Harm Reduction Psychotherapy

A NEW TREATMENT FOR DRUG AND ALCOHOL PROBLEMS

Featuring Case Examples by:

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Patt Denning

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Andrew Tatarsky

Foreword by Alan Marlatt

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ANDREW TATARSKY

A JASON ARONSON BOOK

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I dedicate this book to the countless men and women who have been incarcerated for the unjust crime of possessing or using a substance to alter their states of consciousness. It is my hope that this book will contribute to changing attitudes and laws to reflect greater understanding, compassion, respect, and freedom of choice for these and all of our fellow citizens.

Contents

Foreword

It gives me great pleasure to welcome readers to Andrew Tatarsky's excellent new book on harm reduction therapy. As a long-time friend and colleague, I have had many long and interesting conversations with Dr. Tatarsky, often over dinner in one of Manhattan's inviting restaurants. Many of these conversations were about the topic of this book, and I encouraged him to pursue his plans to put his thoughts into writing. All this has been well worth the wait since we first started our discussions about harm reduction in the mid-1990s. We now have the fruits of his efforts in the form of a ground-breaking volume that provides readers with both an overview of harm reduction therapy and a series of ten "stories" or case studies treated by different therapists that vividly illustrate this treatment approach with a wide variety of clients.

In his Introduction, the author describes harm reduction as a "new paradigm" for treating drug and alcohol problems. Some would say that harm reduction embraces a "paradigm shift" in addiction treatment, as it has moved the field beyond the traditional abstinence-only focus typically associated with the disease model and the ideology of the twelve-step approach. Others may conclude that the move toward harm reduction represents an integration of what Dr. Tatarsky describes as the "basic principles of good clinical practice" into the treatment of addictive behaviors. As such, harm reduction therapy repre-

sents a kind of "paradigm redux" in which the basic principles of psychotherapy are reintroduced and amalgamated into the treatment of clients with alcohol or substance abuse problems that often co-occur with other behavioral or psychiatric disorders. As such, the paradigm is shifting from the traditional "top-down" approach in which treatment goals are dictated by the program provider, to a more client-centered approach involving the collaborative development of "shared goals" between therapist and client as an integral component of the therapeutic alliance.

I am often asked by colleagues whether or not I would recommend harm reduction as an approach for a particular client, typically a case with the worst possible prognosis in terms of the severity of substance abuse problems. Would I recommend a nonabstinence goal for someone with severe addiction problems? My response, like that of many therapists whose cases are described in this book, is to shift the issue of goal choice back to the client. I am willing to work with clients, whatever their goal may be, from abstinence to moderation. Clients often change their goals as treatment progresses (or fails to progress), from harm reduction to abstinence or the other way around. Changing addictive behavior is often a complex and complicated process for both client and therapist. What seems to work best is the development of a strong therapeutic alliance, the "right fit" between the client and treatment provider. Without the "right fit," clients are more likely to give up and drop out of treatment. Given the ups and downs of the behavior change process, the role of the harm-reduction therapist is closer to that of a guide, someone who can provide support and guidance throughout the difficult journey. A reliable mountain-climbing guide would never desert a client who fails to make it to the peak or who stumbles and falls on the upward climb. The therapist-guide offers validation and respect for each client, along with a willingness to meet the person where he or she "is at" on the journey and to help them achieve the next step toward their goal.

The case studies presented here represent a broad spectrum of therapeutic "schools," ranging from psychoanalytic to cognitive-behavioral therapy. Despite these theoretical differences, all the therapists share a common set of values associ-

ated with harm reduction, including a compassionate, client-centered therapeutic relationship that treats each client as a unique individual. Harm-reduction therapists also adopt a holistic and humanistic approach when it comes to treating dual disorders or co-occuring problems, as illustrated in several chapters. Clients often resort to alcohol or other drugs as an attempt to adapt to or cope with other problems in their lives, as stated in the self-medication hypothesis outlined by Edward Khantzian and other authors represented in this volume. One of the main tenets of harm reduction therapy is *not* to attempt to eliminate a client's main adaptive coping response (including alcohol or drug use as self-medication) until other more effective coping mechanisms are in place. This compassionate principle is highlighted in many of the case studies presented here.

Overall, Andrew Tatarsky does a fine job of introducing each chapter and setting the stage for the case study or "story" that follows. Each case is also followed by his insightful commentary and conclusions that tie together and integrate the various themes he raises in the introductory chapter. The overall final product is well worth the reader's time and effort in understanding how harm reduction works in the "nuts and bolts" of clinical practice. I congratulate Andrew Tatarsky for his creative vision in communicating the heart and soul of harm reduction therapy.

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Acknowledgments

I've learned many things on the adventure that culminated in the completion of this book. Most important is that the ideas expressed through my writing reflect the gifts given me by the many clients, colleagues, teachers, and family members I have had the honor and pleasure to have known over the course of my life.

