use in several countries such as England, Holland, Croatia and Norway, among others, especially in the European Union (Alves, 2009; OEDT, 2011).

Thus, the initial objectives of the harm reduction approach were to make it possible for users who were psychoactive dependents to lead a more stable and useful life, and to minimize the harmful health effects of drug use. However, after the 1980's, with the spread of the HIV/AIDS virus due to the large contamination originated from the sharing of needles, the harm reduction strategies also aimed at preventing this contamination among the users of injectable drugs.

As a consequence, due to some positive results obtained in the prevention of contamination in several countries such as Belgium, Australia, Germany, Switzerland, France and others (Brasil, 2001; Paes, 2006), many harm reduction programs appeared as public health strategies. Brazil was one of the countries that has most recently adopted this approach, when in 1994 the harm reduction model was embraced as the official policy by the Health Ministry (Brasil, 2005), resulting from the recognition of the harmful use of alcohol and other drugs as a serious public health problem. In addition, the observation that the majority of drug users are not capable or do not want to stop consuming such substances weighed heavily on this decision[8]. However, it is important to point out that despite all the incentives created by the Brazilian government, there has not yet been a significant adherence to this strategy that would allow for the institutionalization of the harm reduction policy in the entire public health system (Passos & Souza, 2011).

From a public health perspective, the adoption of harm reduction as a strategy for the treatment of addiction to psychoactive substances aims to recover the users' self-regulating

[8] One of the reasons why drug users do not want and/or do not manage to interrupt the consumption is the fact that they have already incorporated the drugs they use to their personal and relationships routine (Rothschield, 2010). Besides, in most cases, such substances are a source of jouissance, which they are not willing to do without (Laxenaire, 2010; Olievenstein, 2002).

role and citizenship, while stimulating their inclusion and mobilization in the society, through the expansion of their social relationships and the increase of the chances within the society in which they live. Theoretically, the objectives of the harm reduction proposal can be reached through the adoption of certain strategies of action, namely those that seek to reach users who, due to their socio-economic characteristics (lack of permanent housing, close relationship with illegal practices, lack of health concerns, etc), are generally excluded from health services (Marlatt & Witkiewitz, 2010; Pinheiro, 2002; Stevens, Hallam & Trace, 2006). Furthermore, there are other strategies that intend to promote drug users' moderation of consumption, such as drug consumption rooms and target delivery of healthcare.

As a consequence, the harm reduction proposes that, with the implementation of this new treatment model, users of alcohol and other drugs can receive counseling and adequate treatment in order to avoid the most serious consequences of drug abuse, such as deaths by overdose, organic damages and virus contamination. This way, there is the hope of contributing to a safer drug use and a global and less prejudicial understanding of this phenomenon.

In fact, many authors argue that the treatment of drug users with the harm reduction approach is not only more efficient but also less costly, when compared to the abstinence model policies of drug use combat, because it contributes to decrease the number of deaths and illnesses associated to the use of drugs and to improve the social functioning of psychoactive substances users (Marlatt & Witkiewitz, 2010; OEDT, 2011; Stevens, Hallam & Trade, 2006). Nonetheless, this effectiveness is difficult to be supported by statistical data, partly because, although abstinence and harm reduction are grounded in apparently opposite philosophies, many drug users that start treatment with the objective of achieving abstinence end up redefining their goals during the process and begin to seek moderation in consumption (Neale, Nettleton & Pickering, 2010). From this perspective, in a number of health services, abstinence and harm reduction become part of the same treatment strategy, and can actually be used together (McKeganey, 2011). Besides, because studies on efficacy, effectiveness, and cost-effectiveness of the varied types of treatment have often employed methods and research designs of varied quality (such randomized controlled trials, clinical trials, case series, reviews, meta-analysis, etc), it is difficult to make a direct comparison of the different interventions. These are the reasons why there is a growing need for the development of more research focusing on these issues (CIAR, 2008).

In spite of this, it is possible to state that, because it places lower demands, the harm reduction proposal seems more attractive to many users, and decreases the number of patients that give up treatment (Alves, 2009; Rothschild, 2010). In addition, some authors defend that the rampant increase in the consumption of illicit drugs and the growth of the progression from the use of least to most powerful drugs are less frequent in countries and areas that adopt the harm reduction perspective (Alves, 2006; OEDT, 2011).

Especially because of these reasons, harm reduction is considered an "ethical landmark" in the field of prevention and treatment of disorders associated with the use of alcohol and other drugs. From this perspective, the proponents of harm reduction programs defend that this approach "recognizes each user in his/her *singularities*, designing with him/her the strategies to defend his/her life" (Brasil, 2005, p.42)[9].

[9] All the translations from the Portuguese original versions were made by the author.

