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## **Bridging the Worlds of Harm Reduction and Addiction Treatment An Interview with Dr. Andrew Tatarsky**

William L. White

### **Introduction**

For more than three decades, Dr. Andrew Tatarsky has championed the integration of harm reduction principles and practices within the treatment of substance use disorders. Through his work, he has promoted understanding of the full spectrum of substance use problems and an integrative harm reduction psychotherapy approach to their treatment. His book, *Harm Reduction Psychotherapy: A New Treatment for Drug and Alcohol Problems* and its further explication in subsequent papers and presentations have been particularly influential in the United States and in other countries. Dr. Tatarsky founded and directs the Center for Optimal Living in New York City. I recently (January 2016) had the opportunity to interview Dr. Tatarsky about his work and its impact on the practice of addiction treatment. Please join us in this most engaging conversation.

### **Background**

**Bill White:** Dr. Tatarsky, you entered the addiction field through your doctoral work in the late 1970s. What level of addictions training was provided through the doctoral programs during that era?

**Dr. Andrew Tatarsky:** My doctoral coursework in clinical psychology spanned the late 1970s through 1980, and I then did a clinical internship in 1981 at Kings County Hospital Downstate Medical Center. There was no training in addictions in my undergraduate training, my doctoral training in clinical psychology, or in my clinical internship. All of my early training was on-the-job training and I think that was pretty typical for psychologists trained in that era. Unfortunately, this trend has continued as psychologists are not required to take courses on addiction or receive clinical training on how to work with people with substance use disorders.

**Bill White:** What led to your specialization in the treatment of addictions at a time few psychologists were choosing that specialty?

**Dr. Andrew Tatarsky:** Well, it seems like a simple question, but the answer is a very complex one. There were conscious, and, I think, unconscious motivations operating within that choice. First, an interesting set of coincidences led me to see a number of patients struggling with drug and alcohol problems throughout my graduate training. I saw such patients at the Psychological Center at The City College of New York where I did my training, and then I saw several patients with substance-related problems on my internship. Although none of my supervisors were specifically expert in substance use or addiction, I got a chance to work intensely with a variety

of people with such difficulties and that made a very deep impression on me and stoked an interest in the field.

These experiences began to challenge my thinking about what were then the prevailing and very limiting ideas about people who struggle with problematic drug use. I was seeing a very diverse group of people who were motivated for change, who were struggling with a wide variety of early traumatic issues and current life stresses that all seemed related to their substance use and who took varying paths to recovery and positive change in their lives. One of my early patients found therapy to be very helpful, but he ultimately discovered that he needed to also attend AA as a way to finally stop drinking, whereas other patients of mine did not find AA to be appealing to them and were really able to make good use of the therapy. These variations contributed to my interest in the field. I saw a group of people who were not being offered sophisticated, individualized treatment in the specialized field of addiction treatment. I perceived this as a real limitation in the field and my sense of social justice spurred me to want to help this underserved group of people.

There were also a number of other more personal issues that contributed to this interest. I had experienced a family history of problematic drug use that contributed to my interest, and I grew up in the New York art scene in the 1950s and '60s where there was a lot of drug and alcohol use. And growing up in the '60s as a teenager, there was a lot of drug use in my social group, and I had witnessed a number of people using drugs, some without difficulties and others who got into serious trouble with drugs. All of these experiences fueled a curiosity about the complexity and challenges of working with people experiencing problems with alcohol and other drugs. And there was this pervasive question: Why do some people get into trouble with their drug use while others do not?

Throughout the course of my career, there have been these interesting coincidences, or defining moments, that seemed to guide me into this field. I don't necessarily believe in magic, but a number of these moments were so timely that you have to wonder. Earlier in undergraduate and graduate school, I had actually specialized in and worked my way through school working with individuals with developmental disabilities, another stigmatized group of people. I had assumed that was where I would end up in my career. After my clinical internship, I was hired for a job in this field. However, before I started the job, I saw a small advertisement in the *New York Times* from an addiction treatment center up in East Harlem. They were looking for counselors with doctoral training, and it was as if this advertisement was speaking directly to me. I think all of these forces I've mentioned drew me to call and apply for that job. I was interviewed by five people on the day that I went up there. They offered me the job and I took it. And that was my entry into the field.

