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Journal of Substance Abuse Treatment 25 (2003) 249–256

Journal of Substance Abuse Treatment

Discussion

Harm reduction psychotherapy: Extending the reach of traditional substance use treatment

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Received 22 March 2003; received in revised form 22 March 2003; accepted 24 April 2003

Abstract

Harm reduction is a paradigm-shifting idea that has the potential to significantly improve the treatment of problem substance users. The essence of harm reduction is the recognition that treatment must start from the client's needs and personal goals and that all change that reduces the harms associated with substance use can be regarded as valuable. The paper presents harm reduction's rationale, principles, treatment implications, and application to psychotherapy. The author describes his model of Integrative Harm Reduction Psychotherapy, an approach that integrates a strategic skills-building focus with an exploration of the multiple meanings of substance use and the importance of the therapeutic alliance. © 2003 Elsevier Inc. All rights reserved.

Keywords: Harm reduction; Psychotherapy; Addiction treatment

1. Introduction and overview

Harm reduction is an important new idea in the substance use treatment field. Like earlier paradigm-shifting ideas, such as the disease concept and the self-medication hypothesis, harm reduction has the potential to significantly improve our ability to treat the majority of problem drug and alcohol users.

Harm reduction first emerged as a "public health alternative to the moral/criminal and disease models of drug use and addiction" (Marlatt, 1996). Originally geared toward active substance users who were unable or unwilling to stop using, harm reduction became accepted in the United States in the late 1980s and early 1990s as a set of public health strategies for reducing the spread of HIV and other risks associated with active substance use (Heather, Wodak, Nadelmann and O'Hare, 1993). These included syringe exchange, condom distribution, methadone maintenance, and the designated driver.

Marlatt (1998) has called the philosophy of harm reduction "compassionate pragmatism" (p. 277). The essence of this model is the pragmatic recognition that treatment must meet active substance users "where they are" in terms of their needs and personal goals. Thus, harm reduction approaches embrace the full range of harm-reducing goals including, but not limited to, abstinence. This means that small incremental positive changes are seen as steps in the right direction.

Over the last 12 years, harm reduction philosophy has been accepted by a growing group of researchers, clinicians, and policy experts who have developed applications for drug and criminal justice policy, medical practice (S. Stancliff, personal communication, December 4, 2002), substance use treatment (Marlatt, 1998; Rotgers, 1996) and psychotherapy (Tatarsky, 1998, 2002).

2. The rationale for harm reduction

2.1. Many users do not wish to stop

The overwhelming majority of people in the United States with substance use problems are not being treated. Many, if not most, substance users are unable or unwilling to embrace abstinence for a variety of reasons I will discuss below. Some data suggest that many substance users avoid seeking help altogether because they do not have life-long abstinence as their objective (Rotgers, 1996), which is the only treatment goal offered by the majority of drug and

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0740-5472/03/$ – see front matter © 2003 Elsevier Inc. All rights reserved.
doi:10.1016/S0740-5472(03)00085-0

alcohol treatment programs in the United States (Roman & Blum, 1997). By accepting goals other than abstinence as reasonable starting places for treatment, harm reduction opens the door to this group of people in a way that traditional abstinence-oriented approaches cannot.

2.2. The diversity of substance users and the need for individualized treatment

Substance users vary widely on severity of substance use, personal goals regarding substance use (i.e., safer methods of using, moderation, or abstinence), motivation and stage of readiness to change (Prochaska, DiClemente, & Norcross, 1992), emotional and psychiatric status (Carey & Carey, 1990), personality strengths and vulnerabilities (Khantzian, 1985, 1986) and socioeconomic variables. This diversity of issues working against abstinence would explain why an abstinence-only, one-size-fits-all approach would run the risk of failure with the majority of users. It also points to the need for a flexible, inclusive, and comprehensive model that could embrace the myriad needs of this diverse group of people and be open to a variety of treatment goals aside from abstinence. Miller and Rollnick (1991) have written about the importance of addressing ambivalence about using substances and other motivational issues before it is possible to set behavioral goals and pursue behavioral change with many substance abusers. Within such a model, treatments can be matched to the unique needs of the individual to maximize overall success. Denning (2000) has written about the importance of matching interventions to the client's current stage of change in relation to a specific behavior. Tatarsky (2002) has argued that many of the issues commonly associated with substance use problems, such as early trauma, severe superego-"inner critic" pressure, and (serious) Axis I and II disorders that substances are used to self-medicate, often must be identified and addressed before it becomes possible to consider modifying substance use patterns. Given these considerations, harm reduction may be considered an umbrella concept that encompasses the broad spectrum of treatment modalities that can be matched to the needs of this diverse group of problem users.