However, it is worth debating whether the ethic that the harm reduction strategy deals with actually takes into account the subjectivity of each user. Regarding this aspect, it is important to highlight that, in mental health practices based on harm reduction, the place occupied by the subjective aspects of the one who resorts to intoxication remains open to questioning. In this respect, it is valid to inquire whether this approach considers the dimension of *jouissance* coupled with the intoxication practices[10].

This issue deserves a thorough, deep discussion, to avoid falling in the empty promise of change, which will lead us to trade a practice that just considers the use of drugs as a disease, either physical or spiritual, for another practice that takes the drug use in its exclusively social dimension. Hence, it is important to note that drug addiction is a complex and multifaceted phenomenon. Thus, it is not possible to adopt a reductionist position, be it biological, moral, social or psychological, in relationship to it. This reservation derives from the assumption, advocated by some authors, that social inclusion and citizenship recovery in mental health, though important, tends to neglect the subjective nature entailed by the psychic suffering and the mode of *jouissance* of each subject (Kyrillos Neto, 2007; Rinaldi, Cabral & Castro, 2008).

The request for the inclusion of the singularities and the listening of the patient in mental health practices is strongly considered by some psychoanalysts (Figueiredo & Tenório, 2002; Valentine & Fraser, 2008), who, although recognizing the advances obtained by psychosocial rehabilitation, highlight that the emphasis on the citizen of rights can lead the current mental health practices to a new kind of subjective dismissal (Fernandes & Freitas, 2009). This is because there is a contemporary perspective in psychoanalysis that adverts that any rehabilitation proposal can only succeed if it follows the subject's discourse, since the rehabilitation that denies the clinic will inevitably fall into the trap of re-education (Viganó, 1999).

In this way, to psychoanalysis, the emphasis is placed on the subject, which makes the psychoanalytical practice different from the other approaches that are centered on the social determinants of the phenomena considered psychopathological, in spite of the agency and subjective choices (Valentine & Fraser, 2008). Thus, the psychoanalytical treatment focuses attention on what the patient says about him/herself, since the meaning of the symptoms, and consequently, the production of what Freud (1905/1996) called 'talking cure', will only be possible to emerge from the elements that the subject him/herself brings. Hence, the importance of psychoanalysis lies in the fact that this approach opens a space in which the patient's talking can be listened to, interpreted and analyzed.

5. The psychoanalysis proposal

Thus, psychoanalysis also presents a specific proposal for treating users of alcohol and other drugs. This psychoanalytical proposal for the understanding and treatment of drug addictions was outlined along psychoanalysis' own history. For, in this field, it was Freud who first became interested in this phenomenon, laying the conceptual foundations that

[10] It is important to emphasize that, from the psychoanalytical perspective, every type of drug use provides some kind of jouissance. However, in the case of drug addiction, the jouissance provided invades and dominates the user, in such a way that the subject remains subjected to the psychoactive substances.

made possible the subsequent development of psychoanalytical-based propositions on drug use such as the ones developed by Abraham (1908), Rado (1933), Krystal (1975), Lacan (1976), McDougall (1978), Wurmser (1995), Khantzian (1995), among others. Although all the theories formulated by these authors refer to the conceptual field of psychoanalysis, they are very different. Explaining each one of them is beyond the scope of this chapter, so the following considerations are embedded in the framework of Lacanian psychoanalysis, which stands out for having remained faithful to the Freudian doctrine and for being the only one that can explain why, in the use of drugs, pleasure and harm are inexorably interwoven (Loose, 2000).

Nevertheless, it is important to highlight that, despite the existence of so many psychoanalytical readings on drug use, "the association between psychoanalysis and drug addiction is not common" (Laxenaire, 2010, p. 524). One reason is the fact that there is currently a strong demand for evidences of cost-effectiveness of the several existing treatments. And psychoanalysis is usually assessed as a long-term treatment, which proofs of efficacy are still insufficient (CIAR, 2008; Harrison et al, 2003). One of the main explanations for this assessment is the fact that psychoanalysis does not work on the same efficacy parameters that are adopted by other fields. Because the therapeutic efficacy is always related to a certain conception of cure and the psychoanalytical view of cure differs from the other fields, since psychoanalysis recognizes the existence of something incurable in the subject, and hence, is warned that it is not possible to ensure a full state of well-being, for suffering, to some extent, is at the core of human existence (Freud, 1930/1996; Lacan, 1966/1998; Loose, 2000). Even so, many psychoanalysts have published works that demonstrate promising effects of the psychoanalytical treatment for drug addiction through the reports of clinical cases[11] (Rothschield, 2010; Loose, 2000; Marlo & Kalinian, 2002).

To start discussing the treatment proposal oriented by psychoanalysis, it is crucial to highlight that the psychoanalytical treatment operates under a view that is radically different from the therapeutic proposal originated in the medical-psychiatric field and from the one derived from the moral field as well (Silva, 2010). This is because psychoanalysis works with the notion of the subject of the unconscious, conceived as being beyond the individual and beyond the illness.