**Bill White:** How would you describe the state of addiction treatment as you entered the field?

**Dr. Andrew Tatarsky:** I was very excited to take this job and learn the state of the art of addiction treatment. I expected it would build on what I had learned in my graduate training. But what I encountered was Jellinek's simplistic disease model informed abstinence only approach to treatment that completely dominated the field then and still largely does today. Essentially, I was told that everything I had learned in graduate school I needed to throw out because addicts needed a very different approach. I was told that addiction was permanent, chronic, progressive that is only arrested by complete and total abstinence. While it never quite felt right to me, I learned to work within that model for the first eight years of my career in the

field. From this psycho-educational, abstinence only perspective, we educated people about the disease and the importance of complete and total abstinence, and then counseled them about the triggers and cognitive traps that could take them back to using. That was the state of the art at that time.

I worked in several different places and ultimately (between 1987 and 1990) served as Clinical Director at the Washton Institute on Addictions. Arnold Washton was a very important mentor and figure in my career. He was the director at the first clinic that I worked at and brought me into the addictions field. Then in 1987, when he was opening his institute, I stumbled upon another ad for positions there at a time I was looking to leave my present job. I reconnected with Arnold and we built the Washton Institute over the course of the next four years. It was one of the premiere intensive outpatient programs at the time. Arnold's thinking was very progressive. He and I were trying to integrate psychological theories of addiction and new ways of working with people, but still under the dominant abstinence-only disease ideology. Even in these progressive settings, there was a tremendous tension between the part of me that had been trained as a psychotherapist to understand problematic behavior as multiply meaningful and complex, and what was then a quite simplistic model of treatment and recovery. It was this conflict within me that ultimately led me to begin to question the model and look around for alternatives.

Between 1988 and 1990, I began to question this traditional model and its abstinence requirement and I started experimenting in my newly-developed private practice treating active drug users without requiring them to commit to abstinence as a goal. They were sufficiently motivated to engage meaningfully in treatment and seemed to be good candidates for therapy. Many of them made significant positive change in their substance use, some cutting back and some deciding to stop using, as well as making positive changes in the wide variety of other personal issues that were related to their substance use problems. In 1994, I had a pivotal, life-changing conversation with Alan Marlatt. I was describing my quandary, seeing the limitations of traditional treatment and the success that I was having in working with active drug-users. Alan said to me in that conversation, "You're doing harm reduction." That was like my spiritual awakening and a major paradigm-shifting moment for me. Alan introduced me to harm reduction as an alternative framework for helping, which is really how I've come to see it. I saw harm reduction principles as having tremendously positive implications for psychotherapy, counseling, and substance use treatment. That led to a commitment over the course of my career to draw out the therapeutic implications of the harm reduction model.

I began to further integrate this into my clinical practice and began to write about it, with my book coming out in 2002. Shortly after that, I began to get invitations to train people and that led to a whole amazing adventure of national and international training, which has been one of the catalysts for the development of my approach to harm reduction psychotherapy, what I call Integrative Harm Reduction Psychotherapy (IHRP). Then in 2010, while I was training and supervising a few senior psychologists, it occurred to me that there should be a home for IHRP in New York City. I envisioned this as having a therapy center that would be a laboratory for the ongoing evolution of IHRP and a showcase for what IHRP looks like in a comprehensive therapeutic setting and would also have an education and professional training component. I began to talk to others about this hugely important and complicated decision to open such a center. A pivotal factor in the final decision to do so was a conversation I had with Tom Horvath. I'd worked with Tom in a number of different professional contexts and I was very impressed by his work in La Jolla at Practical Recovery where he was developing what he calls a

more evidence-based, empowering approach to helping people with drug and alcohol problems. In a conversation with him, I shared my thoughts about opening the center, and he gave me the final encouragement and push to do it. So, in 2010, we formally opened the Center for Optimal Living in New York City, which has been a new and very exciting chapter in my work.

## **Harm Reduction and Addiction Treatment**

**Bill White:** How would you describe your ongoing development of harm reduction psychotherapy and its contrast with prevailing treatment methods?