Most important to this project have been the many clients who had the courage and generosity to invite me into their lives, sharing their stories with me and teaching me about substance use and misuse and how people change and grow. To you whose names may not be mentioned, I am deeply grateful—you have inspired in me a powerful belief in the strength of the human spirit to overcome all obstacles in its quest for freedom and loving connections.

Many thanks to the psychotherapists who contributed stories about their work that reflect a level of honesty, humility, and sensitivity rarely seen in the psychotherapy literature. Their words touched and inspired me deeply.

For their hard work, generosity, and commitment, I also especially want to thank four psychotherapists who contributed important stories that are not appearing as they did not fit within the ultimate focus of the book. Their stories explore important issues in the field and are each important contributions to the treatment of substance use: Richard Yensen and

Donna Dryer ("Addiction Despair and the Soul: Successful Psychedelic Psychotherapy, A Case Study"), Leon Wurmser ("The Analysis of a Case of Alcoholism, Masochistic Character, and Perversion"), and Elizabeth Zelvin ("Carla: A Case Study").

A special thanks are due to my good friend and treasured colleague Alan Marlatt for introducing me to harm reduction, being a trailblazer in the field, and encouraging me to speak the truth and stand up for what I believe.

For their insightful comments and criticisms that propelled the development of my work, I especially want to acknowledge my dear colleagues and friends Julie Barnes, Michler Bishop, Antonio Burr, Patt Denning, Armand DiMele, Lisa Director, Jeannie Little, Mark Goldenthal, Marc Kern, Robert Lichtman, Deborah Liner, Bart Majoor, Michael Morrison, David Ost, Stanton Peele, Stephen Reisner, Debra Rothschild, Gordon Rovins, Jeremy Safran, Mark Sehl, Michael Varga, Ora Yemini, Arnold Washton, and Alexandra Woods.

I owe a debt of gratitude to the harm reduction community for providing me with a large group of thoughtful, socially committed, loving friends and colleagues who have become a spiritual family to me. You have reminded me that the personal is the political, supported me in "coming out" about harm reduction and in my personal and professional development in more ways than you will ever know. Special thanks are due James Cannon, Allan Clear, Donald Grove, Ernie Drucker, Jason Farrell, Mark Gerse, Don McVinney, Ethan Nadelman, Anna Oliveira, Joyce Rivera, Paula Santiago, and Edith Springer.

For their loving, gentle support for my undertaking the challenge to learn to write I have intense affection and gratitude for my writer friends in the Thursday night Write Club who read and commented on sections of the manuscript, gave crucial suggestions to me, and taught me about the process of writing: Jonathanavery Landerz, Peter Rondinone, Stephen Michaels, Errol Selkirk, Chris Ross, and Evan Lerner.

I am grateful to Michael Moskowitz for initially encouraging me to begin this project—he's a rare psychoanalyst with a clear commitment to seeing the intersection of the personal and political dimensions of human functioning.

I am indebted to Liz Rymland for her help down the stretch

with important editorial suggestions, sweet language, an injection of spirit and manuscript preparation; these gifts raised the overall level of the work.

Most importantly, I am forever indebted to my loving family who have sustained my life. To my mother, Sheindi, who gave me life and planted the seeds that flowered in my discovery of harm reduction; to my fathers, Jack and Dick, who inspired me to think large and believe that anything is possible in love, beauty and truth; to my siblings, Laurie, Miles, and Nikolas, who have been wonderful company in the darkness and light; to my amazing children, Alexandra, for reminding me to stay open to the great mystery of spirit and lightness, helping me to believe in magic, and reminding me of the joys of dance and poetry, and Lucas, for helping me to keep my heart soft and open, enjoy the interplay of strength and vulnerability in all that is, and for filling my life with delight; and to my wife, Dr. Wendy Miller, you have made my life possible by your warm sustaining love, brought the joy to my life, and supported me in uncountable ways that made this book possible.

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Patt Denning, Ph.D., worked in San Francisco Community Mental Health as a clinician and program director for 16 years. She developed specialties in differential diagnosis, psychopharmacology, psychotherapy with seriously disturbed patients, HIV, and substance use disorders. She has been in full-time private practice since 1993 as the founder of Addiction Treatment Alternatives, a comprehensive assessment, treatment, and training program based on harm reduction. In 1997 Dr. Denning completed the Diplomate-Fellow training in Psychopharmacology and also was named to the Drug Policy Resources Directory for the Media in the area of Dual Diagnosis. She is a certified addiction specialist through the APA College of Professional Psychology. Dr. Denning is a locally well-known speaker on

issues of drug policy, chemical dependency treatment, dual diagnosis, HIV, and the organizational development of alternative treatment settings to meet the needs of a drug-using population. She and a colleague have just started a nonprofit treatment and training program, The Harm Reduction Therapy Center, which is in the initial funding and start-up stage. She has just finished a book on the subject, *Practicing Harm Reduction Psychotherapy* (Guilford Press, 2000), and is the author of several articles on the subject. She can be contacted through: www.harmreductiontherapy.org