2.3. The multiple meanings and adaptive values of substances

Substances may be thought of as multi-purpose tools often used in the service of adaptation. For many, the substances have important personal meaning or have come to serve life-sustaining functions and are believed to be vitally important as long as no better alternative solutions are identified or available. These include self-medication (Khantzian, 1985), affect/feeling defense (Wurmser, 1978), coping with negative emotions (Rotgers, 1996), personality or ego "prosthesis" (Weider & Kaplan, 1969), sense of identity (as a drug user/rebel/non-conformist/etc.), personality integrator (i.e., enables the user to connect with generally split-off aspects of the self; Krystal, 1977), liberator of creativity, and a primary source of pleasure.

Whether these motivations are within or outside the person's awareness, any consideration of stopping is frequently met with intense anxiety or is simply unthinkable. Given these important functions that substances play, it is often necessary for users to "unwrap" the multiple meanings the substance has for them and discover alternative ways of performing the functions while they continue to use before any consideration of modifying substance use patterns is possible.

2.4. The question of moderation

Given the positive roles that substances play in people's lives, they often have the desire to moderate, or otherwise reduce the harmful consequences of their use, without stopping altogether (Cunningham, Sobell, Sobell, Agrawal, & Toneatto, 1993; Rotgers, 1996). Whether this is realistic or possible for a given individual must often be answered before abstinence can be considered. A supported attempt at moderation is often the best way of discovering from within one's own experience whether moderation is a realistic goal. Difficulties encountered in a guided attempt at moderation can lead to increased motivation for abstinence.

3. Principles of harm reduction: Matching the spectrum of needs

3.1. Accepting that many substance users do not initially wish to stop

Harm reduction includes abstinence as one possible goal for substance users, for many the best possible harm reduction outcome, but rejects the presumption that total abstinence is the best or only acceptable goal for all problem substance users, and it is certainly not a required goal at the outset of treatment. Some clients are unwilling to pursue the goal of abstinence because, for them, abstinence represents a submission to a symbolic controlling authority. Examples of this can be found, for example, in Denning's (2001) case of Diana and in Tatarsky's (2002) case of Tom. In many clinical situations, as illustrated in these two cases, the pursuit of abstinence sets up the urge to rebel through excessive drinking. Moderation goals, on the other hand, are more acceptable because they reflect an autonomous choice that offers a way out of the "submit or rebel" bind. This principle opens the door to that large group of untreated people by recognizing the need to *really* focus the treatment on the client's goals. This is not a pessimistic acceptance that problem users cannot change, but rather a way to begin an ambitious process of change, the endpoint of which is

cannot be foreseen at the outset. The goal is to support the client in going as far as they possibly can toward the harm reduction ideals of optimal health, self-sufficiency, self-actualization and satisfaction in the world of relationships.

3.2. Engaging the active user in treatment is the primary goal: Relationship is the key

Many clients are lost in the initial engagement phase of treatment due to failures to respect and empathize with the client's concerns and definition of the problem. By accepting the client's definition of the problem as the legitimate starting point for intervention, harm reduction seeks to join with that which motivates the client to seek help, meet the client's needs, and, around this motivation, facilitate a positive treatment alliance.

3.3. Any reduction in the harms associated with substance use is seen as valuable

Harm reduction sees substance use as varying along a continuum of negative consequences and seeks to assist users in modifying their use in the direction of reduced harm. This reframing of the definition of the problem avoids the pitfalls of more global and arguable questions such as "Am I an addict?" or "Do I have a disease?" Instead, this model keeps a more concrete and molecular focus on discovering the specific harmful aspects of substance use and generating specific goals to address them. Marlatt (Marlatt, Larimer, Baer, & Quigley, 1993) did a study of high risk college binge drinkers that provides support for the clinical value of this re-focus. He found that virtually all of his subjects did not identify themselves as problem drinkers. However, a majority of his subjects did admit to specific problematic aspects of their drinking such as drinking to the point where their judgment was impaired, drinking that interfered with other important activities such as studying, and suffering frequent hangovers. Further, when asked if they would be interested in guidance to reduce these negative consequences, the majority said yes.