**Dr. Andrew Tatarsky:** I've come to see the harm reduction framework as offering a powerful, effective approach to healing and a corrective to much of what is wrong with the current addiction treatment system. Part of the mission of opening the Center was to have an institution that puts harm reduction psychotherapy front and center in its approach. We wanted to show that a harm reduction approach to substance use treatment could exist in the field alongside the other approaches. But we faced several questions: Would it be viable? Would it be effective? Would it be supported by the community? To date, we've developed a therapy center that has grown from three clinicians to twelve clinicians, grown in terms of our patient census, and have experienced increasing acceptance and stature in the community among professionals and the public.

IHRP is highly personalized treatment that begins with what I think is the essential place to begin: comprehensive evaluations and working collaboratively with patients to develop their treatment plans. Plans can be as minimal as a once-a-week therapy session or group or as intensive as multiple individual sessions, multiple groups, family therapy, and couples therapy. We work closely with several addiction psychiatrists and a group of complementary practitioners--medical doctors, nutritionists, physical trainers, and so on. We can put together extremely comprehensive plans for people that are holistic and encompasses many domains. I would say what characterizes this approach and what distinguishes it from others is that all of our work is individually tailored in collaboration with our patients. We don't have structured intensive outpatient programs that people go through in a kind of systematic way. There are some patients who really benefit from that kind of treatment, so it's not that I'm at odds with that, but what we offer is a highly personalized process that puts the patient's needs and motivation at the center of the treatment.

I've been more recently thinking about the paradigm shift and scientific revolution that's happening in our field right now. We are now unfolding and increasing our understanding of the full spectrum of problematic substance use and addiction. The clinical implications of this involve a shift away from a one size fits all, authoritarian, prescriptive approach to treatment that says: "I know the nature of your problem, I know what you should do about it, and I'm going to try to get you to do it in any way that I can." And that can be from a loving or, in some cases, very punitive and threatening approach to treatment. The shift is toward a collaborative model that empowers the patient to become actively involved in constructing, co-constructing the treatment from the beginning to the end.

There's a growing group of colleagues in the field who are calling their work by different names, but this collaborative, empowering approach is a common thread. We think about harm reduction psychotherapy as informing all aspects of treatment. My integrative harm reduction psychotherapy emerged as an individual model for treatment, but part of the evolution of the center has been adapting that model to different modalities and with different sub-populations of

patients. We've been working on an integrative harm reduction approach to group therapy, family therapy, and couples therapy. In fact, we have several team members is a couples therapist who is about to launch a multiple couples group organized around these principles.

**Bill White:** Are there other elements that distinguish harm reduction psychotherapy from more traditional addiction treatment approaches?

**Dr. Andrew Tatarsky:** Yes, let's think about the core principles in integrative harm reduction approach. One of the central principles is a shift from abstinence only—the position that abstinence is the only acceptable goal of treatment. Acceptance of that goal is often a prerequisite to entering and remaining in treatment. I think that that is one of the major stumbling blocks in the field. That position shuts the door on the majority of people that are struggling with drugs and alcohol who are not ready, willing, or able to embrace abstinence. I believe this includes nearly everyone at the point when they begin to become concerned about their substance use. The abstinence-only prerequisite is a tremendous obstacle for people to begin a therapeutic or a healing process and severely limits who can enter treatment. The fundamental harm reduction position is that we embrace any reduction in drug-related harm and any improvement in the issues that impact problematic drug use. This enables us to start the therapeutic process wherever the patient is ready to begin thus making therapy appealing and relevant to each patient. The harm reduction position of starting where the patient is amounts to lesson one in a first counseling or psychotherapy class, but it's typically not what's done in the addictions field. Harm reductionists are rigorously committed to starting where the patient is and, for me, that translates into a primary emphasis on therapeutic alliance and collaboration throughout treatment.

You can't start where the patient is and establish a true therapeutic alliance if you're requiring or demanding the patient to buy in to certain goals that the patient is not ready to accept. Our interest is in seeing how we can create an alliance with a patient around goals and tasks that we agree on and to use that positive relational experience to inspire the patient to become and remain meaningfully engaged in the change process. We see the process of change as occurring in small, often infinitesimal positive directions, not just in the problematic substance use, but on a whole spectrum of issues that affect and are affected by substance use.