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Edward J. Khantzian, M.D., received his medical degree from the Albany (NY) Medical School. He served residencies in psychiatry at the Massachusetts Mental Health Center and The Cambridge Hospital and completed his psychoanalytic training at the Boston Psychoanalytic Society and Institute in 1973. Dr. Khantzian is now Clinical Professor of Psychiatry, Harvard Medical School, and a founding member of the Department of Psychiatry at The Cambridge Hospital, where he is currently Principal Psychiatrist for Substance Abuse Disorders. He is also the Associate Chief of Psychiatry, Tewksbury Hospital, Tewksbury, Massachusetts. From its inception in 1986 to 1991, Dr. Khantzian was a supervising physician for the National Football League Drug Control Program and now serves as a senior consultant to the NFL/NFL Players Association program of substance abuse. Dr. Khantzian has a private practice in psychiatry and psychoanalysis in Haverall, Massachusetts, is a participant in numerous clinical research studies on substance abuse, and a prolific lecturer and writer on psychiatry, psychoanalysis, and substance abuse problems. He has spent more than 20 years studying psychological factors involved in drug and alcohol abuse. His studies, publications, and teaching have gained him international recognition for his introduction of the now widely accepted "self-medication hypothesis" as one primary motivation for using substances and contributions on self-care deficits in substance use disorders, and the importance of modified techniques in group therapy for substance abusers. Dr. Khantzian has authored several book and numerous scientific articles and book chapters, including: *Addiction as a Human Process* (Aronson, 1999), *Addiction and the Vulnerable Self: Modified Dynamic Group Therapy for Substance Abusers* (Guil-

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Introduction

Ideas have different meanings at different moments in history. Ideas that once appeared crazy, dangerous, or incomprehensible later become so much a part of accepted truth that society temporarily forgets the time when these ideas were dormant. New ideas arise in response to current conditions as an attempt to make sense of and help guide us in responding to these conditions. Ideas determine our view of reality, both expanding and limiting our possibilities. As history marches on and conditions change, ideas that were once progressive and useful can become stale, empty, regressive barriers to change. When the dinosaurs of outmoded ideas die, the ideas that have been hiding in the hinterlands creep back into the mainstream to repopulate the field. New ideas once again arise that attempt to explain the limitations of those that came before. This is as true for individual psychology as it is for scientific paradigms.

Within the drug and alcohol treatment field, there have been a number of great ideas that have represented new paradigms for understanding problematic substance use. The application of these ideas to clinical treatment led to revolutionary changes in practice that resulted in dramatic improvements in the care available to people with substance use problems. The addiction-as-disease concept (Jellinek, 1962) challenged the moral model of drug misuse, which blamed the problem on the inappropriate

values or immoral character of the user. The disease paradigm opened the way to treatment, rather than punishment, for these problems. The self-medication hypothesis (Khantzian, 1985) pointed out that for many, drug use is a form of self-care that reflects an attempt to cope with painful feelings. This idea highlighted the important dimension of the meaningfulness of drug use and the necessity to recognize and address the underlying issues the user is trying to heal through drug use. Relapse prevention (Marlatt and Gordon, 1985) pointed out that, rather than viewing a return to problematic drug use after a period of abstinence or diminished use as failure, relapse should be seen as a common, natural part of the process of changing behavior, which can be an opportunity for learning that might decrease the possibility of future relapses.

Harm reduction is the most recent of these important new ideas in the substance use treatment field. It heralds a paradigm shift in the way we understand and respond to problematic drug and alcohol use. Harm reduction rejects the presumption that abstinence is the best or only acceptable goal for all problem drug and alcohol users. Harm reduction sees substance use varying on a continuum of harmful consequences to the user and the community. In doing so, harm reduction accepts small, incremental steps in the direction of reduced harm with the goal being to facilitate the greatest reduction in harm for a given person at this point in time. Inherent in this change in the treatment focus is a radical redefinition of the relationship between the client and the clinician, a departure from the paternalistic model associated with more traditional substance use treatment. Harm reduction places respect for the client's strengths and capacity to change as the starting point for developing egalitarian relationships in which clients are encouraged to collaborate in setting up the treatment and choosing goals and strategies that they find useful. This shift in basic assumption is actually consistent with psychodynamic and behavioral models of drug misuse and has many beneficial implications for treatment that will be discussed in this book. A growing group of clinicians, researchers, and public policy makers have recognized that the philosophy of harm reduction has a critically important role to play in our efforts as a field and

in the larger society to improve the treatment of people struggling with substance use problems.

