

Harm Reduction Psychotherapy

Harm reduction is a movement that began in Europe in the 1970's as a public alternative to the moral and criminal models of addressing problematic substance use. The essence of this philosophy is to reduce the harmful consequences of substance use to both the individual and society without requiring abstinence as a goal or precondition of treatment; a requirement of many traditional mainstream treatment approaches to this day. Harm reduction has now spread throughout most of the world and is part of the national drug policy of most developed countries, except the United States.

Harm reduction psychotherapy (HRP) is a relatively recent and almost uniquely American invention that reflects the encounter of psychotherapists who were working with psychodynamic and/or cognitive-behavioral approaches to addiction treatment with the insights of the harm reduction movement. The aim of this chapter is to present a distillation of the essence of HRP that draws on the work of such major innovators as Edith Springer, Alan Marlatt, Andrew Tatarsky, Patt Denning, Jeannie Little, and Frederick Rotgers.

Background

In the late 1980's, with the advent of the HIV-AIDS epidemic, harm reduction gained a foothold throughout the world. Once it became apparent that substance users, particularly intravenous injecting heroin-using individuals, were not only likely to get the disease, but also were at risk for transmitting it to others, the stage was set to shift the focus from drug-use cessation to stopping the spread of HIV. Needle exchanges and "low-threshold", easily-accessible methadone programs became front-line actions in efforts to stop the spread of the disease. The focus was on strategies to help patients

change their behavior in a positive direction to reduce the harmful consequences of their substance use. In short, as Drucker and colleagues have pointed out, AIDS took precedence over addiction.

Harm Reduction Philosophy

Out of the incorporation of this public health perspective, a new clinical philosophy emerged that Marlatt has called “compassionate pragmatism”. Tatarsky, in his book, has outlined six core ideas that characterize the harm reduction model. These are:

1. *“Meeting the client as an individual.”* This reflects a belief that patients come with different internal worlds, strengths, needs, vulnerabilities, biologies, social backgrounds, and use histories; consequently, their patterns of use and the meanings that they hold will be unique for each user. For treatment to be successful, it must be tailored, as best as possible, to their specific needs.
2. *“Starting where the patient is.”* This means accepting them with whatever goals and level of motivation for change that they come in with.
3. *“Assuming the client has strengths that can be supported.”* Patients are more than their problems. In many respects, to have survived in a world of active users and drug dealers speaks to deeper inner resources. The goal here would be to use these to help the patient move forward in a positive way.
4. *“Accepting small incremental changes as steps in the right direction.”* For most people, change will involve small steps, steps that may take time to integrate before the person can move on.
5. *“Not holding abstinence (or any other preconceived notions) as a necessary precondition of the therapy before really getting to know the individual.”*

The belief is that the goals of the treatment will emerge out of the therapist-patient relationship and dialogue. This enables patients to begin where they are motivated to begin and have a therapy that is shaped to their needs.

6. *“Developing a collaborative, empowering relationship with the client.”* In line with psychotherapeutic traditions, there is an emphasis on egalitarianism, on a teamwork approach to clarifying issues, choosing goals, developing strategies, and implementing actions.

Understanding Drug Use

From an HRP perspective, people use substances to meet a variety of psychological, social, or biological needs. The psychological reasons incorporate the view that substance use can be “adaptive”, a view embodied in Khantizian’s “self-medication hypothesis.” For example, substances may be used to: quell the pain of anxiety or depression, help block intrusive traumatic memories, overcome a sense of inner deadness, increase the ability of those with ADHD to focus, and reduce the symptoms of psychosis. Wurmser, in turn, has looked at the role of the “Inner Critic” or the harsh, punitive Superego in the use of substances. For many, alcohol or drugs serve as a kind of revolt against or escape from this experience of internal tyranny.

Tatarsky emphasizes that many of these “adaptive” uses of drugs also carry relational meaning that is related to difficult interpersonal histories. Given these histories, current relationships or internal relational schemas cause individuals pain and difficulty and, as a way of coping, they have found that the drug takes away the pain, at least temporarily. A drug may also be seen as a comforting and controllable stand-in for people who are experienced as untrustworthy and unpredictable.

A useful metaphor for integrating these ideas is to view people as being in relationships with the substances they use. These relationships fall along a continuum from healthy to unhealthy – just like relationships between people. Denning suggested that the terms “abuse” and “dependence” are ways of envisioning types of relationships to substances.