Therefore, harm reduction accepts small, incremental steps in the direction of reduced harm as legitimate goals. These might be steps toward abstinence or moderation, what Miller (Miller & Page, 1991) has called "warm turkey", as well as the full range of other issues that motivate people to seek help including: clarifying personal goals regarding substance use, resolving ambivalence about substance use, using in a safer manner, preventing overdose, and resolution of the emotional and interpersonal issues intertwined with substance use. Joining the client around goals that the client is motivated to pursue lowers the threshold for entry to treatment. Small steps may lead to other small steps as people's confidence in their ability to change (self-efficacy) increases, and they learn that positive change is possible.

3.4. Mobilizing the client's strengths in the service of change

In contrast to the traditional absolute position that active substance users cannot benefit from psychotherapy, harm reduction assumes that many substance users have strengths and motivation that can be enlisted in the service of positive change at every point along the continuum of severity of substance use. I regard this issue as analogous to how it is generally regarded in the treatment of other potentially harmful problems such as anxiety or depression. We do not require that anxious and depressed people give up their problems as a prerequisite for entering treatment. Each of these problems fall along a continuum of severity. At the more extreme levels of severity, people with all of these problems are less likely to be able to benefit from psychotherapy and may require medication or hospitalization to stabilize them, keep them safe, and reduce the problem severity. However, in the lower ranges of severity, this issue must always be assessed on a case-by-case basis. It is not necessarily substance use per se that would interfere, but other variables such as amount and frequency of use, poor motivation for therapy or change, and limited self-reflectiveness—all variables that must be assessed individually.

3.5. Clients and treatment collaboration

Inherent in this principle is the assumption that clients may know what they need better than their therapist does. This facilitates the delivery of services that the client will experience as useful and thereby enhances the development of a collaborative treatment alliance. Rotgers (1996) has reviewed a group of studies supporting this principle. These studies suggest that a majority of problem alcohol users want to determine their own drinking goal and, when given their goal choice, retention rates and the overall success of the treatment are increased.

3.6. The importance of de-stigmatizing substance users

Harm reduction recognizes that much of the harm associated with substance use is due to the tendency in our society to deal with substance users in stigmatizing, devaluing, coercive, and punitive ways. Since these negative attitudes are ubiquitous in our culture, they may exist not only in treatment providers, but also in the substance users themselves. In treatment providers, they have the potential to contribute to negative countertransference reactions that may be expressed in punitive, angry reactions to clients who continue to use, rather than in efforts to help clients to deal with the relevant issues more constructively. Clients, in turn, may reject treatment when it is needed because of an expectation of being treated in negative ways (Marlatt & Kilmer, 1998). More insidiously, these negative attitudes are often internalized by substance users themselves and can find expression in self-sabotage of efforts to change. An example of this is what

Marlatt and Gordon (1985) have called the "abstinence violation effect." This refers to a reaction that may occur when a client uses a mood-altering substance while pursing abstinence. Based on the presumption that abstinence is the only measure of success, they react in a very self-critical manner that negates all the progress actually made. "You see, I really am a pathetic junkie/loser who can't ever change." This self-devaluing tendency may prevent clients from recognizing the changes they have made and seeing that a (temporary) return to old habits is a normal, expectable part of the process of changing; an event from which learning can be derived. This tendency may also be projected onto the treatment provider as a shame-filled expectation that the provider will be critical and, in that way, become an obstacle to treatment. For these reasons, working to de-stigmatize substance users in society and in the treatment situation is an important value of most harm reduction approaches.