This book represents what I have learned in my twenty years in the field of substance use treatment as a psychotherapist, psychologist, supervisor, program director, and teacher. I will share with you some of the experiences that led to my coming to embrace harm reduction as a clinical principle essential to effective treatment of substance misuse. This book presents harm reduction psychotherapy as treatment that works psychotherapeutically, and it examines how and why.

The practice of harm reduction is a needed corrective to the limitations of our current professional and public policy response to drug use problems in this country. I will present my perspective on harm reduction psychotherapy and why I think it has great promise for dramatically improving our success at helping people struggling with substance use problems. Each chapter focuses on a specific aspect or application of harm reduction psychotherapy. The stories in this book demonstrate how harm reduction psychotherapy is rooted in the basic principles of good psychotherapy practice and is consistent with psychodynamic and cognitive-behavioral models of substance misuse. I will discuss how harm reduction psychotherapy specifically lends itself to effectively addressing several important emotional dynamics commonly associated with substance use problems.

Additionally, each chapter contains a detailed story describing the psychotherapeutic process with a client experiencing a substance use problem. All but one of these stories were contributed by other psychotherapists in the field. The stories were chosen to illustrate the particular topic of each chapter, but each is like a multifaceted gem containing much more than I am able to address. As a collection, the stories show the range of treatment approaches that fall under the harm reduction umbrella as I understand it. They differ in theoretical bias, psychotherapist style, and outcome; some result in moderation of substance use and others lead to abstinence. I discuss how I see them each falling within the continuum of treatment linked by the harm reduction principle.

Each story can also be read as a window through which to

view the very unique interplay between client and clinician that characterizes all good psychotherapy. We witness how successful therapeutic relationships are established, how goals emerge as problems are clarified. We discover that the general ingredients for the successful psychotherapy of drug use problems are hard to distinguish from those of effective psychotherapy with other kinds of clients.

The following stories humanize the diversity of faces of individuals with unique drug and alcohol problems, a group of people generally stereotyped by their drug use. They reveal the wide range of people who can develop drug and alcohol problems and enable the reader to identify and empathize with their struggles and respect their efforts to change and grow.

The stories also demystify the work of psychotherapy, bringing the reader into the consulting room like a fly on the wall witnessing some of the actual processes. The stories humanize the psychotherapists as they reveal what the therapists thought and felt about their clients as they worked.

To my mind, the basic principles and ingredients of successful psychotherapy with clients with drug and alcohol problems are essentially the same as those used with other groups of people. The argument can be made that the term "harm reduction" really stands for the re-introduction of basic principles of good clinical practice into an area where they have often been absent. I hope this book will contribute to that effort.

WHY HARM REDUCTION?

I got my first job after completing my internship in clinical psychology as a psychotherapist at the Division of Drug Abuse Research and Treatment at New York Medical College in the fall of 1982. This was a research-oriented "multimodality" outpatient substance abuse treatment clinic in East Harlem, New York City. I had no way of knowing at the time that this job would be the start of a twenty-year journey through the world of substance use treatment that would bring me to embrace harm reduction as the most effective approach to helping the broad spectrum of people with substance use problems.

I had worked with several clients with drug and alcohol problems during my training, but I was by no means an expert. In contrast to the bleak and negative stereotypes about substance-using people with which we have all grown up, I found the clients to be a varied group of very interesting people with many strengths, open to working in psychotherapy to change. My initial experiences working with substance users were so gratifying that I decided to complete my dissertation in the area and specialize in the field.

I had been trained in a psychoanalytically oriented graduate program and began to use a psychodynamic approach with my patients. While I felt that this perspective enabled me to thoroughly understand my clients and the meaning and function of their substance use, the psychodynamic approach offered a limited set of specific clinical interventions to actively help people change their substance-using behavior. Patients didn't stop using and, by that criterion, my approach was not effective. I was introduced to the more active, strategic focus of traditional drug counseling, Alcoholics Anonymous, cognitive-behavioral interventions, and a variety of the developing pharmacological interventions. I began to integrate them with my psychodynamic thinking, which emphasized the multiple meanings that drug use can carry and the importance of the therapeutic relationship in treatment. I gradually developed a more effective integrative approach that blended dynamic, cognitive, behavioral, and biological strategies, which combine to target the drug use as well as the broad range of other biological, psychological, and social issues that factor into drug use and misuse.

After leaving my first job, I designed and directed two outpatient programs in which I taught and supervised clinicians in this integrative approach, and I continued to use this approach with clients in my private practice for many years. I have experienced much satisfaction in helping many of my patients to achieve stable long-term sobriety from drugs and alcohol. I have maintained contact with numerous clients through the years, and I am inspired by their continued progress.

