second edition

Practicing Harm Reduction Psychotherapy

An Alternative Approach to Addictions

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Principles of Harm Reduction Therapy

The principles of harm reduction psychotherapy have emerged from public health, from evidence-based models of drug use and change, from psychodynamic psychotherapy, and from our clinical experience. Our highest

value is the individuality of people who use drugs. For those of us who came of age in the 1960s, it is obvious that drugs are used by many people for many different reasons and with many different outcomes. The stoned-out hippie who is now a stockbroker is a stereotype of the transformation that occurred in the 1980s in the United States. The shirt-and-tie engineering student who went through the 1970s mesmerized only by a slide rule became addicted to cocaine in the 1980s, quit using in the 1990s, and now runs a successful business. And, of course, there is the person who started out shooting heroin and is now on the streets, HIV-positive, thin as a rail, and still shooting up. What differentiates these people? How is it that the use of drugs can be so variable with regard to both personality types and outcome? Our model is driven by our appreciation that each individual drug user has a different relationship with drugs, unique needs and goals, varying patterns and rates of change, and different needs for treatment. The following principles encompass all of the models and all of our attitudes that inform our work with drug users.

The Nature of Drug Use

Not All Drug Use Is Abuse; Drug Use Occurs on a Continuum

Drug use and getting high are not, for the most part, pathological. Most people in the United States use some type of drug, and most do not have problems. Rather, substance use occurs on a continuum from nonproblematic, benign experimentation to regular recreational use to purposeful self-medication problematic or chaotic use, the last of which is usually thought of as addiction or alcoholism. Substance *abuse* is a biopsychosocial phenomenon that is unique to each individual. As is the case with other behaviors, the continuum of drug use is not an inevitable progression. It is a fluid dynamic in which individuals may move in and out of various levels of use.

Popular conceptions are that anyone who uses the most addicting drugs (heroin, cocaine, tobacco) is bound to develop dependence, and that almost any drug use is likely to result in significant problems. Lifetime prevalence data cannot provide information regarding who among all drug users will develop problems. Data from the National Comorbidity Study (Anthony et al., 1997), can, however, be used to measure the differences between the number of people who use a certain drug and, among them, the number who eventually become dependent on that drug, figures that were confirmed in a replication study involving 3,199 English-speaking adults ranging in age from 18 to 44 years (Kessler et al., 2004). The data show that of 91% of Americans who have consumed alcohol, 16.4% are alcohol dependent; of 51% who have used illicit drugs, 18% are dependent; of 46% who have used marijuana, 9% are dependent; of the 1.5% of Americans who have tried heroin, 23% are dependent; and most strikingly, of 75% who have used tobacco, 32% are dependent.

These data contradict popular opinion. Even with drugs known for their addictive potential, with the notable exception of tobacco, less than one-fourth of users become dependent. How can we explain for this? First, more familiar research results most often come from treatment samples, people who have *already* developed drug problems. The use of client samples to assess the development of a drug disorder is obviously biased given the universal outcome among them. Second, there must be certain presently unknown factors that increase or decrease the risk of using a drug and perhaps different factors that are related to eventual dependence. In other words, there may be particular vulnerabilities in a person that we can cite as predictors of drug dependence.

People Do Not Have Addictions; They Have a Relationship with Drugs

We find it more reflective of the diverse types of drug use to say that people have a *relationship with drugs* rather than an addiction. Harm reduction therapy is based on the belief that addictions are a complex combination of biopsychosocial forces. There is a relationship between users and their drug of choice, in which the drug takes on many elements of a primary attachment figure. Users may idolize the drug, only to feel hateful toward it when suffering during a hangover or withdrawal. Promises never to do the drug again are reminiscent of a person swearing never again to go out with a lover who treats her badly. Alternately, people may use when they need reliable relief from anxiety or boredom. All of these relationship patterns can occur equally with drugs as with people. A careful psychosocial history often reveals clear emotional or social problems for which the individuals once actively sought solutions and then discovered drugs in their search. It is important for therapists to realize that *drugs worked*, at least a little and at least for a while. This is one of those ideas that, once articulated, seems obvious and based in common sense. People are not stupid. They find what works and stick to it. The primary motivation is usually self-care, not self-destruction.

People Use Drugs for Reasons

A postcard from a local card shop shows three hypodermic syringes overlaid with the words "100,000 heroin addicts can't be wrong." What we know of *neurobiology* supports the fact that people, especially those with physical, mental, or emotional illness, get significant relief from street drugs.