The social motivations for drug use are two-fold. The first, as Denning and Springer have argued, is that many people suffer from their position or role in society due to poverty, unemployment, minority group membership, sexual orientation, or living in a high crime environment and have, or believe they have, few possibilities for changing these difficult circumstances. Drug use becomes a method for coping with the pain associated with these difficult social realities.

The second, and overlapping, path is that substance use is a way to make social connections and to forge an identity. Anderson has made the case that for those who are having difficulty making successful claims to mainstream identities, the drug culture provides a “rebel” or “outsider” identity that is often fairly easy to gain access to. Kellogg has noted that this social view incorporates a more complex view of substances as providers of reinforcement and meaning. For many individuals, not only does abstinence mean giving up a chemical, but also it means giving up a world and an identity in that world.

The third motivating force, which is interwoven with the other two, is the role of biology in reinforcing the use of substances. In the best of situations, people differ genetically in their responsiveness to different substances and these differences render people more or less susceptible to finding drug use pleasurable. The scientific evidence

is mounting that exposure to trauma – whether acute and dramatic or continuous – can lead to changes in brain chemistry and leave the individual in chronic states of discomfort and/or make them more vulnerable to the effects of stress. It is also likely that the effects of poverty and other social ills can have a similar effect on the brain. These kinds of brain alterations can set the stage for the ability of a substance to, temporarily, bring the brain into an optimal state. This neurobiological model provides an organic understanding for the “self-medication” hypothesis and the trauma-oriented observations of those working in the psychological realm.

The end result is a situation in which drug use, abuse, and addiction can be understood as a complex biopsychosocial phenomena. Treatment conceptualizations and plans will need to be geared toward an understanding of the interplay of these forces.

Therapeutic Process

Therapeutic alliance

Harm reduction therapists give the relationship with the patient, or the therapeutic alliance, central importance in their efforts. Without an alliance, there can be no work and no recovery. Making requirements about abstinence at the start of treatment for patients who are not prepared or willing to stop does not foster a good connection and is thus seen as being profoundly anti-therapeutic and something to be avoided. Since many of these patients also have histories of problematic attachments, it is to be hoped that the therapy relationship will provide them with one that is attuned and affirming.

Assessment

Therapy begins with a period of assessment, and this is done within a multiple-meaning framework. Therapists are not only interested in the amount, duration, and

frequency of use, but also they want to know about how drug use is connected to different personal and social experiences in terms of their meaning and function.

The assessment process also serves as a vehicle for building the therapeutic alliance. As Denning put it, the goal will be the creation of an “investigative team”. Beyond that, assessment is viewed as an ongoing primary focus of therapy that is geared toward an ever-deepening clarification of the nature of problematic substance use and its relation to the larger context of the person.

Psychotherapeutic goals

A treatment plan will be developed collaboratively based both on the therapist’s assessment and what the patient wants from therapy. This will most likely include substance and nonsubstance-related situations. Goals for each of these problems will be chosen and strategies for reaching each of them will be formulated. Marlatt and Rotgers each found that when patients were offered the option of pursuing either moderation or abstinence goals regarding their drinking that retention and positive outcomes significantly increased – regardless of the goal chosen.

In terms of substance use, the information from the assessment, combined with the motivational state of the patient, can be used to decide whether the goal will be to: (1) continue with the current pattern but monitor it for problems; (2) make changes to reduce harm; (3) move toward a state of moderation; or (4) embrace abstinence as a goal.

Marlatt has suggested that substance use is best viewed as varying along a continuum of harmful consequences with chaotic use on one end and moderate non-problematic use and abstinence on the other. From this perspective, the goal of harm reduction interventions is to support the patient in making changes in substance use that

move along the continuum in the direction of reduced harm. Thus, any step that reduces harm is defined as a success. Kellogg, taking a somewhat broader perspective on the role of goals in harm reduction interventions, has emphasized the importance of seeing abstinence or moderation as the ultimate, if not the immediate, goal of the harm reduction enterprise. By keeping this endpoint in mind, the therapeutic encounter will, hopefully, contain a positive tension between the immediate or short-term goals of the patient and the long-term goals of abstinence or “true” moderation. This “gradualist” perspective on the interrelationship between goals and action can help increase the psychotherapeutic momentum.