The psychoanalytical concept of the unconscious refers to a psychic system that runs parallel to the conscious system, and that operates in a determined way, having an order and structure of its own (Fink, 1995). But, unlike the conscious system, the unconscious can only appear as a stumble, just in the gaps of the conscious manifestations, in what Lacan (1957/1999) coined as the formations of the unconscious: dreams, lapses, faulty actions (Freudian slips), jokes and symptoms, which reveal a meaning that so far had been hidden to the subject him/herself. By doing this, the unconscious indicates to the self the existence of an instance which is, at the same time, inside and conflicting with it.

Whereas the consciousness operates in articulation with the reality principle, the unconscious operates in articulation with the pleasure principle, and, most importantly,

[11] This method of demonstration of results is justified because, as psychoanalysis emphasizes the singularity and the subject, it would be absolutely incoherent to expect that its efficiency could be demonstrated by statistical evidence. Hence, what can be expected from further research in this field are meta-analysis based studies that provide within-subject measures related to drug consumption, demonstrating the improvement of drug users that have undergone psychoanalytical treatment.

with the beyond pleasure principle. Whereas the reality principle, because it is articulated to the material reality, makes detours and delays in search of satisfaction, the pleasure principle seeks satisfaction in the shortest and most direct way (Freud, 1911/1996). The beyond pleasure principle, in turn, is articulated to the death drive, which Freud (1920/1996) defined as a certain tendency, inherent to all living beings, to seek the pacification of all the tensions – which ultimately can only be achieved with death.

This is why, in psychoanalysis, the resource to intoxication is understood as a choice of the subject who, moved by the unconscious laws, searches actively for a *jouissance* that is extended towards death. To psychoanalysis, this search does not happen despite the subject, as other psychotherapeutic approaches propose. Yet, it is a choice[12] made by the subject him/herself, but a choice that does not come from rational and logic elements alone, but also results from desires that many times escape rationality, since they resort to the unconscious and are articulated to the death drive.

In fact, according to Laxenaire (2010), the unconscious search for death is well evidenced in drug addiction. Thus, one of the main particularities of the psychoanalytical proposal in comparison to the other treatment modalities lies on the emphasis given to the subjective structure at the expense of the pathological phenomenon. This is so much true that, while the medical-psychiatric diagnosis is most of the times phenomenological and based on a set of previously defined signs, the psychoanalytic diagnosis is structural and is from this structural diagnosis that the psychoanalytical treatment will develop.

The structural diagnosis refers to the differentiation of the three clinical structures: neurosis, psychosis and perversion, which concern the mode of the resolution of the Oedipus Complex. This diagnosis results from the evaluation of the position assumed by the subject before the Other (Figueiredo & Tenório, 2002). This is explained by the fact that, to psychoanalysis, what marks out the structuring of the human psychism is the relationship with the Other, understood not as another person, but as the whole symbolic universe to which the individual finds him/herself referred to (the discourses, rituals, codes, beliefs, etc). Although this symbolic universe is initially transmitted by one primordial other (such as the mother or the one who is in charge of the child's insertion in the world of language), in the Lacanian theory the Other represents the entire culture, and is considered an indispensable element for the human subject constitution, in that it makes it possible for the individual not to be a mere biological representative of the human species, but to become a being provided with thoughts and feelings, and inserted into social bonds (Lacan, 1939/1985). From this perspective, every human subject is dependent on the Other, since no subject can engender him/herself on his/her own (Laxenaire, 2010).

From this viewpoint, addiction would be a posterior dependence, but anchored exactly in the mode of relationship the subject established with the world around him/her (Laxenaire,

[12] The term choice is used by psychoanalysis not in the sense of a pondered decision, but as something that is chosen because it relates to what is most intimate to the subject, his/her unconscious. Hence, to psychoanalysis the choices are overdetermined by his/her psychic reality. In other words, psychoanalysis refers to choices that are not always rational, such as for example, the choice of abusive intoxication that many times threatens the subject. However, despite the sometimes hazardous effects caused by the subjective choices, psychoanalysis emphasizes how important it is for health professionals who work with drug addiction issues to keep alert to the fact that, in some way, users make the choice of intoxication.

2010). This is why the structural diagnosis is of paramount importance in the psychoanalytical treatment of drug addiction, keeping in sight that it will enlighten the reasons why the inexorable dependence on the Other was transmuted into the dependence on a fixed object, which may give access to a kind of *jouissance* that is steady and repetitive, and to which the subject, from a certain moment on, becomes subordinated.

Thus, psychoanalysis defends that if, in the beginning, the consumption of drugs has basically a recreational function, it is during its use that the drug, for some users, turns into a product that acquires a vital and indispensable role, configuring thereby an addiction. Several reasons converge to explain why addiction happens only in a subgroup of drug users. Among them are individual, social, economic, cultural and family factors. However, the psychoanalytical treatment emphasizes the subject that resorts to drugs, and consequently, to the particular function that drugs have in the psychism of each drug user and/or addict, and also highlights the importance of a diagnosis that differentiates between drug consumption and drug addiction.