Unfortunately, the definition of substance abuse—continued use despite negative consequences—is often applied de facto to the use of illegal drugs because to use them entails engaging in illegal behavior despite the risks of that behavior! We prefer to sidestep this problem, which oversimplifies some people's harmful use of drugs. Some people do abuse alcohol or drugs, and some lose control. Most, however, do not. Most people have very specific reasons for using. Whether for recreation, group affiliation, escape from boredom or discomfort, mood enhancement, or altering of consciousness, the initial use of drugs is most often adaptive, that is, beneficial in some way. Some people self-medicate internal discomfort. Some use drugs to cope with environmental stress or an inability to manage the demands of particular social situations. Others, including organized religious or spiritual groups, seek to alter consciousness in particular ways and for particular ends. When people do get into trouble with alcohol or other drugs, only then should we concern ourselves with substance abuse.

Harm reduction psychotherapy stresses the role of psychological problems in the development of the most serious drug use disorders. Clinicians' and researchers' recent attention (the last 30 years or so) to dually diagnosed clients—those who have both significant psychiatric and substance use problems—is laudable. However, these clients have languished for the past 50 years, after dual diagnosis was first identified, while both the mental health field and the chemical dependency field argued (and still argues) over who would care for them. Most often, these clients received no care and were referred to as "double trouble." Because harm reduction therapy views drug *use* as adaptive and drug *abuse* as a result of biopsychosocial forces, efforts to distinguish between psychological and drug use disorders are unnecessary. One can assume that all people use drugs for reasons and, furthermore, that those people who develop what Peele (1991) calls severe, *persistent addictions* are all dually diagnosed in the strictest sense of the term.

Drug, Set, and Setting: The Unique Relationship with Each Drug Used

In a dramatic story published in *The New Yorker* in February 2010, Gladwell revisits the role of culture in drinking habits, based on the original 1958 groundbreaking research by anthropologist Dwight Heath. After spending a year in Bolivia doing fieldwork, Heath published his observations of the drinking patterns of the indigenous Camba population. His unique report shed new light on a heretofore neglected aspect of alcohol use: the role of culture. Heath reported that despite drinking massive quantities of laboratory-grade alcohol on weekends until falling-down drunk, the Camba people had no problems typically associated with this level of heavy drinking. Alcoholism researchers at Yale University, who had also noticed that Italian drinkers in New Haven showed few problems with alcohol compared with their Anglo counterparts who drank similar quantities, attributed the lack of problems associated with heavy drinking to the cultural norms that did not *assume* that drinking was pathological. Instead of the violence and other problems associated with heavy drinking in much of the United States, the Bolivians did nothing but laugh hysterically and then fall asleep. The entire *culture's* relationship with drugs influenced the drug experience itself.

Because every drug has its own pharmacology and can be used for different reasons, we develop very different ways of using and depending upon different drugs. It is common for a person who is abusing alcohol to smoke marijuana occasionally, with no apparent harm. A chaotic speed user may also be physically dependent on Valium but use this second drug only for the muscle spasms secondary to speed use. Still another person who ordinarily drinks alcohol in moderation will, when depressed, binge drink. Research in the area called "drug, set, and setting" (Zinberg, 1984) identified the interaction between these three factors in the initiation and maintenance of "controlled intoxication." *Drug* refers to the actions, or pharmacology of the drug itself, and includes considerations of potency, route of administration, adulterants, and legality. *Set* describes aspects of the person using the drug and includes concepts such as risk taking, mood, motivation (why the person is using right now), expectancy (what the person expects to get from using right now), and emotional problems. Finally, *setting* refers to the context of drug use and includes the location of drug use and whether the person is using alone or with others, whether those others are trusted friends or strangers, and cultural norms regarding getting high, including, again, the legal status of the drug being used. These three elements interact for each person at each instance of drug use and provide potent information for client and clinician. Drug, set, and setting is a central model in harm reduction therapy that we use in the assessment and treatment planning processes and is discussed extensively in later chapters of this book.

The Nature of Change

Change in Addictive Behavior Is Typically Gradual and Is Different for Each Person

The stages of change model (Prochaska, DiClemente, & Norcross, 1992) explains the process that people go through to change addictive behaviors.

Rather than "bottoming out" or having an "aha" moment, during which people "surrender" their attempts to control drug use, everyone moves through a predictable set of stages. Prochaska et al. show that change is *most* effective if we work through the stages one at a time, thoroughly and in order. Each person's unique relationship with drugs influences the trajectory of change. In addition, the psychological phenomena of motivation, ambivalence, and resistance are central to the change process. Developing motivation to change harmful drug-using behavior is the primary goal of harm reduction therapy. How long does this process take? It takes just as long as it takes. Every person is different and everyone has their own internal and externally imposed timetable. In harm reduction psychotherapy, we start where the client is at, build a relationship and motivation for change, and stay *with*, rather than *ahead of*, our client.