When I first began working in the field, the disease model position was that you had to address the disease first by establishing abstinence before you could address any other issue. Our psycho-bio-social model sees multiple factors interacting in ways that are unique for each patient and that get expressed in problematic substance use. We think we need to create a space to collaboratively access and clarify the unique nature of each person's relationship to substances. We can then work together to identify the unique factors that are at play for each patient and bring interventions to this whole set of factors that affect substance use: trauma, difficulties with affect regulation, the multiple meanings that substance use takes on, and functions that substance use takes on for people in terms of their feelings, self-esteem and identity and interpersonal relationships.

Another piece is what we call enhancing self-management or self-regulation skills. We see that for many people, self-regulation is really deficient or disturbed; that is, the capacity to manage feeling states, self-esteem, and relationships and engage in self-care. We integrate cognitive behavioral self-management skills as well as mindfulness practices and breathing techniques to help people develop a greater capacity to sit still with the discomfort that frequently gives rise to the addictive impulse. One of the techniques used is called urge surfing.

It's a term that Alan Marlatt introduced into the addiction field. It's about helping people cultivate a mindful, accepting attitude that supports the capacity to tolerate the distress associated with the urge and opens up the possibility of developing other ways to respond to that urge. By helping people "unwrap the urge," we uncover the multiple meanings, needs, and parts of the self that are often contained within the urge and can begin an exploration of alternative ways to express, resolve or care for them.

Another therapeutic task we focus on is what we call embracing ambivalence. People are inevitably going to be ambivalent about changing and about giving up a behavior or a substance that is serving an important function, even if it is creating serious harm in their lives. The emphasis on alliance and creating safety in the therapeutic relationship makes it possible for us to invite the patient to bring out their ambivalence about changing so that we can do the work of discovering what the grip on the substance is all about. We invite those parts, those needs, those feelings into the room and that opens up the possibility of thinking about new solutions. We call that harm reduction goal-setting. If we can now identify what's driving the urge to use in problematic ways, we can think about alternative solutions, including supporting the patient who wants to cut back or stop to make a positive change in the problematic use.

**Bill White:** Will some patients initially choose abstinence but then migrate to alternative approaches and others choose a harm reduction incremental change approach and then settle on the goal of abstinence? Is there a high degree of variability of where patients end up with their goals?

**Dr. Andrew Tatarsky:** Absolutely, and that's one of the beautiful things if we place the initial emphasis on engagement and alliance and starting where the patient is. It increases the relevance and appeal of the treatment. Those are the major questions that the larger treatment system needs to take on: How can we make treatment more appealing and more relevant to people that are struggling. If we begin wherever the patient is ready to begin, the therapy is really oriented toward supporting the patient in getting clearer about the nature of their problematic relationship to the drug and what goals and what approach to change best suits them. They may come in with one goal, but discover through the process that it's not a realistic goal or a good fit for them. Very frequently, patients switch goals, and we have patients switching back and forth. The harm reduction framework enables us to keep patients in the same support system, in the same group, with their family support, with the same therapist, while they explore different goals. It's all part of the learning process.

My book describes how this plays out within harm reduction therapy. I present ten case studies, one of my own and nine from other harm reduction therapists. If you look at the outcomes of the ten cases, about half of them chose and successfully achieved moderate drinking, and about half of the cases chose and successfully achieved abstinence, some with Twelve-Step participation. We can help people begin the journey of discovery without knowing the final destination at the outset. There were some studies done in England in clinics that offered both moderation and abstinence as goals for patients entering treatment. They discovered that when people were offered both goals, an increased number of people entered treatment and an increased number of people completed treatment successfully, but not necessarily with the goal that they initially came for. We see that also.

I had one patient who entered my group about two years ago heavily drinking and his initial goal was to moderate. Over the course of six months, he discovered that he was just having an impossible time of it and began to attend AA while he was attending my group. He

stopped drinking with the support of AA and about three months later, decided to leave group so that he could just focus on AA. Eighteen months later, he called me up to say he had been abstinent for eighteen months and was now interested in re-exploring whether moderation is something that he can be successful at. About a month ago, he re-joined our group and there was still some of the same members that knew him from back when, and he has begun to experiment with occasional drinking and approaching it in an extremely thoughtful, systematic way with an experimental attitude, which is what we suggest people bring to any positive change goals and strategies that they may be exploring. If you can explore the goals and the strategies as experiments, whatever happens is going to yield valuable information about the issues and about whether this goal or these strategies are workable or not.