3.7. Treatment implications

These principles have implications for improving the treatment of active substance users at two levels. As an umbrella concept, harm reduction suggests the need for an integrated treatment system with linkages across the spectrum of treatment modalities that are matched to the needs of people along the spectrum of diversity. As a therapeutic principle, harm reduction has implications for how therapy is conducted in the room with clients at every stage of the psychotherapy—starting with the initial engagement and assessment through the process of goal setting and the facilitation of change.

4. Harm reduction psychotherapy

Harm reduction psychotherapy (HRP) is the category of psychotherapeutic approaches that may vary in theoretical orientation and clinical approach, but share in the commitment to the reduction of harm associated with active substance use without assuming that abstinence is the ideal goal for all problem substance users or a necessary prerequisite for entering treatment. A growing number of clinicians from various perspectives have contributed to the development of this approach (Carey & Carey, 1990; Denning, 2000; Marlatt, 1998; Miller & Rollnick, 1991; Peele, Bufe, & Brodsky, 2000; Rotgers, 1996; Rothschild, 1998; Tatarsky, 1998, 2002).

The specific approach that will be presented here is an integrative harm reduction psychotherapy model (Tatarsky, 1998, 2002). This approach draws on the valuable contributions of the psychodynamic and cognitive-behavioral traditions along with the affirming stance of the humanistic approaches. While this approach builds on my own clinical experience as well as that of the increasing number of professionals who are working with patients in similar ways, to date there has been no empirical evaluation of these techniques and practices. With the publications of guides by Denning (2000), Marlatt (1998), and Tatarsky (1998, 2002), the field has probably reached the developmental stage in which this kind of research is both needed and desirable. The clinical perspectives and interventions described are a portrait of a way of working with, and being with, substance users. Whether they will be effective in other settings, with diverse patient groups, as administered by therapists with varying backgrounds and levels of experience, remains to be determined.

Clients who enter treatment come in a state of distress while being simultaneously engaged in their own process of change. Harm reduction psychotherapy aims to support this process of self transformation through developing an empathic resonance between clinician and client, deepening the identification and understanding of what is distressing to the client (that is, what is harmful about substance use and other issues), setting harm reduction goals that can be hypothesis tested to determine if they are realistic for the client, and working toward change with strategies that meet the client's unique needs and strengths.

The integrative approach combines a skills-building/self-management focus with an exploratory focus on "unwrapping the multiple meanings" of the substance. The skills that are involved in the identification of harm, in setting goals for reducing harm, in unwrapping the multiple meanings of substance use, and in working toward positive change are a set of capacities that can be learned and internalized in the therapeutic process. These capacities are developed or strengthened in a relational "space" in which the client feels recognized and empathically connected to the therapist through the therapeutic alliance.

The development of these capacities can be facilitated in several ways. The general aspects of a good therapeutic relationship are one arena. In addition, empathic questions that support the client's capacity to reflect with curiosity and tacit encouragement of the client's autonomy may serve as an antidote to the client's ties to early figures who frequently did not support autonomous self-care (Krystal, 1977). Our caring anxiety at risky behavior may, under the right conditions, become internalized as healthy self-caring attention to danger. The direct teaching of such coping methods as assertiveness, relaxation, and substance refusal may serve the direct goal of skill transfer, while simultaneously, and through ongoing relational support, help the patient internalize a capacity to function more autonomously.

Harm reduction target goals represent the part of the person that wants to change, and these inevitably come into conflict with the parts of the person that are attached to the old ways of using drugs. The process of setting harm reduction goals brings this conflict more into the client's awareness. The exploratory focus of HRP supports the client in becoming more aware of those aspects of self—the needs, wishes, feelings, attempts at coping, defenses against anxiety, symbolic expressions, and interpersonal communications, etc.—that are all embodied in the desire to use as

before. As these motives are identified, it becomes possible to consider alternative solutions as modes of satisfying or expressing them.

5. Engagement as a therapeutic focus

5.1. Establishing the alliance

The therapeutic alliance is the cornerstone of psychotherapy, and it anchors the client in treatment by creating a context of relative safety in which the work of therapy can proceed (Safran & Muran, 2000). Engaging the client to begin and sustain a process of positive change is the primary focus. Thus, establishing the collaborative alliance is of utmost importance.

> "Start where the client is at".