For patients who are not seeking to achieve abstinence, Tatarsky has suggested that the *Ideal Substance Use Plan* be developed. This plan is worked out with the patient and is geared to maximize the positive benefits of drug use while minimizing the dangers to self and others. This is an exercise designed to support the patient in assessing what is problematic about substance use and what are realistic goals for the individual.

Difficulties in following through with the plan are examined in detail. Exploration of these “failures” can be a source of rich information about the patient’s inner world. Actual techniques could include a retelling of the story with particular attention to the emotional valence of the situation, asking the patient to associate to the various details of the event, or, as Young does in his work, having the patient bring up images or memories from the past that connect to what has transpired.

Motivational interventions

Harm reductionists have embraced the Stages of Change model that was developed by Prochaska and DiClemente, and Springer and Denning have addressed this

within the broader harm reduction context. In the *Precontemplation stage*, the individual is not acknowledging that they have a problem with substances. The goal here is to develop a positive therapeutic alliance that will promote the self-reflection and self-assessment that may lead patients to discover or identify the problematic consequences of their use.

In the second phase, *Contemplation*, the patient is ambivalent about their drug use. Two interventions are commonly used here. Marlatt has emphasized the utility of using a *Decisional Balance*, a cognitive-behavioral technique in which patients list the positives and negatives of both their current situation and of making a change.

Motivational Interviewing is a reflective psychotherapeutic approach developed by Miller. In this work, the therapist seeks to draw out and accentuate the inner conflict that the patient has about their drug use. As the conflicting forces within become clearer and the cognitive dissonance more pronounced, the patient may be willing to consider resolving the conflict by changing his pattern of consumption.

The *Preparation* stage follows. Here the patient is going from the abstract to the concrete. Long-term goals are selected, short-term strategies and objectives are devised to help reach those goals, barriers are acknowledged and plans to overcome them are made, and systems of support that could help in the process are identified.

The *Action* stage has been the primary focus of mainstream treatment programs. Here, the patient implements the planned action – be it using clean needles more frequently, changing the method of taking their favored substances, eliminating specific drugs from their life, or joining a methadone program.

The *Maintenance* stage follows. As awareness has grown of the high rate of relapse following treatment, increasing attention has been paid to the importance of maintaining the gains that the individual has achieved. Marlatt's classic work on this issue, *Relapse Prevention*, has outlined an approach for helping patients in this phase. This work involves identifying the internal and external risk factors that could increase the likelihood that they would revert back to the earlier behavior. The plan is to teach patients new attitudes and new coping skills to help them successfully navigate these situations in ways that support their new choices.

Treatment techniques

Given the comprehensive nature of HRP, psychotherapists will, ideally, be skilled in the psychodynamic, cognitive-behavioral, and experiential techniques that are commonly used in integrative psychotherapies. A good place to begin is to help the patient become more aware of their drug-use process. This can be done by increasing their awareness through self-observation which involves the cultivation of a stance of nonjudgmental, compassionate observation of the self. The benefit of this "observing ego" is that the person is no longer completely consumed by the addictive practice; instead, they are creating some inner space that provides them with the possibility of internal dialogue and change.

Denning and colleagues have been inspired by Zinberg's work on drug, set, and setting. This view is based on the idea that the totality of the substance-induced experience develops out of the nexus of the neurotransmitter changes induced by the chemical (drug), the personality and cognitive attitude of the user (set), and the particular setting (i.e., with friends or alone, in a familiar or unfamiliar setting). Because these

combinations will be different for each user, the resulting drug experiences will again be unique, and since each of these contribute to the outcome (although not necessarily in equal amounts); effective changes can be made through targeting one or more of these factors.

Pioneering work was done on changing drug-use patterns in this arena by Dan Bigg of the Chicago Recovery Alliance. Known as Substance Use Management, the interventions focus on making alterations in the amount, type, frequency of drug use, and/or the route of administration. Intervening with a person's set involves understanding that people may use the same substance in different ways or use different substances at different times depending on their emotional state. In terms of setting, the most straightforward is the question of whether people are using alone or with others. For those who go to bars and then repeatedly drive when they are too intoxicated to do so safely, it might be wise for them to drink at home. For those who tend to isolate and are using dangerously high levels of drugs, it might be best for them to try to use with others so that their use does not become fatal.

