CHAPTER 1

Why Practice Harm Reduction Psychotherapy?

FIRST, DO NO HARM

Life teaches. We have spent years in school and more years in training. And yet it is life that teaches best. Our lives and the lives of our friends, family, colleagues, and clients provide the fundamental stuff of knowledge. As therapists in training, we were taught that substance abuse treatment could be conducted only by specialists and that anyone with an alcohol problem or using drugs was to be referred to "a program" or to Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). To this day, standards of care recommend that substance abuse be treated in specialized programs, not during the course of psychotherapy. Those standards assume that the therapist, if he or she continues to treat a client, will require abstinence and attendance at 12-step meetings as a condition of continuing therapy. In the face of such restrictive practices, we were on our own in deciding to treat active drug users and problem drinkers as any other person in therapy. During the first years, we stumbled along, making our way using things we had read and things we imagined, always trying to defer to our clients' lead. The admonition "First, do no harm" became a guiding principle for us in the development of our clinical treatment model.

Patt Denning's Story—Circa 1986

Maria, a 27-year-old woman, came to a community mental health outpatient clinic asking for therapy to help her deal with family problems. Her

husband of 10 years was working too hard, and every night he would come home and drink himself into a relaxed but useless state. Maria was less and less able to care for their three children by herself. Her husband became angry when she asked for help with the dishes or with bathing the kids. She was uncomfortable with how often she had to call her husband's office and make up excuses for why he would be late or absent.

Maria's difficulties seemed to arise primarily from her husband's drinking. From what I had been taught about substance abuse in families, I concluded she was exhibiting classic behaviors that were often termed "codependent": taking full responsibility for the care of their children and protecting her husband from the consequences of his tardiness and absences from work. Since alcohol and drug treatment was not offered within the mental health system, I knew all I could offer Maria was information and referral to an alcohol and drug treatment program. After counseling Maria about the harm done to the family by her husband's alcoholism and her codependent responses, I referred her to a local drug treatment program, where she could receive counseling even if her husband refused. I felt I had done a good job of assessment and referral. This was confirmed by the counselor at Maria's drug treatment center, who was focusing on Maria's "intractable" codependency by confronting her in both individual and group sessions.

As a trained marriage and family counselor, I was concerned that his approach lacked a coherent view of the family dynamics and focused only on Maria's complicity in her husband's alcoholism. But I was not the expert in alcoholism treatment; he was. So I did not voice my doubts.

Six months later, Maria again called to make an appointment for therapy. I met with her for the first time since referring her to the alcohol treatment program. She looked tired. She thanked me for having referred her to the alcohol program, saying that it had "saved her life" and helped her see the dynamics in which she had played a part. Now, however, the family was in dire straits. With the encouragement of her alcohol counselor and the group members, she had stopped protecting her husband. When she stopped calling his employer to make excuses for his absences, he was fired. Despite advice and confrontations from the counselor and the group about how she should divorce her husband, she found that she just could not leave him. After he lost his job, the family of five was now dependent on welfare. The husband's "recovery" (abstinence from alcohol) was intermittent, and Maria was overwhelmed. Evaluation showed Maria to be anxious and dysphoric, with insomnia, hopelessness, difficulty concentrating, and irritability with the children. She expressed both fear and resignation regarding her husband's alcoholism and her continued ability to help him and her children.

I was alarmed and distressed. *What had I done? What help did I give her?* She and her family had far more serious problems than when I had first seen her, and she was clearly more distressed. I was haunted by the healer's promise to *first, do no harm*.

I became convinced that, even though I had viewed her behavior as a sign of codependency that supported her husband's alcoholism, I had done a disservice to this family. Who was served by my actions? What were the benefits? By refusing to think "outside the box," I had failed to take into account the *adaptive* nature of Maria's codependent behaviors, which had served to shield the family from poverty by protecting her husband's job. By focusing on her as an individual rather than an important member of a family, I failed to see her lifesaving role. By that failure, I had contributed to the ultimate family breakdown. It was the last time I ever mistook adaptive behavior for codependency. It would not be the last time, however, that I failed to see the adaptive nature of drug use itself. Concern about the probable damage done by alcoholism blinded me to the possible damage done by treatment.