**Bill White:** That experimental stance seems very congruent with what you've described as the need to shift from a one-truth model to a meta-model of multiple truths.

**Dr. Andrew Tatarsky:** Yes, thanks for bringing that up. Something that I've been most concerned about in the field is this tendency to believe that there's one explanation for addictive experience and only one solution, with the field devolving into polarized battles about who's right. One of the things that I have learned and feel deeply committed to is that all of the healing traditions and approaches to positive change in the addictive behaviors field have been life-saving and useful for some people. Probably all of them have been damaging and unhelpful to other people. So the argument about which is the right path is really a doomed argument and does the whole field a disservice. People who struggle with substances are unique people within unique social and cultural circumstances. Our job as a field is to help people find the path that best suits them. We have to move from a one-truth model to a multiple truth model to achieve that.

**Bill White:** That position demands a high degree of clinical humility and a profound respect for the people that we're working with.

**Dr. Andrew Tatarsky:** Yes, I entirely agree. And this is what I think is the radical edge of a harm reduction stance and one of the reasons that I love it. I'm aware that harm reduction may not be the best or the only way of describing it. If we think about the shift from presuming that abstinence is the best goal for the patient to a stance that does not presume to know what is best for the patient, it challenges the clinician to meet the patient with no presumption about who that person is, the nature of their problem, or what goals or strategies will work best for this person. That stance enables the clinician to be radically open in listening to the patient and supporting the patient in his or her own process of self-discovery. To fail to do that through an authoritarian stance can end up being a reenactment of trauma. The "You don't know what's best for you, but I do" authoritarian stance is disempowering and can re-traumatize people

**Bill White:** You've used the term *treatment trauma* to convey this idea of harm in the name of help.

**Dr. Andrew Tatarsky:** Yes, and I can share my own personal experience to illustrate this. It's been a long journey for me to get to a moment where I think it's important to talk about my own experience of having been a survivor of treatment trauma and how that's informed my life and

my passion and my commitment to making positive changes in the field. Initially, I think it was operating unconsciously. It was a number of years after I was already in the field, was developing my integrative harm reduction therapy model, and playing an increasing leadership role in the field that I made the connection to an experience that I had when I was a teenager that I had buried. I had completely dissociated it.

When I was thirteen and fourteen, I began to use drugs. This was the late '60s, and it was an exciting time and a lot of people in my age group were experimenting with different drugs. I got involved with smoking pot and taking psychedelics. My use was primarily recreational and social, although I now know that I was also self-medicating, personal issues were potentially problematic in a variety of ways for me as a thirteen- or fourteen-year-old to be using such substances. I had some very wonderful drug experiences, and I had some very terrifying experiences on LSD. My family and I decided that it would be useful for me to get away from that peer group and to stop using these drugs, and we found a nonresidential therapeutic community for me to join. I was in the program for ten months. It started out as wonderful experience of becoming part of a community that seemed to be devoted to helping people explore their feelings and learn how to be more authentic and feel safer in a group. It provided structure, and it provided opportunities for me to develop skills in taking on various jobs around the center. But about halfway through the experience, I broke a rule, and my experience went from one of heaven to hell.

I experienced the most brutal, attacking, humiliating experiences that you could imagine. You and Bill Miller described in your paper on confrontation and addiction treatment exactly what I went through. This was 1970 and the program was one started by several graduates of Daytop Village and modeled after it. I had to wear a sign. I was put in the middle of groups where others were verbally attacking me and calling me names. I felt blindsided and immobilized, not able to think or speak. And then I began to kind of gather myself together and I thought, "Okay, so this is about expressing myself and getting into my feelings," and I began to try to fight back and let people know that I felt really hurt and angry and betrayed. The staff just upped the ante. They brought in other staff, some people I didn't even know, in a series of groups and, essentially, shut me up through verbal attacks. I ultimately came to feel that I needed to leave because this wasn't about supporting me. It seemed designed to break me down and shut me up. So, I left at the age of 15 with no follow-up contact.