Drug use during treatment

As a core principle, it is to be expected that people will be using substances while in treatment. HRP aims to understand the specific meanings this has to the patient and respond accordingly. In terms of in-session intoxication, the patient may be trying to express their ambivalence about changing their pattern of use. It may also be an attempt by the patient to share their experience of being intoxicated directly with the therapist so that he or she will better understand them. Lastly, patients also drink or get high to give them the courage to speak about things that are frightening or painful. Continued

substance use outside of the session may reveal an issue about their level of motivation. Again, it may also reflect the possibility that the meanings that underlie their use have not been sufficiently addressed.

HRP is, at its core, about the reduction of harm and bringing a better quality of life to the patient. At times, substance use is clearly self-destructive, life threatening, and potentially harmful to others; it may also reflect suicidal, self-harming, or homicidal wishes. In situations in which the patient is putting him- or herself in immediate danger, the therapist will be required to take action. Harm reduction in these circumstances means not colluding with self- or other-destructiveness; it involves taking a position in favor of life and positive change, and it may look very much like a traditional limit-setting intervention. This can range from suggesting that the evidence is mounting that moderation or controlled use is clearly not working, that they may need to consider abstinence as a goal, and/or that they may need to enter more intensive, structured treatment.

Countertransference

Working with patients of any kind engenders feelings, and sometimes strong feelings, in the therapist. Substance users may be a particularly evocative group of patients, in this regard. There are several reasons for this.

Given the ubiquitous nature of addictive behaviors, it is quite likely that psychotherapists have had unpleasant or even traumatic encounters with people who use alcohol and drugs in their personal lives. This personal experience, consciously or unconsciously, often contributes to their motivation to work with substance users. In

these cases, it is likely that personal countertransference reactions based on this history will be evoked by experiences with the patient.

In mainstream addiction treatment settings, the clinical institution may be putting overt or covert pressure on the therapist to “get” their patients sober. This pressure may also be rooted in obligations to funding sources. This means that counselor “success” may be based on patient abstinence. Understanding therapeutic success in this manner is likely to lead to feelings of frustration and dislike as the practitioner is trapped between the patient and the administration.

A related kind of countertransference can take place with a practitioner who has successfully overcome their own addiction. Knowing that it can be done, it seems particularly frustrating to work with patients who appear to refuse to take the steps that would lead to their healing.

With addictions and drug use, countertransference also has societal roots. Kellogg and Triffleman have argued that addiction is unusual among the psychiatric disorders in that our society is torn between whether it envisions problematic drug and alcohol use as a disease to be healed or as a crime to be punished. This ambivalence permeates the treatment system as a whole – including the psyches of the treatment staff and the patients. While harm reduction, at its best, represents the triumph of the medical over the criminal model, it does not mean that, even with the best of intentions, therapists do not carry punitive and stigmatizing voices within them. The solution is that therapists will need to engage in some form of self-examination and monitor their experience during and after their sessions to identify what has been triggered within them.

Horizontal and vertical interventions

Lastly, it may be helpful to envision the challenge of HRP as the ability to work on two dimensions simultaneously. Traditional or mainstream treatment approaches have often focused on what might be called *horizontal* interventions or on therapeutic activities that are primarily focused on changing drug-using behavior. Earlier psychodynamic models tended to focus on what might be called *vertical* interventions; that is, they sought to understand the traumas, conflicts, and pain that were often at the root of the continued use. It now seems likely that each of these alone is an incomplete way to treat individuals who use substances in problematic ways, and that harm reduction psychotherapists will need to be able to work skillfully in both dimensions.

Conclusion

Harm reduction psychotherapy is a new and exciting addition to the addiction treatment armamentarium that has great potential to make treatment more attractive to drug-using patients, increase patient retention, and improve successful outcomes. It is based on an expanded view of who can be treated and a corresponding emphasis of the need for treatment to be highly flexible and individualized to fit to the unique complexity of the individual. HRP aims to engage patients wherever they are interested in beginning treatment and support them in a process of positive change with abstinence as one possible goal among many. Thus HRP builds upon abstinence-based treatment in its more ambitious goal of expanding the reach of traditional treatment.

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See also Client engagement; Harm reduction, Public Health; Moderation approaches for alcohol problems; Moderation in use; Moderation Management; Needle exchange programs

Further Readings

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