This is one of the core slogans of the harm reduction movement. Its relevance to our work is that the alliance is fostered when clients feel empathically recognized and offered help that meets their needs as they experience them. Therefore the initial therapeutic focus is around the client's reason for coming.

5.2. The importance of the clinician's attitude

The therapist must meet the client without preconceived ideas about the client's needs, strengths, and appropriate goals (Denning, 2001). Prior assumptions about the client should be seen as countertransference reactions that have the possibility of derailing the treatment from the outset. Making the harm reduction position explicit at the outset is a way to counter the client's expectations of being treated coercively. In addition, stating the assumption that client is quite likely to be ambivalent about the cessation of substance use because of its adaptive value is a strategy for countering client shame.

5.3. Shared goals

A collaborative stance that aims to have client and clinician working toward shared goals is likely to strengthen the alliance. Thus the focus of therapy is on the client's experience of the problem and the identification of goals that "feel right" to the client. I have called this the "right fit" between client and treatment (Tatarsky, 2002). This flexibility enables active users to come for help for issues both related and unrelated to substance use. Unrelated topics could include problems with anxiety and depression, life direction difficulties, and a past history of abuse and trauma, while substance-related issues, in turn, could include weak motivation to change, unclear goals, a desire to moderate or develop other safer using practices, or the desire for abstinence. Of course, even "unrelated" topics may be interwoven with the substance use, but working with them may not necessitate detailed discussions of drug use. Differences of opinion between client and clinician can be dealt with by establishing the alliance around the goal of discovering together what is most realistic for the client.

6. Assessing harm and setting harm reduction goals

6.1. Assessment and goal setting as treatment

The assessment of the nature of the client's concerns and the setting of harm-reducing goals can be seen as both the initial focus of treatment as well as the ongoing focus of the therapeutic process. The alliance around addressing the client's concern creates the context in which the harmful aspects of substance use and other relevant issues are assessed. Assessment is a therapeutic activity in that it is the process by which the client's recognition of the harmful aspects of the substance use is facilitated. As the harmful aspects of the substance use are identified through the collaborative inquiry, it becomes possible to set harm reduction goals to address them.

It is always essential to have the client get a medical evaluation to assess the physical impact of substance use. This can also yield important objective information to add to the determination of the harmfulness of substance use (see also Miller, Zweben, DiClemente, & Rychtarik, 1995).

6.2. Goals

Where substance use has become excessive, abusive, self-defeating, compulsive, addictive, or is, in some way, significantly threatening or compromising other important needs and values, a harm reduction approach would initially aim to support the user in modifying substance use to reduce the harmful impact. While abstinence is considered the ideal goal for many users, as are regular exercise, healthy diet, and a reasonable balance between work and play, harm reduction psychotherapy does not see the acceptance of abstinence as necessary to begin the process of change. Thus, moderating use as well as a wide range of other harm-reducing goals are accepted. These latter include learning safer drug-using practices, utilization of clean syringes, taking drugs with others, being knowledgeable about overdose risk and prevention, switching to less dangerous substances, and having clear ideas about dose limits.

7. Facilitating the capacities for change

Assessment and goal setting are both based on, and geared toward, facilitating the client's capacities to self-reflect and to tolerate uncomfortable feelings or affect tolerance. Self-reflective awareness and affect tolerance are both required for personal transformation. Affect tolerance and self-reflective awareness experienced in the relative

safety of the therapeutic relationship make it possible to identify the various forces that are propelling excessive substance use. The identification of these issues makes their resolution possible.

7.1. The ideal substance use plan

The ideal substance use plan serves as a framework for identifying a pattern of use that maximizes the benefits of substance use, if there are any, and minimizes the costs or risks. It is a strategy for identifying the harmful aspects of substance use and setting harm reduction goals. These are several ways to facilitate this. I ask people to "re-write the negative script" of what has been problematic and to think through how their use would be different if it were not problematic. This entails a microanalysis of what is wrong with current pattern of use regarding dose, frequency, methods of use, and negative consequences. Denning (2000) has suggested doing a cost/benefit analysis of the current pattern that aims to see how the positive aspects of use balance with the negative consequences. Rothschild (1998) has discussed exploring both sides of the client's conflicting feelings about substance use. I have found Stone's (Stone & Winkelman, 1988) "voice dialogue" technique useful as a way to facilitate this. In this technique, the therapist dialogues with different aspects of the client (or, in Stone's terms, sub-selves), that are related to both sides of the conflict about using. I suggest a hypothesis-testing approach to evaluating the positive changes or harm-reducing value of the new use plan and whether it is realistic or possible for a given client to achieve.