Hence, from a psychoanalytical perspective, "it is necessary to differentiate the simple uses of stupefiers from the imperative of treatment of the organism by a toxic drug, when this becomes the only means to shelter, on a daily basis, the body from an intolerable pain" (Kaufmann, 1996, p. 542). Thus, to psychoanalysis, drug addiction is defined as an "intense and exclusive relationship, in which the use of drugs has already been established as a function in the subject's psychic life" (Conte, 2000, p. 11).

For this reason, from a psychoanalytical viewpoint, the drug is not a problem in itself, since what can become problematic is certain types of drug use that some subjects make, which can turn into a form of the subject's own destruction. This means that, in the psychoanalytical treatment of drug addiction, it is a matter of removing the biological characteristic from the drug (although not denying its existence), to give value to something else, converting it in something other than a simple object that produces psychological or physiological effects, which, by the way, can only be apprehended by the signifier, by what the patient reports. In this sense, if the treatment modalities based on abstinence claim that the drug makes the addict, to the extent that drugs are considered as having the supposedly intrinsic power to get the subjects addicted, psychoanalysis states that the drug addict makes the drug (Freda, 1989/1993), because it understands that this is a private relationship between the subject and the object, that grants to the latter the power to become a source of satisfaction which the subject himself cannot do without.

From a psychoanalytical point of view, then, the addictions and the symptom have similar forming mechanisms, insofar as they both are a solution to an underlying conflict, but a solution that is not perfect, since it does not solve everything. But even being imperfect, it is a repeated solution, because there is something in it that the subject is not willing to give up, despite all the suffering that it brings (Loose, 2000). Hence, in the psychoanalytical treatment for drug addiction, it is understood that the subject's choice to use drugs, the relapses and the excessive use of the psychoactive substance will only stop being an escape for the subject when the treatment enables him/her to find other forms of symbolization that allow him/her to abstain from drugs, in cases when this outcome is possible – for there are cases in which, due to a extremely unstable psychic configuration, the addiction is simply the one and only way the subject finds to manage to continue living.

Thus, in the psychoanalytical treatment, it is necessary to take into account the function and the meaning of the drug use to each subject, in order to make possible the identification of the relationship established between the subject and the drug. And to psychoanalysis, this identification is only viable when it comes from the knowledge produced by the subject him/herself during the treatment. According to this perspective, the role of the psychoanalyst in toxicomania treatments is to conduct a quality listening of the subject, enabling the emergence of the unsaid, of what is not obvious, of what is beyond the pleasure principle, which, by nature, point at the subject of the unconscious. In other words, if addictions result from the choice for a *jouissance* in the body, a *jouissance* that does not express itself through language, so the psychoanalytic treatment objective is to enable the subject to make a movement "from ad-diction to diction" (Loose, 2000, p. 80).

According to Loose (2000), drugs and alcohol can only exert massive and extreme effects on the subject because they work pushing him/her out or against the language domain. In this sense, re-inserting him/her in the symbolic chain, in the diction domain, means going exactly in the opposite direction of the drug effects. Thus, the main difference from the psychoanalytical treatment is due to the ethic that guides psychoanalysis, which is radically different from any moralizing perspective. This is because, similarly to the medical-psychiatric treatments, the treatments originated from the moral model assume to know, *a priori*, about the subject and what is supposed to be the best for him/her. This characteristic results from the fact that the moral model aims at responding to a social demand of standardization and adaptation of deviant behaviors, rather than fulfilling the users' needs. Hence, the treatments based on this model end up promoting the subject's orthopedic framing or re-education, to the extent that they intend to teach him/her what is considered as the adequate behavior, which is, in this case, the social ideology of sobriety and aims at a certain preservation of the other citizens' life.

Still in regard to the moral model of treatment, psychoanalysis advises that, when the professional embodies the position of knowing about the subject, there is no room for the subject to produce any knowledge about him/herself (Bastos, 2009). And in a context in which the subject is not given the means to produce his/her own knowledge, it is very likely that he/she will remain at the mercy of the professionals or institutions, being unable to make his/her own choices and/or to be responsible for them. Consequently, instead of becoming responsible, the subject under treatment remains in a state of tutelage, in which there is an attempt to remove all of his/her possible responses that do not conform to the expectations of the health professionals and institutions. In sum, the great contribution that psychoanalysis offers to the treatments of drug abuse and addiction is to call the attention to the fact that, if the subject choses his/her addiction as a solution that makes him/her suffer and at the same time brings him/her *jouissance*, then, only the subject him/herself is able to, through treatment, choose what to do with what affects his/her body and life so radically.