When you're a "splittee" from one of these programs, you're banished and unable to contact others in the program. And that isolation happened at a time when I was just starting a new high school. I completely buried the experience and moved forward in my life. There were post-traumatic symptoms from that experience that I only later connected, such as problems sleeping and difficulty speaking in public. Symbolically, the experience of attempting to speak in the program and being met by such a wall of attack contributed to this anxiety. I think on a subliminal level that was a big part of what drew me later in my life to become interested in the limitations and the problematic aspects of the addiction treatment system. In beginning to articulate what I thought was wrong and what would be corrective to the treatment system, I was finding my voice--the voice that I had lost in treatment. It was about ten years or so after I had discovered harm reduction that I made these personal connections.

There are two reasons that I've decided to talk about this publically: one is that in my own personal work on myself, now 45 years later, I continue to discover the deeper and deeper realms of the impact that these experiences had on me. It is through this personal exploration, and my increasing therapeutic work with patients who have experienced versions of this, I have

learned just how profoundly impactful these kinds of experiences have been on my life, and, by extension, I've begun to wonder how many hundreds of thousands of people have gone through experiences like this, and, in some cases, much worse.

How important is it for us as a field to name this phenomenon, which at this point I'm calling it treatment trauma, and to get the message out that people may be suffering from the fallout from experiences like this? I think it could help people get some relief as I have.

**Bill White:** The field has never fully acknowledged the extent of that harm nor has it attempted to make any kind of amends or restitution related to that.

**Dr. Andrew Tatarsky:** That's right, and I wonder how we might do that.

**Bill White:** What was the response from the field as you began using your voice in expressing ideas and approaches to harm reduction?

**Dr. Andrew Tatarsky:** I have had almost universally positive responses, and maybe it's because I am very inclusive. I frame this work, not at odds with abstinence-based treatment, but as a harm reduction umbrella embraces and includes abstinence-based treatment and Twelve-Step programs. I take a very inclusive stance, and I believe that people in all of these different settings want the same thing: we want to know how we can, as a field, be better able to help more people. When framed in that way, I have had very little opposition. Most of the people that I meet and talk to are very much in sync on this. In fact, I'm right now in the midst of some discussions with the people in the federal government, who, even though they're not supposed to say it publically, fully embrace these ideas.

These newer models for understanding clinical complexity and diversity within the field, such as the stages of change model and the mild, moderate, severe substance use disorder model that's now in DSM all affirm that we have a large majority of people that are struggling somewhere in the spectrum of problematic substance use who, for a variety of different, legitimate reasons, are not ready, able, or willing to embrace abstinence. Our traditional treatment system has really been irrelevant to that larger group of people. So the question becomes how the field can adapt itself to become more appealing and more relevant to the needs of that large group of people.

**Bill White:** Do you see great potential in the future integration of harm reduction psychotherapy with traditional models of treatment and recovery support?

**Dr. Andrew Tatarsky:** I feel very optimistic about such integration. Not only do I believe that it makes intellectual sense, everyday I'm seeing people from traditional treatment settings seeing the wisdom of a continuum of care that engages people along the entire spectrum of positive change goals and motivational stages and affirming the idea that people should be able to enter any door and be supported in moving in a positive direction to the extent that they're ready. There is an emerging vision of a seamless system from syringe exchange to moderation support to abstinence-based treatment. I've had an increasing number of conversations with people from very traditional rehabs who support this full continuum of care view. I think there's openness in the field right now to recognize that our traditional abstinence-only treatment or incarceration options have been an abysmal failure for far too many people. We're now increasingly

recognizing that drug-use is a health issue rather than a stigmatized moral or criminal justice issue. As we shift to seeing substance use as a health issue and see people vary along a spectrum of problem severity, it makes sense that we explore creative ways of reaching that entire spectrum of people.

### **Writing and Teaching**

**Bill White:** Teaching and writing seem to have been a very important way for you to express the voice we've been referring to. How have you integrated writing and teaching and the international work within your clinical work? A lot of clinicians would ask, "How do you ever find time for that?"