Jeannie Little's Story—Circa 1991

I was sitting quietly in a circle of chairs awaiting the start of the morning "focus group." The setting was a dual diagnosis inpatient unit at a Veterans Administration (VA) hospital in San Francisco. The hospital was located in Land's End, the farthest point west on the San Francisco peninsula, with sweeping views of the Golden Gate Bridge and the bay. It was a sunny morning. Needless to say, this was a wonderful way for a group of people detoxing from alcohol and other drugs to start their day—not to mention a great way for a staff member to start her day! One client was in the room with me reading a magazine. While he read, I gazed out the window.

The peace and quiet of the morning was suddenly broken as my co-leader, a long-time staff member on the unit, swept into the room. She came up behind the client, snatched the magazine from him, and said, "You know there is no reading allowed in group." He and I were equally stunned. Fortunately, he was *not* a veteran with severe posttraumatic stress disorder (PTSD), or such a move might have been dangerous. Fortunately also for the client's ego, no one else was in the room to witness the event. I stayed silent, thinking any reaction on my part would only make things worse. To this day, I regret that I did not actively defend the client's right to enjoy a little downtime in the quiet companionship of his group leader.

This incident symbolized for me what was wrong with the treatment that I was observing around me: arbitrary rules, authoritarian staff, and a lack of respect for each patient's fundamental autonomy. Before this job,

I had never set foot in a drug and alcohol treatment program, and I was appalled at the assumption that staff could tell patients what they should do, now and forever, and that any protest by patients was confronted as "denial." It went against all of my social work principles. Yet our program, which provided integrated dual diagnosis and was staffed by psychiatrists, psychiatric nurses, and clinical social workers, was better than most, as I learned when I visited other treatment programs, which engaged in far more punitive and humiliating practices in an effort to control clients. Yet, despite our sophisticated treatment model, when it came to substance abuse counseling, it was business as usual: confrontation of "denial," rigid insistence on active participation in "recovery" activities, and immediate expulsion for relapse. This was made worse by the fact that many of our patients were homeless, with nowhere else to go. It became apparent to me that something completely different had to be created.

WHAT IS HARM REDUCTION?

Harm reduction is an approach to working with drug users that aims to reduce drug-related harm to individuals, their families, and communities *without necessarily reducing the consumption of drugs and alcohol*. The damage done by drug and alcohol use and drug prohibition, not the drug use itself, is the primary focus of attention. Abstinence from mind-altering drugs is only one of many worthy goals and outcomes of harm reduction work.

> The first priority of Harm Reduction is to decrease the negative consequences of drug use. By contrast, drug policy in North America has traditionally focused on reducing the prevalence of drug use. Harm Reduction establishes a hierarchy of goals, with the more immediate and realistic ones to be achieved as first steps toward risk-free use or, if appropriate, abstinence. . . . A harm reduction framework offers a pragmatic means by which consequences can be objectively evaluated. (Chicago Recovery Alliance, 2005)

As conceived by the Harm Reduction Coalition, the United States' first harm reduction organization, harm reduction comprises a set of strategies employed to reduce the negative consequences of drug use. Harm reduction practitioners make use of a full spectrum of strategies, from safer drug use (such as use of clean needles) to moderation management (e.g., controlled drinking) to abstinence (perhaps from one but not all mind-altering substances). Harm reduction accepts, for better and for worse, that licit and illicit drug use is part of our world, and chooses to work to minimize their harmful effects rather than simply ignore or penalize the user. Working

with drug users from a harm reduction perspective involves accepting that some people simply are not going to give up using drugs no matter what we think or what we try to do about it.