However, despite the many successes along the way, I became increasingly concerned about a serious problem that I experienced in my work and saw in the field as a whole. At the last

clinic that I directed, I did an informal study that produced evidence that we were not helping most of the patients who came to us initially. Our experience was similar to that of other traditional abstinence-oriented treatment programs; we had a fifty percent rate of no-return patients, who dropped out after the initial evaluation or were discharged because of "slips" or relapses of their habits. Added to the number of patients who returned to drug use after completing the program, the individuals who relapsed represented the majority of visitors to the clinic.

I was astonished and deeply troubled by this information. I studied the literature to see what others were reporting and found that we were doing no more poorly than others. Studies report, at best, a thirty-percent success rate, and most treatments cannot claim outcomes this high. For example, see the summary of drug and alcohol outcome research by Hester and Miller (1995). Yet this was considered the best that could be expected. These statistics don't begin to include the users who never seek help because of the unrealistic expectations that characterize mainstream treatments in this country. It was common for rehabilitation programs to tell their patients that only one out of ten of them were "going to make it," that is, stay sober.

These poor outcomes have generally been explained as reflecting the lack of motivation of substance users or the difficulties inherent in treating people with substance use problems. A popular scapegoat for this poor success rate is the disease itself: "the cunning and baffling nature of the disease of addiction."[1]

I began to rethink the "abstinence-only" requirement that informs traditional substance use treatment. The assumption that abstinence is the only cure for addiction is related to the addiction-as-disease concept. According to this model, people with substance use problems cannot benefit from psychotherapy while they are using, must accept abstinence as a goal

1. This is a slogan commonly used in the Alcoholics Anonymous community that is presumably based on the description of alcohol in the "Big Book" of AA (Alcoholics Anonymous, 1939, pp. 58–59) as "cunning, baffling, powerful!"

of substance use treatment to be in treatment, and must achieve and maintain abstinence in order to be allowed to remain in treatment. When clients say that they believe that other issues are more important, they are told that they are in denial about the central, primary nature of their "disease" and that these other issues must be put on the shelf while the substance use is tackled.

Most treatment programs have "high threshold" access, meaning that there are many requirements to which clients must agree to gain access to treatment: for example, urine testing, attending Alcoholics Anonymous meetings every day, breaking contact with other substance users. Clients unable to live up to these requirements are often referred for more intensive treatment, while unwilling clients are routinely discharged from treatment with the statement that they should come back when they are ready.

Two true stories will illustrate how this often plays out in practice. Several years ago, a competent, experienced professional associate who runs a well-respected intensive outpatient program for substance abusers told me about a woman whom he had seen for an evaluation. At the end of the initial interview, he told her he thought she clearly had an addictive disorder and recommended that she enter his program, which, he said, could help her stop using. She reacted with surprise, stating that she had not come to stop using but, instead, thought that she needed to cut down. He replied that his program was only able to help her stop and that he thought she should come back when she was ready to do that; there was nothing else he could offer. The interview was over with no other recommendations made. I wondered about the look on her face and the emotional impact that abrupt conclusion must have had on her.

Another story illustrates the problem from the psychotherapy perspective. Several years ago, a student in a class I was teaching, a social worker, related the story of a recent occurrence. She had seen a new client in a general psychotherapy clinic for five sessions before presenting the case to her supervisor, a senior social worker at the clinic. The client was a woman in her late twenties who had a serious drug problem in the past for which she had completed a drug rehab program. She came

for therapy to work on several issues including problems at work, a stormy relationship, self-esteem problems, and a return to occasional drug use. The therapist felt that they were off to a good start in their work together; there was the beginning of a solid treatment alliance, and the client seemed to be settling into working on her issues, apparently feeling good about the therapist's input. The supervisor's response was quick and final; the client had to be terminated from treatment because the clinic had a policy of not providing psychotherapy to active drug users. She added with authority, "You can't trust what drug abusers have to say until they have been clean for at least six months; they cannot effectively make use of therapy until then."

The social worker was nearly in tears as she described to the class her client's reaction to this agency mandate. When she informed her client in the next session of the clinic policy, she quickly tried to express empathy for the client's feelings and discuss making a referral to a good drug program but it was too late; she knew immediately that the client was lost by the pained, withdrawn look in her eyes. The client did not return for her next session.

Unfortunately, these stories are not uncommon. The abstinence-only assumption operates in subtle ways. Another director of a large, well-known substance abuse treatment program said in a panel presentation to a group of employee assistance professionals, "I would work with someone who is actively using drugs for a limited period of time, but I would make my assumptions clear: I do not believe an addict can moderate his use and I would like the patient to prove me wrong if possible." This stance is taken by many clinicians who may or may not verbalize these views to their clients, and it has a different, dangerous impact on the therapeutic encounter. How does a troubled substance user approach a course of healing when the person being paid and consulted for help believes that what he is trying to do is impossible? How does a client enter a therapeutic relationship with a clinician who secretly believes that the client is not capable of being honest or is emotionally unavailable for treatment?