**Dr. Andrew Tatarsky:** Well, with not enough sleep. I've thought about how leaders are not necessarily people who are any smarter or any more skilled than people who are not leaders, but leaders are the ones that are willing to step up. Almost all of my early writing was done in response to an invitation and I didn't realize how much work it would be, particularly with my book. My first paper in 1998 on an integrative approach to harm reduction psychotherapy was in the first special issue of *In Session: Journal of Clinical Psychology* that was guest-edited by Alan Marlatt and Judith Gordon. It was actually in that paper that I coined the term harm reduction psychotherapy. Shortly after the paper came out, I was having a party at my apartment and a friend of mine who was an editor at the time at Jason Aronson heard about the paper and said, "Hey, why don't you do a quick and dirty book, kind of a casebook on cases of addiction treatment?" His "quick and dirty" invitation sounded like it would be an easy thing to do, and so I agreed not knowing it would take four years and different evolutions in the form and the focus of the book. So, it is a tremendously difficult balancing act to write a book in the context of having a clinical practice. But, increasingly, I've found tremendous support amongst my colleagues to support me in doing these other activities. I've been able to cut my personal clinical practice back a bit, which creates more time for me to write and to train. And the last several years, I've been doing international training up to six times a year, which I frequently attach it to a vacation. My patients have come to accept and understand that there will be periodic breaks so it has not been terribly disruptive.

### **International Work**

**Bill White:** You've trained in Lebanon, Indonesia, Switzerland, France, Chile, Russia, China, Austria, and Poland. What have you learned from those experiences and seeing how your ideas have been integrated into those countries?

**Dr. Tatarsky:** The international work has been a tremendous adventure, and I've felt tremendously honored and privileged to have the opportunity to do this work. The international invitations came in response to my publications. So, I would advise people who are interested in having a larger audience and having some amazing adventures to first focus on writing. My writing led to international talks and trainings, which in turn have been a major spur for my own professional development and the development of integrative harm reduction psychotherapy. It's really in attempting to take my work to new communities around the world that I've learned how to become a trainer. That's been an ongoing part of my professional evolution. The training has

also been a major spur for the development of the model. Each time I'm training, I'm really on the edge of my understanding, and the training process supports and pushes continued clarification of different areas of the model that need to be refined.

I've learned how universally applicable these ideas are. Despite the cultural differences and the differences from region to region, I discover again and again how universally human we all are and globally struggle with the same kinds of realities, truths, needs, and aspirations. That's been a wonderful experience that has affirmed my hope for humanity. At our core, we're all the same. I've really wondered what it is about us essentially as humans that give rise to ambivalence about drug use. So many of us are prone to excessive drug use at the same time our societies have responded to such use in punitive ways. Humanity's essential conflicts about pleasure and autonomy can get played out in problematic ways around drug use. These are universal dynamics that I see at play around the world.

### **Career-to-Date Reflections**

**Bill White:** What personal rewards have you experienced through your advocacy of harm reduction psychotherapy?

**Dr. Andrew Tatarsky:** What is most rewarding to me is having the opportunity to bring a perspective on helping to many people who have felt so hurt, un-helped, and blamed. I get feedback from people all over the world that the harm reduction psychotherapy perspective is inspiring, life-saving, and a hopeful alternative to the messages and experiences that they've had throughout their lives. I have that experience through the patients that we treat at my center, through people that I meet in trainings, messages that I get on social media, that all affirm that I'm on the right path and I'm doing something that many people find extremely helpful. It's a tremendous privilege to have connected with an amazing global community of exceptional people who are committed in their countries and in their cities to making a difference by challenging what's not working and trying to bring something that's more hopeful, useful, and healing. I feel lucky to be part of this wonderful global community of helpers.

**Bill White:** Would you have any guidance for individuals who would like to pursue training in harm reduction psychotherapy or integrate IHRP principles into their traditional treatment settings?

**Dr. Andrew Tatarsky:** I would recommend they start by reading the literature of harm reduction psychotherapy, books, and articles by myself, Patt Denning, Jeannie Little, Alan Marlatt, Fred Rotgers, Tom Horvath, Debbie Rothschild, and Bill Miller. We do an intensive three-day training in integrative harm reduction psychotherapy in conjunction with The New School here in New York that people may find quite helpful. We also have a one-year certificate program in integrative harm reduction psychotherapy at The New School in New York. People can get on the Center for Optimal Living mailing list and be kept abreast of our training activities around the world. There are a number of upcoming training opportunities that people can participate in.

**Bill White:** Dr. Tatarsky, thank you for taking this time to share your ideas and experience.

**Dr. Tatarsky:** Thank you, Bill, for the opportunity.

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### **Selected Publications and Recommended Reading**

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