People Do Not Have to Quit Using Drugs in Order to Make Positive Changes

People can and do make changes in their lives while still using drugs or alcohol, and if allowed to lead the way, they do participate in treatment. Just as in other areas of behavior change, success in solving drug-related problems is a function of the client's belief in his or her own power to effect change. If the therapist or counselor attends to the client's hierarchy of needs, then the client has the opportunity, *in treatment*, to change what is most important to him or her. When any change is successfully negotiated, self-efficacy is boosted and other changes become possible.

Redefining Success

Harm reduction psychotherapy allows clinicians to perceive and define success in radically different ways. Our clients have become significantly better. Not all improved dramatically in regard to their use of drugs, but many became abstinent after long periods during which they were attempting to learn moderation. Others had stable housing and finances but were still actively using and expressed little desire to quit. An encouraging number of others eliminated the problems that brought them into treatment by modifying their drug or alcohol use. Almost all have become psychologically healthier and do not have the crises that brought them into treatment. What is not known when each person enters treatment is how long such changes will take. Some people quit drinking within weeks of entering treatment, others after 3 or 4 years. Others cut down on smoking crack by $10 a week over a period of 5 years. Still others stopped shooting heroin but took up opiate pills at the same time as they began taking needed psychiatric medications. What we realize is that, for them and for us, the definition of "success" had changed. We define "success" as any movement in the direction of positive change, any reduction in drug-related harm. We clinicians need to remember that we all learn best when given help, encouragement, and the freedom to get it wrong before we get it right.

Any Reduction in Drug-Related Harm Is a Step in the Right Direction

In developing goals and a treatment plan, one should keep in mind that harm reduction psychotherapy, like "regular" psychotherapy, engages the client in a process of incremental change. Evaluating success is often an arbitrary process except in some behavioral interventions. The best guide for monitoring treatment effectiveness is to delineate the specific harms associated with the person's drug use and count any reduction as a success, "a step in the right direction" (Marlatt & Tapert, 1993). Rogers and Ruefli (2004) developed a methodology for determining truly client-driven goals that are relevant to drug users' lives and realistic about change.

Success Is Related to Self-Efficacy

Self-efficacy, or the belief that one has agency and control over one's life and future, is a powerful agent of behavior and of change. According to Bandura (1982),

> Self-perceptions of efficacy influence thought patterns, actions, and emotional arousal. In causal tests the higher the level of induced self-efficacy, the higher the performance accomplishments and the lower the emotional arousal . . . Perceived self-efficacy helps to account for such diverse phenomena as changes in coping behavior produced by different modes of influence, level of physiological stress reactions, self-regulation of refractory behavior, resignation and despondency to failure experiences, self-debilitating effects of proxy control and illusory inefficaciousness, achievement strivings, growth of intrinsic interest, and career pursuits. (p. 122)

What this enormous list of impacts means is that people have to experience the *power* of their own choices, not just the consequences. In MI (Miller & Rollnick, 1991, 2002), this relates to the principle of supporting self-efficacy. Harm reduction interventions support self-efficacy by framing drug use as adaptive and by pointing out the many other ways that the user evidences efficacious behaviors and choices.

Abstinence Is a Harm Reduction Outcome; It Just Isn't the Only One

The biggest controversy and the most common confusion that surrounds harm reduction is the place of abstinence on the harm reduction continuum. We often hear, from clinicians and programs that do or would like to embrace harm reduction, "Is harm reduction or abstinence more appropriate for this client?" This is a false dichotomy. As we described earlier in this chapter, harm reduction is a philosophy, a way of working with people to facilitate healthy choices, *and* set of practical strategies to reduce harm. As a philosophy, it is a person-centered approach that fundamentally respects and accepts each person's choices. As a way of working, it is about facilitating decision making that supports client-driven goals. As a set of practical strategies, it is about helping clients choose the least harmful manner of using drugs. Abstinence, as a harm reduction strategy, is chosen by many. For some people, and for some drugs, being abstinent is the most effective way to reduce harm!

The difference lies between abstinence-*only* or abstinence-*oriented* programs and harm reduction programs. In the former, abstinence is a preselected goal of treatment and is usually a condition of entry. In the latter, the counselor or therapist starts from a position of not knowing what a client's goals are, what his or her priorities are, or what might be best for his or her health and welfare. The goals and the outcomes are chosen by the client, may be big or small, and are *facilitated*, not *driven*, by the therapist.