Oriented toward working with the whole person, harm reduction programs and policies create environments and develop, side by side with drug users, strategies for behavior change that are practical, humane, and effective. These programs meet their consumers "where they are" and help them become more conscious of the harm in their lives and identify options for reducing that harm. Because harm reduction demands that interventions and policies are designed to serve drug users by reflecting on specific individual and community needs, there is no universal definition or formula for implementing harm reduction. The ideas, needs, and wishes, of each individual user and his or her family, not the theories, wishes or biases of professionals, drive interventions and strategies. There are as many ways to reduce harm as there are people who use drugs!

WHY DO WE NEED HARM REDUCTION?

What is the context for this model of understanding and treating problems with alcohol and other drugs? Why is it needed? A review of American attitudes toward intoxication, and our resulting abstinence-only treatment system, will make it clear that harm reduction therapy brings us a needed change.

History of Intoxication and Attitudes toward It

From public drunkenness and saloon brawls to Prohibition, from rum trading with American Indians to their having the highest rates of alcoholism and alcohol-related disease of any group of Americans, from a plethora of morphine- and cocaine-infused medicines and tonics to the imprisonment of Chinese opium smokers, from champagne at weddings, a bowl of marijuana at the end of a hard day, and Native American peyote ceremonies to the War on Drugs, the United States has had an ambivalent and polarized relationship with drugs, alcohol, and intoxication since the Europeans first colonized the New World. Some Europeans, for instance, brought with them their drinking habits and plied the native peoples with their drink. In contrast, the Puritan colonists, who brought with them their extreme religious practices, prohibited various pleasures of the flesh, including intoxication (Zinn, 2003).

Patterns of drug use have changed over time and are the product of interacting social, political, religious, and economic forces. Alcohol, usually

in the form of beer and other malt beverages, was used by people of many cultures, from ancient to modern times. In medieval and renaissance England, the daily allotment of beer was one gallon for every man, woman, and child (Manchester, 1992). The reasons behind this practice most likely include the euphoric effects of alcohol, its pain-killing properties, and the uncertain water quality of their ponds and slow-moving streams.

Drugs, of course, have an equally long history of use, both for day-to-day utility and in religious ceremonies and shamanic traditions. Since before the arrival of the Europeans and their alcohol, people in the Americas have used stimulants, including coca leaves (which contain the drug cocaine) in South America, to increase stamina. Kava, qat, psychedelics such as peyote, mescaline, ibogaine, and the components of ayahuasca are indigenous to North or South America, Asia, or Africa and have been incorporated into community rituals for thousands of years (as has alcohol in Europe).[1]

Narcotics control also has a long history in this country. Not only medical practice but also international political forces and racial prejudice within the United States lie at the heart of these drug laws (Musto, 1987; Gray, 1998). Every drug law passed in the early 20th century was preceded by racist campaigns against specific populations. Whereas the opium in medicinal tonics was controlled by the Pure Food Act in order to protect citizens against dependence, the smoking of opium (identified primarily with Chinese immigrants) was banned outright. The first anti-drug law in the United States was an 1875 San Francisco ordinance that outlawed the smoking of opium in opium dens. Cultural studies of the time showed that opium dens occupied a place in Chinese culture roughly comparable to that of saloons among the white culture. That is, most patrons visited them on the weekend, partook of the intoxicants, and returned to their jobs the following Monday with no apparent interference in their work (Brecher, 1972).

In the first 15 years of the 20th century, hysterical reports of violence associated with cocaine use preceded its control under the Harrison Act of 1914. One of the original ingredients in Coca-Cola (until its removal in 1901), cocaine became particularly (and inaccurately) associated with African Americans in the South. Prior to passage of the Harrison Act, sensational newspaper and journal articles and campaign posters depicting black men high on coke raping white women and assaulting white men dominated the news about cocaine (Musto, 1987; Streatfeild, 2001). Musto (1987) points out that these "reports" were entirely unfounded but nevertheless coincided with a peak period of violence against African Americans

[1]See the drug section of *Over the Influence* (Denning, Little, & Glickman, 2004) for a detailed history of the uses of the various classes of drugs.

and lynchings. The same campaign was used in the 1930s when the Marijuana Tax Act effectively prohibited marijuana in this country. Reports of crazy Mexicans high on "loco weed" panicked lawmakers. In reality, marijuana has never been associated with violence (Brecher, 1972; Musto, 1987; Gray, 1998; Zimmer & Morgan, 1997). Cocaine, crack cocaine in particular, the demon drug of the 1980s and 1990s, is seen as being used primarily by racial minorities, who continue to bear the brunt of legal and moral attacks (Reinarman & Levine, 1997). Only in 2010 has the sentencing disparity between powder and crack cocaine begun to be rectified.