7.2. Awareness and relaxation training

This is useful for strengthening the capacity to self-reflect as well as the capacity to tolerate uncomfortable feelings. It facilitates unwrapping the multiple meaning and functions of substances by identifying the event-thought-feeling-impulse sequences that are connected to the desire to use a substance and by strengthening the capacity to identify and sit with an experience rather than move into impulsive/alexithymic action. Some people find this easiest with eyes closed, but it can be done with eyes open or closed. The client is then moved through the six stages of: (1) awareness; (2) getting a tension/anxiety/discomfort reading; (3) slow deep breathing; (4) identifying a word or phrase that captures the feeling state they wish to call up; (5) using visualization to create a safe space; and (6) reviewing and integrating the experience.

8. Integrating strategies for positive change

A comprehensive understanding of the factors contributing to the substance use problem is then translated into a treatment approach that integrates strategies that target all the relevant factors for a given client. The diversity of substance-using clients means that the therapy can look very different from client to client. Thus, harm reduction psychotherapists must be attuned to the unique qualities of each client and be flexible in blending the different kinds of psychological, behavioral, and pharmacological interventions that match these qualities.

As the multiple meanings and functions of substance use are identified, cognitive and behavioral strategies can be used to support the learning of more adaptive and drug-free coping strategies to deal with the issues currently being addressed by the substance. Behavioral strategies include relaxation training, anger management, and assertiveness training. Cognitive techniques that deal with the unrealistic beliefs that are often related to substance use include stress inoculation, rational disputation, and "thinking it through."

Psychodynamic techniques may be necessary to work through the symbolic attachments that clients have to these self-defeating solutions. There are often early relational ties that are being expressed through the use of the substance that must be recognized and grieved in order for the new solutions to be embraced. For many patients, the therapeutic relationship offers a new relational experience that can serve as an alternative to the early negative ones and can also provide a context in which the old ties can be identified and grieved in the presence of the therapist.

9. Implementing HRP

For Harm Reduction Psychotherapy to take its place in the substance abuse field as a viable and accepted intervention, there are a number of hurdles that will have to be crossed. Among some of the more pressing questions are: Does it work? Which practitioners could be trained to implement it? And how will it work within the confines of such mandated treatment situations as criminal justice referrals, welfare-to-work programs, and job-related EAP referral systems.

As is clear from the previous discussion, HRP is rooted in psychological and psychotherapeutic approaches that are deeply connected to the mental health traditions. In many respects, HRP represents one more situation in which we see the "reclaiming" of the problem of substance abuse and addiction by the mental-health treatment field (Lichtman, 2002; Rothschild, 2002). From the psychodynamic world, we see the revitalization of the idea that substance use is a symptom of, a response to, or a medication for underlying conflicts and issues. Perhaps to a lesser degree, we see the cognitive-behavioral emphasis on understanding that the same learning principles are in involved in addictive behaviors as are involved in other psychological disorders (Marlatt & Gordon, 1985). Given this background, it would seem logical that this is an approach most suited for those who have a primary training in the mental health field (i.e., social

workers, vocational rehabilitation counselors, psychologists, and psychiatrists) rather than those come from the more traditional substance-abuse treatment backgrounds (i.e., counselors in therapeutic communities and credentialed alcoholism and substance abuse counselors).

Eventually, the issue of the efficacy of the treatment will need to be addressed if it is to expand beyond the offices of private practitioners and the occasional "lone wolf" counselor. To date, there have been no studies on the efficacy of this or related approaches. However, at least one of the core concepts in HRP, the centrality of the *working alliance*, has been supported in the psychotherapy research field. As Teyber & McClure (2000) have written, "The term *working alliance* was formulated by Greenson (1967), and it reflects the extent to which the therapist and the client agree on the goals of their work, agree on the tasks that facilitate attainment of these goals, and experience an emotional bond with each other" (pp. 70–71). This definition reflects the essence of the HRP philosophy. On a more empirical note, they point out that "the working (helping and therapeutic) alliance has emerged as perhaps the most important variable in predicting effective treatment outcomes" (p. 70). Again, since an empathic bonding between therapist and patient is understood to be the vital, life-changing mechanism in helping substance-using patients change their lives, there is at least a possibility that HRP could be effective.