The Nature of Treatment

Active Drug Users Can and Do Participate in Treatment

Without this belief, borne out in our clinical experience, we could not work with drug users. Despite the compulsive, repetitious nature of many serious alcohol and drug problems, most people can take steps toward change if they have an active and empathic therapist. We believe that lack of treatment success is a result of unrealistic expectations of abstinence and clinicians' skepticism about motivation for change in clients who continue to use at the same time as they ask for help. We consider such expectations and skepticism a broad countertransference response to drug use and drug users, a response born out of our culture of abstinence and perhaps of our own unhappy experiences at the hands of drinkers and users. These countertransference positions need to be examined and removed in order to begin treatment that will result in a cooperative working alliance.

Harm Reduction Therapy Is a Collaborative Process Model; Not an Outcome Model

Harm reduction requires that drug user and treatment provider work *together* to identify problems and to plan solutions. It is a partnership in which both therapist and client are experts, with the client having, on the whole, more expertise than the therapist. What therapist brings to the partnership is some information about drugs, information about counseling and therapeutic techniques that tend to work, and access to resources that clients cannot reach directly. The client, on the other hand, brings specific knowledge about his or her drugs and their interactions with her (1) physical and mental states, (2) history, (3) needs, (4) sense of what works for him or her, and (5) internal and external resources. The client, and the client alone, gets to choose treatment goals. Our experience has shown that when the client is offered the opportunity to choose the goals and the direction of his or her own treatment, the resistance often seen in traditional settings is rendered less potent and can be used constructively as an indicator of normal ambivalence.

Start Where the Client Is (and Stay with the Client!)

On this principle hinges all of harm reduction therapy. It is not new to harm reduction. It is the first principle of social work. It is implied in the philosophy of client-driven or person-centered treatment. It is implied in the principles of MI. Discussed less often but often heard as a protest is "How long do I have to hang in there before I *DO* something?" Or "I think I am causing more harm than good by *letting* the client keep doing what he or she is doing."

To this we say: First, you have to do this for as long as it takes. We therapists or counselors cannot determine anyone's pace or process of change, although we can influence it by the skilled use of MI and psychotherapy. Second, we clinicians do not have the power to let or not let anyone do anything. We can reserve that role for handling our 3-year-old child but not for our clients. As therapists or counselors, our only real power is to kick someone out of treatment. We do not recommend this as a helpful intervention unless you have decided that you do not want to treat drug users in your practice!

People have the right to make their own decisions in life. We have witnessed the continuum of healthy to risky lifestyle choices in all of our clients, and respecting clients' decisions works equally well when they have substance use disorders. The fact that they may make treatment choices and life choices that conflict with our professional or personal beliefs does

not relieve us of the responsibility to offer them what help we can. We are communicators, not enforcers. It's a harder job, but the results are better.

CONCLUSION

Although the disease model offers a coherent, easily applied treatment approach, its lack of individuality and flexibility reduces its appeal and appropriateness for many people seeking help with a drug or alcohol problem. Additionally, it has low efficacy—approximately a 35% success rate when measuring abstinence—and so is not a potent intervention in terms of populations, though it may be decidedly useful for a particular individual (Ferri, Amato, & Davoli, 2006; Peele, 1998a; Anderson, 2009). Ironically, despite the fact that the goal, and the standard of success, of most treatment programs is abstinence, many outcomes of substance abuse treatment are reported as "reduction" of drug/alcohol use and improvement in other behaviors related to drug use and abuse: criminal activity, employment, medical and psychiatric crisis, incarceration rates, and other such harm reduction outcomes. The first such report that came to our attention was the Services Research Outcome Study, published in 1998 by SAMHSA. Since then, we have noticed many such changes in outcome reports. It is confounding that almost all programs continue to demand abstinence as both a condition and the outcome of treatment. It is the only outcome embraced by treatment providers (and 12-step groups), yet it is the least impressive.

On the other hand, adaptive model adherents are often uninformed about drug effects and tend to view drug use as a symptom of some (more essential) problem or process. Thus, the adaptive model cannot by itself offer an interconnecting theory that will support therapeutic interventions. Harm reduction psychotherapy models offer such a coherent, multidimensional, and multidisciplinary approach to people with a drug or alcohol problem. Harm reduction therapists begin with an attitude of respect for drug use and the drug user; understand the complex interactions among the person, the environment, and the drugs; and offer a range of possibilities for change, of which abstinence is only one.

PART II

HARM REDUCTION PSYCHOTHERAPY AS AN INTEGRATED TREATMENT