An individual who uses drugs or alcohol does so within a social context that is defined and limited by the current mores of society. Only occasionally will a radical reorganization of these mores take place. Prohibition banned alcoholic beverages during a time when some Americans had become convinced that alcohol was an evil poison. This did not, however, eliminate the use of alcohol. It simply transferred the business to the black market, and is reputed to have been the making of the Mafia in the United States. The 1960s witnessed dramatic changes in patterns of use and attitudes toward drugs. A large minority saw experimentation with different types of mind-altering drugs as a part of the restructuring of society by the altering of individual consciousness. That decade or so of experimentation gave way to stricter controls and to the modern War on Drugs, initiated in 1971 by President Nixon as part of his 1972 reelection campaign. Drug use peaked in the United States in 1979 and has never reached that level again. The 1960's and '70s were decades of massive distribution of and experimentation with many mind-altering drugs. As the young people of these decades aged, the natural diminution of drug use—variously called "maturing out," "spontaneous recovery" (Peele, 1991), or "natural recovery or change" (DiClemente, 2003)—likely contributed to overall reductions in drug use in the country.

Behind the history, the laws, and the realities of drug use lies the most important question that each of us must answer: *Is it okay to get high?* Is it permissible to alter one's consciousness for the purpose of pleasure, religious experience, relief from pain, or escape from reality? If so, for whom is it okay, under what conditions, and with whose permission? What types of mind-altering chemicals should be allowed? We are no closer to truly discussing these questions than we were at the time of Prohibition, and so our national ambivalence rules our laws and our treatment programs.

The Costs of Our Attitudes

In part because of our ambivalence about whether it is okay to get high, we have fashioned a response to drug use and abuse out of a hodgepodge of myths, punishment, and inspirational slogans.

A set of principles for substance abuse treatment was developed more than 10 years ago (National Institute on Drug Abuse [NIDA], 1999). These include individualizing treatment, prescribing medications, treating co-occurring disorders, and respecting client motivation. Despite this, we have observed that our society's moral and legal stance against drug use has created a treatment system that continues to have only one goal—abstinence—and is too often judgmental of the people it serves, punitive in its practice, and largely ineffective in helping people with drug problems. We hear of "those addicts" who "lie"; we hear about their "character flaws." These judgments can then be used to justify confrontation and other punitive practices in the name of treatment. Although dual diagnosis has become widely recognized, still people with serious mental disorders who use drugs are particularly at risk of receiving few or no services, because policies and treatment methods conspire to deny access to or to remove from care people who are not cooperative (Shavelson, 2001). More ominously, parents have been convinced by the rhetoric of the War on Drugs and by the adolescent treatment industry that their children who use drugs are in need of intensive, coerced, and expensive residential treatment in order to save their lives (Szalavitz, 2006).

Tobacco and alcohol are legal drugs, yet they cause the most physical and emotional harm. This irony is underscored by the fact that tobacco causes by far the greatest number of drug-related deaths in the United States (435,000 per year in 2000), and alcohol causes 85,000 deaths (more than half of motor vehicle-related deaths, or approximately 16,653 in 2000) and crime (40% of men and 25% of women incarcerated and on probation were drinking at the time of their arrest). In comparison, all illegal drugs put together were directly or indirectly responsible for 17,000 deaths in 2000 (McVay, 2007).