My own limited success left me feeling ashamed and guilty about my inability to help the people that appeared in my office

or programs asking me for assistance. The idea that people needed to "hit a lower bottom," that is, to suffer more as a result of their substance use in order to become more motivated to stop using, became unacceptable to me. It seemed as if our field was putting the responsibility for our failure on our clients, rather than taking responsibility for the problem by looking at how our treatment approach might be limited by its own basic assumptions and processes. It seemed to me that this level of failure challenged us to find new, more creative, and inclusive ways of working with people. I began to feel uneasy and unsatisfied with the unmotivated-client explanation for our limited success, and I started to wonder whether the abstinence-only assumption might account for a large measure of our failure. Now, I had been trained in the milieu of abstinence-only treatments, so I felt confounded and in a difficult quandary. Although our work had clearly been helpful, in some cases lifesaving, to many people, it became clear to me that the constraints and limits of an abstinence-only treatment system was both off-putting and damaging to individuals urgently pursuing a quest for help. I uneasily began to look for alternatives.

I had begun a private practice in psychotherapy in 1987 in which I was free to work with my clients in a more flexible way. In the late 1980s I began to experiment working with clients who were not interested in stopping their drinking or drug use completely but wanted help to figure out what they should do. They wanted to see if they could learn to use in less damaging ways. I knew I would be breaking the traditional rules by agreeing to pursue these goals, but I had been trained in a graduate program that aimed to *really* meet people where they are. Some of these clients seemed sufficiently motivated, insightful, and open to make me feel hopeful about undertaking this experiment. It seemed to me that stable moderation would be a great improvement and, if not, our therapeutic process might take them steps toward stopping. Either way, there were possible advantages beyond the available practices of the day.

Over the next several years I began to see significant breakthroughs and gains in both moderation and cessation of drug misuse. Some individuals were able to cut down significantly, while others found moderating their use impossible and instead

became motivated to stop using altogether. These successes were not supposed to be possible according to the traditional model. I was concerned that if my colleagues knew what I was doing, my ethics would be seriously questioned.

Sometime in 1994 I was speaking to Alan Marlatt on the telephone about my work. Alan is a psychologist with a long-respected career as a clinician and researcher in the alcohol treatment field who wrote the groundbreaking book, *Relapse Prevention* (1985). I was lucky to have him as a friend and colleague. I told him about my concerns about the limitations in the traditional model and the experimental work I was doing in my private practice. He responded by saying, "You are doing harm reduction." I said, "What is that?" When he introduced me to harm reduction as an alternative to the traditional treatment model, I immediately realized a philosophical and clinical basis for my work.

Since that conversation, I have discovered harm reduction as a philosophy guiding how we meet our clients and ourselves, pragmatically and with compassion; as a clinical theory that can inform treatment across the broad spectrum of substance-using people; as a critique and corrective to the limitations of the existing treatment system; and as a growing movement composed of clinicians, researchers, and policy makers who collectively provide a progressive perspective to the field.

Harm reduction is a framework for helping drug and alcohol users who cannot or will not stop completely—the majority of users—reduce the harmful consequences of use. Harm reduction accepts that abstinence may be the best outcome for many but relaxes the emphasis on abstinence as the only acceptable goal and criterion of success. Instead, smaller incremental changes in the direction of reduced harmfulness of drug use are accepted. This book will show how these simple changes in emphasis and expectation have dramatic implications for improving the effectiveness of psychotherapy in many ways.

This book reflects the path my own work has taken since that conversation with Alan Marlatt to incorporate harm reduction into my approach to psychotherapy. I see harm reduction as an idea that builds upon what has been available before. It challenges and critiques the limitations of existing models of drug

and alcohol treatment in an effort to extend the reach of treatment to the majority of problem alcohol and drug users who have not been helped by the traditional approach.

This book also adds to a growing literature on the subject. In 1998, Marlatt and a group of his colleagues published *Harm Reduction: Pragmatic Strategies for Managing High Risk Behaviors*, an innovative book introducing harm reduction and describing its history, supporting research, and applications to different client groups. In 2000, Patt Denning, another friend and colleague who has been a major contributor to the application of harm reduction to psychotherapy, published the first in-depth exploration of the application of harm reduction to psychotherapy, *Practicing Harm Reduction: An Alternative Approach to Addictions*. In it she presents her multidimensional approach to harm reduction psychotherapy.

This book extends these contributions with my own perspective. It is an exploration of the particular value harm reduction psychotherapy has for dealing with a range of emotional issues commonly associated with problem drug use and a collection of stories showing the variety of forms this approach can take.

THE CHAPTERS

In Chapter 1, I provide the clinical rationale for harm reduction psychotherapy and an outline of the integrative approach that I have developed. This approach considers the complex interplay of personal meaning, conditioning, biology, and social context both in the genesis of drug problems and in the development of individually tailored psychotherapy. The illustrative story, my contribution, is about Tom, a depressed problem drinker who achieved stable moderation from alcohol after having failed at a coerced abstinence-oriented treatment.