6. Psychoanalysis and harm reduction: controversies and convergences

Reviewing the literature, it is possible to confirm the extent to which psychoanalysis, while a specific field of knowledge, has long adopted a critical position with regard to the existing drug use treatments based on the mandatory abstinence (Conte, 2004; Melman, 2000; Queiroz, 2001; Rothschield, 2010). For this reason, in the first instance, it would be possible

to identify an approximation between psychoanalysis and harm reduction proposals, insofar as they both problematize the model of treatment guided by the logic of abstinence.

In fact, according to Paes (2006), "the literature on drugs that has psychoanalytical basis has often been used by technicians who work on the training of harm reducers" (p. 129). Since the 1970s, there has been an increase in the number of professionals with a psychoanalytical focus, who offer chemical dependents a different kind of treatment and express serious criticism to the existent models of treatment (Paes, 2006). One of the main psychoanalysts that represent this viewpoint is the psychiatrist Claude Olievenstein, who, in the 1970s, founded the Centre Médical Marmottan, an institution for the treatment of drug addicts in Paris that became a benchmark and was inspirational for many treatment centers worldwide (Freda, 1989/1993; Marchant, 2010).

Queiroz (2001) also believes that it is possible to consider an approximation between the psychoanalytical assumptions and the harm reduction approach, insofar as the programs that adopt the latter introduce the "dimension of the particularity of the subject" (p. 3) and therefore, acknowledges "drug users as particular subjects and citizens, who have the right to health and to a treatment that is in fact effective and produces meaning" (Queiroz, 2001). In this case, the production of meaning refers to the fact that both the harm reduction policies and the psychoanalytical approach grant drug users the right to use drugs, which makes possible for them to build significations for this use without necessarily having to interrupt it (Marchant, 2010; Rotschild, 2010).

Adopting a similar perspective, Conte (2004) states that not only the harm reduction approach but also the advances achieved by the psychosocial rehabilitation paradigm do come close to psychoanalysis. According to the author, in both of them "there is the common refusal to flatten the subject to a passiveness that asks for social assistance or to a subject-body condition (organic and biologic) that asks for a "medicamental solution" (Conte, 2004, p.26).

On the other hand, Conte (2004) warns that the principles that underlie the harm reduction proposals are not the same that guide psychoanalysis, and in this respect, adverts that "the differences are due to *the ethic*, the objectives of the interventions and those who they turn to" (p. 27). Hence, this proposal of conciliation between the singularity dimension, represented by the subject's clinic and grounded in psychoanalysis, and the universal dimension, represented by the perspective of social rehabilitation and consequently, harm reduction, is not consensual.

In this respect, Dufour (2004) presents a more critical position regarding the social emphasis given by some mental health policies, and advocates that "it is not about encouraging carelessness – as one is soon blamed when one shows the slightest reservation about the humanitarian conduct – but observing the effects, opposed to the desired ones, caused by the coercive kindness" (p.37). Therefore, the author indicates the existence of a certain amount of coercion in the psychosocial rehabilitation practices in mental health, and makes sure to explicitly include the harm reduction proposal under this view.

When referring to the movement that he coined as "to limit the damage" or "reduce the harm", Dufour (2004) states that:

the surprising fact in this type of proposal is that it does not take into consideration the opinion of the ones involved. It searches for their happiness and health, regardless of them. Some rebel against it. For example, a patient who lived with an HIV-positive woman used to say about precautions: 'you know, for me, making plastified love is not my business' (p.37).

It is important to pinpoint that, as previously mentioned, because it is a public health strategy, harm reduction is inserted in the psychosocial rehabilitation logic. Then, the harm reduction objectives are to reduce the damage caused by the use of psychoactive substances, and promote the bio-psychosocial well being of the health service users, having for main focus of attention the citizen of universal rights. Therefore, harm reduction aims to provide a treatment for everyone, and is thus based on the principle of equal rights and connected to the universal dimension. This universalizing perspective in public health and in harm reduction may bring a number of complicating factors in regard to the possibility of approximation with psychoanalysis, which points to the singularity of each subject's treatment.

Henceforth, although psychoanalysis and harm reduction may initially come close, because they both oppose the abstinence model, the possibilities of convergence between these two fields need to be more deeply investigated. Whereas psychoanalysis adopts an ethic that foregrounds the subjective position and the modality of *jouissance* achieved by the intoxication practices, the harm reduction approach, being a public health strategy, advocates in its principles the bio-psychosocial well being of the health service users.

7. Final considerations

In the mental health field, it is possible to outline the existence of at least three prevalent models: the exclusively biomedical or pharmacological, the exclusively sociological and the subjective (Rigter at al, 2004; Kyrillos Neto, 2007). The exclusively organicist model has as its object the mental disorders, taken as a "biologizing degradation of nosology", that ignores the subjective, political and social aspects of the psychic suffering, and has the purpose of treating them exclusively through the psychopharmaceutical sovereignty. In the specific context of alcohol and drug abuse, it would be possible to state that this model guides its treatments by abstinence, insofar as they do not consider the subjective and social issues that the use of psychoactive substances imply, and seem to give importance only to the neurochemical effects caused by toxic drugs.