Although we call drug abuse a disease, we incarcerate people who are caught using. The primary harms of the War on Drugs are the incarceration of people for nonviolent drug crimes (e.g., possession), particularly people of color, and in many states permanent disenfranchisement (loss of the right to vote). A Human Rights Watch analysis of prison admission data for 2003 revealed that blacks are 10.1 times more likely than whites to be sent to prison for drug offenses (Fellner, 2009). In 2004, 5.3 million American adults did not have the right to vote because they had been convicted of a drug felony. One in 12 blacks was disenfranchised because of a drug felony conviction, a rate nearly five times that for non-whites. Yet voting is linked with reduced recidivism: King (2006) found a rearrest rate of 27% among nonvoters compared with 12% for voters. The list of disparities goes on, and the "human" costs of the War on Drugs are devastating. In the often-spoken words of Drug Policy Alliance Executive Director Ethan

Nadelman, "More harm has been caused by the prohibition of drugs than was ever caused by their use."

The Limitations of Traditional Treatment Models

Over the past century, paralleling the prohibition of drugs and, for a while, alcohol, two major paradigms regarding the nature of addiction and its treatment have emerged: the *disease model* and *adaptive models* (Alexander, 1987). These models differ primarily in the weight given to biological versus psychological factors that initiate and maintain alcohol and drug abuse. Alexander points out that the disease model views the individual as engaging in mechanical, determined behavior, whereas adaptive models stress the purposeful nature of the activity. Therefore, the models differ significantly in philosophy, strategies, and prognosis. Harm reduction is a major new paradigm in the conception and treatment of drug use and abuse. It is more closely aligned with adaptive models than with disease models, but is a radical departure from both in its move away from the concept of addiction and toward an interest in the broader umbrella of drug use, including normative, nonharmful drug use.

The Disease Model

Even though the term "disease" was used in reference to alcoholism from the early 19th century by Rush (1814/1943), who called it a disease of the will, it was only later in the 20th century that a formal disease model replaced the moral model of addiction, which viewed alcoholics as sinful and weak. Jellinek (1960), in his study on alcoholism, put forward the notion of alcoholism as a disease. He drew his study sample from members of AA.[2] He distinguished between types of alcoholism and considered only the types that included loss of control to be a disease. In modern-day usage, the disease model asserts that addiction is a primary disease (i.e., not secondary to any other condition); has no cure; is characterized by denial and loss of control; and inevitably progresses toward "jails, institutions, and death" if the disease process is not arrested. Recovery is a lifelong process of containment that can be achieved only by abstinence from all psychoactive substances. Finally, only certain people have the disease of alcoholism. For the rest, there is little guidance. Overall, more than 90% of the alcohol and drug treatment programs in the United States are based

[2]Although AA seems to embrace the disease model, it is actually a powerlessness model. There are very few references to the term "disease" in the so-called big book of AA (1939/1976).

on the 12 steps of AA (Peele, Bufe, & Brodsky, 2000; Roman & Blum, 1997, 1998; SAMHSA, 2010).

The advantages of the disease model are that it is simple and comprehensible, it comforts people who otherwise think of themselves as weak or morally reprehensible, and its folk wisdoms and adages are easily transmitted from one person to the next. It is also widely available and free, and it can provide nearly round-the-clock support.

Critiques of the Disease Model

"Just say no," "One day at a time," "Keep it simple, stupid," "Keep coming back," and "Let go, let God" are some of the more familiar slogans heard in drug treatment and 12-step meetings. Comforting as they are, and useful at times, they oversimplify the biological, psychological, social, cultural, and spiritual aspects of an individual's relationship with drugs.

The language of the disease model contains many traps that limit thinking about drugs, drug use, and change. Language creates stigma—"addict," "alcoholic," "drunk," "junkie," "crackhead," "methhead," "speedfreak," "pothead" to name just a few. Concepts such as "Once an alcoholic, always an alcoholic" and "One drink leads to a thousand" limit behavioral possibilities. The language of addiction, dominated by the concepts of loss of control and denial, and the language of recovery, which rules that recovery starts with abstinence from all psychoactive drugs (with the exception of caffeine and nicotine), reflect a dichotomous paradigm—a mode of thinking that puts things, people, and behavior into two camps: clean or dirty, in or out of recovery, drinking or sober, legal or illegal. These constructs are synonymous with religious notions of good and evil and sinner or saved and are restrictive, allowing only two options to characterize users' relationships with drugs.