To bring this to a more scientific realm, it would not seem to be impossible to create an HRP manual—despite the emphasis on individually oriented treatments. The two core components involved in training therapists would mostly likely include: (1) learning skills and interventions (i.e., decisional balance, risk assessment, ideal substance use plan), and (2) fully understanding the harm reduction philosophy and developing the ability to listen and act from this perspective. Interesting outcome measures might include assessments of the therapist behaviors outlined above, the strength of the therapeutic alliance, and a wide variety of outcome measures serving to measure the possibility of the reduction of harm and the improvement in quality of the individual's life.

The integration of HRP into the mainstream substance-abuse treatment would, almost of necessity, involve the interplay of harm reduction approaches with mandated treatment; a combination that has the potential to be quite complex. Wild (1999) has explored some of the dynamics of this mixture, and, among the issues that he has delineated are the two very different perspectives on substance users that exist between the criminal justice institutions and the treatment facilities. For the former, drug use is a criminal behavior, while for the latter it is a disease. To some degree, abstinence-oriented treatment providers may see relapse as part of the recovery process (and even that may not be universal), but this is much less likely to be the case with law enforcement officials, who may be quick to remand the individual back to prison. As Wild points out, to some degree, the only place where these two groups can meet is the shared goal of abstinence. The introduction of harm reduction has the potential to destroy even this precarious balance.

The solution may require a mixture of the insights of HRP with the framework of gradualism (Kellogg, 2003). The first step would be for the criminal justice system and/or the mandating agency to understand and accept the concept that recovery is a process and that relapse is an element of it. Wild (1999) has suggested that mandating agencies should accept reductions in use as a viable outcome, and, in some cases, that may be appropriate. Patients should be allowed to be in treatment for a set period of time in which their drug and/or alcohol use is not reported to the authorities. Other than requiring reports on attendance, the referring agency should have no access to urine toxicologies and clinical data. In this way, the treatment could be a "real" therapeutic experience without the role complications that sometimes encumber therapists in mandated situations and which run the risk of having a deleterious effect on the treatment (Wild, 1999). If patients are given time to work through the issues that are at the core of their addictions, if they are allowed to learn through both successful and unsuccessful experiments what it will take to either control or eliminate their dysfunctional substance use, the long-term chances of success are likely to be good.

10. Conclusion

This paper has provided both an overview of the harm reduction vision, and the details of an active and engaged psychotherapy that draws from both the psychodynamic *and* the cognitive-behavioral traditions. Through the development of the therapeutic relationship, the affirmation of the client's own goals and choices, the uncovering and resolution of the traumatic relational substrate underneath the substance use, and the empowerment of the individual through skill-building and information sharing, the whole person has the opportunity to heal. It is my belief that this healing will help the individual, the family, and the community at large.

Acknowledgments

This paper is adapted from a presentation that was given on April 6, 2001, at a conference entitled "The Great Debate: Abstinence vs. Harm Reduction in Addiction Treatment" that was held at The New School University. This conference was conceptualized and sponsored by the New York State Psychological Association Division on Addictions Executive Committee whose members include: Julie Barnes, F. Michler Bishop, Lisa Director, Scott Kellogg, Robert Lichtman, A. Jonathan Porteus, Marlene Reil, Debra Rothschild, Suzanne Spross, Andrew Tatarsky, and Alexandra Woods. It was also co-sponsored by the

Masters Program in Mental Health and Substance Abuse Counseling at The New School University. Further support for this work was received from the Division on Addictions of the New York State Psychological Association. I would like to thank the NYSPA Division on Addictions Executive Committee and McWelling Todman at The New School University. I also wish to give special thanks to Scott Kellogg for his thoughtful comments and helpful suggestions on drafts of this paper.

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