On the other hand, the exclusively sociological model takes as its object the man in his suffering existence, and is guided by the notion of individual originated from the liberal ideology and the human rights advocated by the constitution of the democratic regime. This model draws attention to the need for development and empowerment of individuals and communities so that, thereafter, they become able to have democratic participation in the actions devised to protect and promote their own health (Duggan, Cooper & Foster, 2002). It is possible to approximate this sociological model to some proposals derived from the psychosocial rehabilitation perspective, insofar as these place the emphasis on the citizen of universal rights and on the socio-political dimension. Thus, in the realm of the treatments offered to drug users, we can assume that this exclusively sociological model would be represented by the harm reduction approach.

Finally, the subjective model has as its object the "subject of desire", defined by Lacan (1969/1992) as constituted from its position before the Other. Among the existing proposals for the treatment of drug abuse, this subjective model is almost exclusively represented by psychoanalysis.

According to Kyrillos Neto (2007), it is noticeable that, unfortunately, these three models are considered mutually exclusive in most health mental services. However, it is important to highlight that overcoming the impasses that arise daily in these services depends on an approach that does not rely only on the exclusive considerations of the social determinations nor on a purely clinical focus, but rather on the articulation of these important factors.

Consequently, it is necessary that the harm reduction strategies, when proposed as a mental health policy, be able to reach these multiple sides that outline the complexity of the phenomenon of drug abuse and addiction. In this respect, psychoanalysis has great contributions to offer, since the psychoanalytical treatment aims at promoting the articulation between the universal aspect of the structure and the singular nature of the psychic reality of each individual, allowing the treatment of the universal (the structure) through the singular (the subject).

Hence, despite the recognized need for more research in the field of treatments offered to drug users, it is important to ponder that any proposed treatment cannot leave out the consideration for the psychic aspects involved in the phenomenon of drug addiction (OEDT, 2011). This is why current reports have demanded more studies analyzing the effects generated by the several types of existing psychological interventions, considering that, until now, the collected data are not sufficient to show evidence of the compared efficacy of each intervention. However, many studies suggest that such interventions are fundamental to act upon both the causes and the psychological consequences associated to drug use, especially when combined with other treatments, such as, for instance, the substitution treatments (CIAR, 2008; Marlatt; Larimer & Witkiewitz, 2012). And it is precisely in this context that psychoanalysis becomes a treatment proposal that, for placing the subject as the focus of any therapeutic action, presents itself as extremely promising.

8. References

Abraham, K. (1908/1927). The psychological relations between sexuality and alcoholism. *Selected Papers on Psychoanalysis*. London: Karnac.

Alves, V. S. (2009). Modelos de atenção à saúde de usuários de álcool e outras drogas: discursos políticos, saberes e práticas. *Cadernos de saúde pública*, 25 (11), p. 2309-2319.

Araújo, T. (2007). Drogas: proibir é legal? *Revista Superinteressante*, *244*, p. 62-71. São Paulo: Ed. Abril.

Bastos, A. (2009). *Considerações sobre a clínica psicanalítica na instituição pública destinada ao atendimento de usuários de álcool e/ou drogas*. (MA Dissertation). Universidade do Estado do Rio de Janeiro, Rio de Janeiro, RJ.

Brasil (2001). *Manual de Redução de Danos*. Brasília: Ministry of Health.

Brasil (2005). *Reforma Psiquiátrica e Política de Saúde Mental no Brasil*. Brasília: Ministry of Health.

Carneiro, H. (2006). As drogas no Brasil: entre o delírio e o perigo. *Revista Nossa História*, *33*, p. 12-26. São Paulo: Ed. Vera Cruz.

Conte, M. (2000). *A clínica psicanalítica com toxicômanos: o corte & costura no enquadre institucional*. (PhD Thesis). Pontifícia Universidade Católica de São Paulo, São Paulo, SP.

Conte, M. (2004). Psicanálise e redução de danos: articulações possíveis. *Revista da Associação Psicanalítica de Porto Alegre*, *26*, p. 23-33.

Decker, S. H. (2008). *Drug Smugglers on Drug Smuggling: lessons from the inside*. Philadelphia: Temple University Press.

Director, L. (2005). Encounters with omnipotence in the psychoanalysis of substance users. *Dialogues*, 15 (4), p. 567-584.

Dufour, A. (2004). Opiacidade. *Revista da Associação Psicanalítica de Porto Alegre*, 26, p. 34-57.

Duggan, M.; Cooper, A. & Foster, J. (2002). *Modernising the social model in mental health: a discussion paper*. England: SPN by Topss.