The greatest danger of a dichotomous paradigm is that much harm can come to drinkers and other drug users who are not "addicted." Opiate overdose occurs with naïve or recently abstinent users who do not have a tolerance to opiates. Deaths resulting from alcohol overdose among college-age drinkers who engage in drinking contests do not tell us anything about alcoholism or lack thereof in this population. Such data do tell us that young people are engaging in dangerous games about which they know too little. Drinking and driving is not just the territory of "alcoholics" but of anyone who takes the risk of driving after consuming more than one drink per hour. By giving all of our attention to addiction and warning teenagers off all psychoactive agents, we fail to educate them about the complex phenomena of drugs, which 50% of them will use regardless of whether we want them to!

The second risk of the disease model is that the counselor, in order to comply with this model, attaches him- or herself to the outcome of treatment, which is invariably abstinence. This singular focus pits the counselor against the client's relationship with drugs. The best outcomes in treatment occur when the goals of treatment are chosen by the client (Ojehagen & Berglund, 1989; Sanchez-Craig & Lei, 1986; Substance Abuse and Mental Health Services Administration [SAMHSA], 1999). Counselor-driven goals arouse resistance in the client, tantamount to behavior change being mandated by a judge or a parent. Such powerful persons might accomplish the goal of exacting temporary behavior change, but they will not facilitate lasting change.

The third problem with the disease model is that it allows for blurred lines between treatment and 12-step programs. Treatment involves the use of trained counselors who have practice with and legal and ethical responsibilities toward clients. The 12 steps were created as part of a voluntary program of mutual support that could guide change. The two can be used side by side but are not interchangeable, though, unfortunately, they often are seen that way. Peele et al. (2000) argue that basing treatment on the 12 steps represents coerced participation in AA or NA, and they have written extensively about this problem. According to current legal interpretation by the Ninth Circuit Court of Appeals, the mandating of people by judges to attend 12-step meetings is unconstitutional based on the Establishment Clause of the U.S. Constitution, commonly referred to as the separation of church and state (Egelko, 2007). There are other disadvantages of using 12-step ideology for dually diagnosed people: It requires abstinence up front; it contains a strong spiritual orientation; dually diagnosed clients may have difficulty relating to typical losses talked about, given that they may never have had a job or a relationship to lose; some 12-step meetings continue to remain hostile to the use of psychiatric medications even though the parent organization (AA & NA) has officially disavowed that stance; and people with mental or emotional illness often experience intense anxiety in large groups, and their social skills deficits may make them feel unwelcome and hinder assimilation (Noordsy, Schwab, Fox, & Drake, 1996).

Finally, it is typical that substance abuse counselors have had drug problems themselves in the past and are "in recovery." In fact, many programs require that counselors be "clean and sober" as a condition of employment. These "experts" tend to make up most of the staffing in drug and alcohol treatment programs. The remainder—psychiatrists, psychologists, social workers, nurses—are expected to have specialized training. As for the rest of the health, mental health, and social services professions, they are left with no option but to "refer out" or send clients to AA or NA. Still to this day most therapists will not, or are afraid to, work with clients

they know are actively using drugs. Given that the majority of people with mental illness will have a drug problem at some point in their lives, this is a terrible state of affairs.

Adaptive Models

Adaptive models include several psychological approaches that are often used in conjunction with each other. Adaptive models encompass a range of psychodynamic, motivational, cognitive, and behavioral treatments, each based on fundamental beliefs about the nature of addiction, health, and methods of treatment. As originally conceived, adaptive models in general hold that problems experienced in childhood—whether innate, family, or social—can create adaptive failures in adolescence (e.g., extreme shyness, problems finishing tasks, learning deficits secondary to poor attention, depression), causing intense distress for affected individuals and their families. These individuals may seek out compensatory mechanisms—people or things, including drugs and alcohol, that help support the weaknesses in their own makeup or in their families or communities. If drug and alcohol use helps to ease distress, it may become interwoven into these individuals' coping mechanisms and, ultimately, influence their personality. According to adaptive model theorists and practitioners, it is imperative to understand clients' early problems in learning and coping. For those who have already developed significant addictions, a retrospective analysis of coping strengths and weaknesses is an essential part of treatment.