Chapter 2 explores the contribution that the psychoanalytic tradition has made to harm reduction psychotherapy, particularly in its emphasis on the importance of the multiple meanings of drug use and the centrality of the therapeutic relationship in effective psychotherapy. The accompanying story, the case of Mrs. G. by Mark Sehl, is about a depressed, socially isolated

elderly woman with severe alcohol dependency who was helped by a harm reduction approach to achieve abstinence from alcohol in the course of addressing her emotional difficulties. The story shows how a harm reduction approach is consistent with a psychoanalytic understanding of Mrs. G.'s drinking. It also challenges prevailing misconceptions about psychoanalytic treatment in describing an analytic psychotherapy that was very different from the classical approach yet remained true to analytic principles.

Chapter 3 discusses the theoretical support that learning theory provides to harm reduction psychotherapy and the value of blending cognitive and behavioral strategies with a psychoanalytic understanding of the meaning of drug use in helping people change. The case of Archie, by Gary Dayton and Frederick Rotgers, is about a man with a serious drinking problem that was related to depression and obsessive compulsive disorder. Like Tom, Archie had found prior abstinence-oriented treatment to exacerbate his difficulties but was able to dramatically reduce his drinking and address his psychological problems with the harm reduction approach.

Chapter 4 looks at the cornerstone of harm reduction psychotherapy, the right fit between client and treatment as central to the success of the work. It explores the importance of the match between the client and the treatment modality, and the therapeutic relationship and how this is built. The accompanying story by Gail Hammer is about Michael, an alcohol-abusing man with AIDS who successfully moderated his drinking. At the start of the story, we read that the therapeutic alliance was almost derailed by the therapist's supervisor's mandate that the client be referred elsewhere to stop drinking. The therapist quickly realized that she had to shift to a harm reduction approach that accepted his continued drinking in order to form an alliance with him that enabled the therapy to get under way. It ultimately supported him in moderating his drinking and addressing a range of other important emotional issues.

Chapter 5 discusses the complexity of the people and problems that can be associated with problematic drug use, the need for psychotherapies that are correspondingly complex and, sometimes, long, and the relevance of harm reduction psycho-

therapy to these issues. The psychotherapy story in this chapter by Valerie Frankfeldt is the story of Donnie, a multiple drug user with severe emotional and communication problems who achieved abstinence after a six-year-long psychotherapy. The story reveals how Frankfeldt was pulled to harm reduction despite her prior abstinence-oriented training because of Donnie's needs. She had to work with great uncertainty about what were appropriate goals for him as he continued to use drugs for a long time before he was able to begin to step down his drug use and eventually begin attending Alcoholics Anonymous and stop using drugs and alcohol.

Chapter 6 explores the importance of seeing drug use as carrying or expressing multiple personal meanings for people and the value this has for promoting change. It discusses the value of seeing drug use as an adaptive attempt to cope with painful feelings and personality vulnerabilities and suggests that until this function of drug use has been recognized and addressed in another way, many people are unable to consider modifying their drug use. The accompanying story, the case of Gary by Edward J. Khantzian, is about an opiate-dependent physician who went to a traditional 12-step oriented drug rehabilitation program followed by psychodynamic psychotherapy and 12-step program attendance and achieved stable abstinence. The story particularly shows how treatment can have an impact both on the drug use as well as on many aspects of personality functioning that render people vulnerable to developing drug problems. Unlike previous stories in this book of failed "coerced" abstinence-oriented treatment, in Gary's case, a coerced traditional treatment was the right fit for Gary and had dramatic positive results. It illustrates how the harm reduction umbrella encompasses traditional treatment for drug users who need it; those whose use is out of control, are unable to meaningfully engage in psychotherapy without outside intervention, and seem to need outside pressure to get moving in a positive direction.

Chapter 7 discusses the role of trauma and early experience in general in shaping the vulnerabilities that may lead people to drugs. It further explores how an appreciation of these experiences early in life can be used in psychotherapy. The case of

Sally by Jerome David Levin was chosen to illustrate these issues. Sally came for help with severe anxiety that was the result of early physical and sexual abuse. A dependence on amphetamines was only revealed some time into the therapy after much work had gone on to create a safe space in the treatment. Until this time the treatment had to progress while she used the drug to hold herself together. The story illustrates the need to accept ongoing drug use in many clients for some time into therapy before it is possible to work directly on changing the drug use. In this case the therapy led to an abstinence outcome.