Faria, J. G. & Schneider, D. R. (2009). O perfil dos usuários do CAPS ad-Blumenal e as políticas públicas em saúde mental. *Psicologia e Sociedade*, *n. 21*, vol. 3, pp. 324-333.

Fernandes, A. & Freitas, L. (2009). Tempos de reforma psiquiátrica: a clínica da recepção e a direção do tratamento no Hospital Juliano Moreira de Salvador – Bahia. *Psicologia: Teoria e Prática*, *n. 11*, vol. 1, 2009, p. 97-109.

Figueiredo, A. C. & Tenório, F. (2002). O diagnóstico em psiquiatria e psicanálise. *Revista Latinoamericana de Psicopatologia Fundamental*, *vol. 5*, n. 1, p. 29-43, mar/ 2002.

Fink, B. (1995). *The Lacanian Subject: between language and jouissance*. Princeton: Princeton University Press.

Freda, H. (1989/1993). Quem lhe disse isso? *Coletânea de textos sobre toxicomania e alcoolismo do Centro Mineiro de Toxicomania* (p. 1-13). Belo Horizonte: Centro Mineiro de Toxicomania.

Freud, S. (1905/1996). Fragmento da análise de um caso de histeria. In: *Edição Estandard Brasileira das Obras Psicológicas Completas* (Vol. VII.). Rio de Janeiro: Imago.

Freud, S. (1911/1996). Dois princípios do funcionamento psíquico. In: *Edição Estandard Brasileira das Obras Psicológicas Completas* (Vol. XII.). Rio de Janeiro: Imago.

Freud, S. (1920/1996). Além do princípio do prazer. In: *Edição Estandard Brasileira das Obras Psicológicas Completas* (Vol. XVIII.). Rio de Janeiro: Imago.

Freud, S. (1930/1996). O Mal-estar na Civilização. In: *Edição Estandard Brasileira das Obras Psicológicas Completas* (Vol. XXI.). Rio de Janeiro: Imago.

Goffmann, E. (1985/2001). *A representação do eu na vida cotidiana*. Petrópolis, RJ: Vozes.

Harrison, L.; Cappello, R.; Alaszewski, A.; Appleton, S. & Cooke, G. (2003). *The effectiveness of treatment for substance dependence within the prison system in England: a review*. Canterbury, Kent: Centre for Health Services Studies.

Kaufmann, P. (1996). *Dicionário Enciclopédico de Psicanálise*. Rio de Janeiro: Jorge Zahar Ed.

Khantzian, E. (1995). Self-regulation vulnerabilities in substance abusers: treatment implications. In: Dowling, S. (Ed.). *The psychology and treatment of addictive behavior*, Madison, CT: International Universities Press.

Krystal, H. (1975). Affect tolerance. *Annual of Psychoanalysis*, 3, p. 179-219.

Kyrillos Neto, F. (2007). *Efeitos de circulação do discurso em serviços substitutivos de saúde mental*. (PhD Thesis). Pontifícia Universidade Católica de São Paulo, São Paulo, SP.

Lacan, J. (1939/1985). *Os complexos familiares na formação do indivíduo*. Rio de Janeiro: Jorge Zahar Ed.

Lacan, J. (1957/1999). *O Seminário, Livro V: As formações do inconsciente*. Rio de Janeiro: Jorge Zahar Ed.

Lacan, J. (1966/1998). A ciência e a verdade. *Escritos*. Rio de Janeiro: Jorge Zahar Ed.

Lacan, J. (1969/1992). *O Seminário, Livro XVII: o avesso da psicanálise*. Rio de Janeiro: Jorge Zahar Ed.

Lacan, J. (1976). Journées des cartels de l'École Freudienne de Paris. *Lettres de l'École Freudienne*, Paris, 18, p. 263-270.

Laxenaire, M. (2010). Psychanalyse et addictions sans substances. *Annales Médico-Psychologiques*, 168, p. 524-527.

Loose, R. (2000). The addicted subject caught between the ego and drive: the post-freudian reduction and simplification of a complex clinical problem. *Psychoanalytische Perspectieven*, 41/42.

Marchant, A. (2010). Answering drug epidemic at the beginning of the 1970s: experimenting new patterns, creating new practices, building standardization in matters of help care policy. *Conference Standardizing and Marketing the Drugs in the XXth Century*. History of Medicine University La Charité: Berlin (Allemagne), 7-8th October, 2010.

Marlatt, G. A. & Witkiewitz, K. (2010). Update on Harm-Reduction Policy and Intervention Research. *Annual Revue Psychology*, 6, p. 591-606.

Marlatt; G. A.; Larimer, M. E. & Witkiewitz, K. (2012). *Harm reduction: pragmatic strategies for managing high-risks behaviors*. New York: The Guilford Press.

Marlo, H. & Kalinian, H. (2002). Utilizing psychoanalytic psychotherapy in the treatment of substance abusers. *Clinical Psychology and Psychotherapy*, 9, p. 211-223.

McDougall, J. (1978). *Plea for a measure of abnormality*. New York: International Universities Press.

McKeganey, N. (2011). Abstinence and harm reduction: can they work together? *International Journal of Drug Policy*, doi: 10.1016/j.drugpo.2011.04.001.

Mcrae, E. (2001). Antropologia: aspectos sociais, culturais e ritualísticos. In: Seibel, S. & Toscano JR., A. (Eds.). *Dependência de drogas*. São Paulo: Atheneu.

Melman, C. (2000). *Alcoolismo, delinqüência e toxicomania – uma outra forma de gozar*. São Paulo: Escuta.

Nery Filho, A. & Torres, I. M. A. (Eds.) (2002). *Drogas: isso lhe interessa? Confira aqui*. Salvador: CETAD/UFBA/CPTT/PMV.

OEDT (2011). *Relatório anual 2011: a evolução do fenômeno da droga na Europa*. Luxemburgo: Serviço das Publicações da União Européia.

Paes, P. (2006). *Ensino e aprendizagem na prática da Redução de Danos*. (PhD Thesis). Universidade Federal de São Carlos, São Carlos, SP.

Passos, E. H. & Souza, T. P. (2011). Redução de danos e saúde pública: construções alternativas à política global de "guerra às drogas". *Psicologia & Sociedade*, 23 (1), p. 154-162.

Pinheiro, R. (2006). Redução de Danos e psicanálise aplicadas à toxicomania. In: Cirino, O. & Medeiros, R. (Eds.). *Álcool e outras drogas: escolhas, impasses e saídas possíveis*. Belo Horizonte: Autêntica.

Pratta, E. M. M. & Santos, M. A. (2009). O processo saúde-doença e a dependência química: interfaces e evolução. *Psicologia: Teoria e Pesquisa*, *n. 2*, vol. 25, p. 203-211.

Queiroz, I. (2001). Os programas de redução de danos como espaços de exercício da cidadania dos usuários de drogas. *Psicologia: ciência e profissão*, *21*, 4, dez/ 2001.

Rado, S. (1933/1984). The Psychoanalysis of Pharmacothymia. *Journal of Substance Abuse Treatment*, I, p. 59-68.

Rezende, M. (1999). *Tratamento com dependentes de drogas: diálogos com profissionais da área de saúde mental*. (PhD Thesis). Universidade Estadual de Campinas, Campinas, SP.

Rezende, M. (2000). Uso, abuso e dependência de drogas: delimitações sociais e científicas. *Revista Psicologia & Sociedade*, *12*, 144-155.

Rigter, H.; Van Gageldonk, A.; Ketelaars, T. & Van Laar, M. (2004). *Treatment of problematic use of drugs. State of the art for evidence based treatments and other interventions*. Utrecht (Niederlande): Trimbos Institute.

Rinaldi, D.; Cabral, L. & Castro, G. (2008). Psicanálise e reabilitação psicossocial: limites e possibilidades de articulação. *Revista Estudos e Pesquisas em Psicologia*, *vol. 8*, n. 1, jan./abr. 2008.

Rothschild, D. (2010). Partners in treatment: relational psychoanalysis and harm reduction therapy. *Journal of Clinical Psychology: In Session*, 66 (2), p. 136-149.

Seibel, S. & Toscano Jr., A. (Eds.). *Dependência de drogas*. São Paulo: Atheneu.

Schulte, B.; Thane, K.; Rehm, J.; Uchtenhagen, A; Stöver, H.; Degkwitz, P & Reimer, C. (2008). *Review of the efficacy of drug treatment interventions in Europe*. Hamburg: Centre for InterdisciplInary Adicction Research (CIAR).

Silva, J. R. (2010). *A clínica psicanalítica das toxicomanias*. (MA Dissertation). Universidade do Estado do Rio de Janeiro, Rio de Janeiro, RJ.

Stevens, A.; Hallam, C. & Trace, M. (2006). *Treatment for dependent drug use: a guide for policymakers*. Beckley: The Beckley Foundation Drug Policy Programme.

Viganó, C. (1999). A construção do caso clínico em saúde mental. *Curinga – Psicanálise e Saúde Mental*, *n. 13*, set./1999.

Valentine, K. & Fraser, S. (2008). Trauma, damage and pleasure: rethinking problematic drug use. *International Journal of Drug Policy*, 19, p. 410-416.

WHO (2004). *Neurociências: consumo e dependência de substâncias psicoativas*. Genebra: WHO Library Cataloguing-in Publication Data.

Wurmser, L. (1995). *The hidden dimension: psychodynamics of compulsive drug use*. New Jersey: Jason Aronson Inc.

IntechOpen