Chapter 8 discusses a common dynamic expressed through drug use: the rebellion against the inner critical voice. It explores how harm reduction psychotherapy is specifically suited to help people find a third solution between the submission-rebellion bind that is often expressed in the cycle of binging, pledging to stop, binging, and on and on. The illustrative story for the chapter, the case of Diana by Patt Denning, is a story of a woman who had a long history of heavy drinking that was related to relationship problems, difficulties feeling and expressing feelings, and depression; all of these in turn related to a severe inner critic that tormented her. The first goal of this psychotherapy—to stop drinking—failed as it was revealed to be a submission to the inner critic. It was only when they shifted to a harm reduction approach that helped her find what was right for her that she achieved a stable moderation of her drinking.

Chapter 9 discusses the long-term residential therapeutic community, one of the oldest approaches to the treatment of people with drug problems. It explores the rationale for the therapeutic community and which clients may be best suited for it. The accompanying story, the case of Ms. E by Barbara Wallace, is the story of a woman with a long addiction to crack cocaine that was related to a childhood history of physical and sexual abuse. Following numerous failed outpatient treatments, Ms. E was mandated to the therapeutic community and, like Gary in Chapter 6, found this to be the push that she needed to get to a treatment context that fit her needs. In this context she began to heal the intense traumatic suffering that underlay her drug use. With the help of ongoing psychotherapy after she left

the program, she was able to maintain stable abstinence and become a model for how to heal trauma. The story also reveals how Dr. Wallace was transformed by her work with Ms. E.

Chapter 10 introduces the harm reduction group as an approach to group therapy that can have benefits that more limited abstinence-only groups do not. The accompanying story, "The Sobriety Support Group" by Jeannie Little, is about the development of a harm reduction group she and a colleague ran for homeless dually diagnosed (drug use problems and psychiatric problems) veterans. She describes the evolution of the group's structure and norms in collaboration with the members and shows how the group was able to be helpful to clients who had been failed by traditional treatments. She particularly emphasizes how the diversity in the group members in terms of goals (moderation or abstinence), mental health, and motivation was what made the group effective.

1

Harm Reduction Psychotherapy

Mainstream abstinence-oriented treatment of alcohol and drug users in the United States today continues to have poor success by anyone's criteria. Clinical observations and empirical studies typically report that a majority of clients seen initially do not successfully complete treatment or maintain their gains after treatment. These poor outcomes are evident in residential and outpatient programs and across different theoretical approaches. The Substance Abuse and Mental Health Services Administration reported that between 1992 and 1997 only 47% of patients completed American drug and alcohol treatment programs with another 12% referred to other programs (SAMHSA, 1999). Several treatment outcome studies suggest that only 20–40% of patients who complete treatment achieve long-term success even when abstinence and moderation are both considered as successful outcomes (Keso & Salaspuro, 1990; Nordstom & Berglund, 1987). For example, Helzer and colleagues (Helzer et al., 1985) looked at three-year outcomes of four abstinence-oriented programs of patients who met D.S.M. III criteria for alcohol dependence. They found only 15.1% reported total abstinence and 18.4% reported some form

of problem-free drinking. Ditman et al. (1967) did a one-year follow up of 301 "chronic drunk offenders" who were randomly assigned to no treatment, Alcoholics Anonymous, or clinic treatment as a condition of probation. Using re-arrest for a drinking-related offense as the primary outcome measure, they found that 68% of the clinic group, 69% of the AA group, and 56% of the no treatment group were re-arrested; the differences were not statistically significant. And, more recently, a large scale controlled study, Project MATCH (Project MATCH Research Group [1997]) was funded by the National Institute on Alcohol Abuse and Alcoholism to compare patients' responses to different treatment approaches. 1,726 people with alcc. ¬l use problems were randomly assigned at sites across the country to twelve sessions of 12-Step Facilitation Therapy (TSF), Cognitive-Behavioral Therapy (CBT), or Motivational Enhancement Therapy (MET). Using complete abstinence during the year after treatment as the measure of success, 24% of individuals in the TSF group were abstinent, 14% of those in the CBT group, and 15% of those in the MET group.

Standard approaches are not equipped to address serious emotional or socioeconomic problems accompanying substance use problems. These statistics for failure in substance abuse treatment do not include people with drug and alcohol problems who never seek traditional treatment, a group that represents the majority of problem users in this country. The United States Department of Health and Human Services (USDHHS, 1997) estimated in 1997 that about 15 million adult Americans are alcohol dependent or abusing. SAMHSA (1999) estimated that there were 2,207,375 admissions to 15,000 American in- and outpatient treatment facilities in 1997. Assuming that some of these were multiple admissions by some people, it is likely that approximately two million people were treated in that year. These data suggest that close to 85% of individuals with alcohol problems in 1997 were untreated in this country. This is supported by the Institute of Medicine's (1990) estimate that 80% of American alcoholics have never made contact with self-help or professional treatment, and by the National Institute on Alcohol Abuse and Alcoholism's (1999) estimate of 10 million untreated American alcoholics. I think it is safe to assume that the