Many adaptive model clinicians are also researchers who make use of their work to develop cognitive-behavioral and motivational interventions. Such strategies work to engage clients in an exploratory process rather than predetermine the nature of their problems. In addition, practitioner–researchers such as Miller and Rollnick (2002), Rotgers (2006), and Hester and Miller (1989) have developed methods that offer alternatives to immediate abstinence from psychoactive drugs, even if abstinence is the desired outcome of treatment.

Critiques of Adaptive Models

The problems with adaptive models have come about not as a result of their understanding of drug use but rather with the assumption by many psychoanalytic therapists that they could effect changes in problem drug use by analyzing "underlying issues." By focusing only on the psychological, to the exclusion of behavioral, physiological, or social considerations, such treatment has been too often ineffective for people with the most serious alcohol and drug problems. Therapists may set aside drug-using behavior as a symptom. At other times, they ignore it or fail to assess for it

in the first place. This has earned psychotherapists a bad name in the eyes of recovery-oriented drug users and treatment professionals and has led to standards of care requiring mental health practitioners to refer clients with substance use problems to specialty programs—licensed substance abuse treatment programs and 12-step groups. Thus, we have a schism between mental health and substance abuse treatment systems that influences treatment cultures and practices as well as national, state, and local funding. It also deprives substance users and abusers of the skilled care of psychotherapists. In our view, emotional issues and drug-using behaviors coexist, with some more important than others at different points in time. Any treatment must take into account the complex interactions among these factors.

It is in the context of tension between disease and adaptive models of addiction that harm reduction therapy has developed in the last 20 years. It was, however, the HIV epidemic that gave rise to the harm reduction movement.

HARM REDUCTION

Edith Springer, a social worker in a methadone clinic in New York (and to whom this book is dedicated), traveled to Europe during the 1980s. Britain had opened a harm reduction clinic in response to the HIV epidemic.[3] At the time Springer was working in in New York. Her time in Liverpool opened her eyes to a completely different way of viewing drug use and drug treatment. She came back to the U.S. and wrote the first article about harm reduction in this country (Springer, 1991). Calling it "harm reduction counseling," Springer built the first bridge between public health HIV prevention methods for drug users and the *attitude* and *approach* with which we should deliver these prevention methods. Since this time, she has been a mentor and teacher to thousands, including us.

Harm reduction is based on the reality that all behavior change (leaving a relationship, changing sexual habits, changing diet, taking an antidepressant medication, taking medications for HIV, or reducing or quitting drug or alcohol use) requires a process of decision making for successful implementation and that ambivalence and resistance are normal and expected parts of the change process. Rather than wait for this change process to take place, harm reduction focuses on the more urgent priority of saving lives by offering immediate practical interventions to protect

[3]The United Kingdom actually had a tradition of harm reduction throughout the 20th century, but the term was not coined until the opening of the Liverpool clinic.

health, regardless of whether or not someone has decided to change their drug use, get HIV medical care, or any myriad other decisions.

Public health programs—needle exchange, wound care (for abscesses caused by injection drug use), overdose prevention, and other health care services for active drug users—were instituted in many countries before any harm reduction counseling programs for changing drug use itself came about. Simultaneous with the development of harm reduction strategies in the 1980s, many cognitive-behavioral psychologists were researching and developing models of relapse prevention, motivation, and controlled drinking and realistic ideas about how people change and what helps them to change. In the beginning, most scholars and practitioner-researchers based their ideas on the assumption that abstinence was the sought-after behavior change. G. Alan Marlatt (1996, 1998) followed Springer in embracing harm reduction and moved many addictive behavior change strategies under the harm reduction umbrella. In his words, "Harm reduction . . . is a pragmatic, nonjudgmental, and humane philosophy" (1998, p. ix). Marlatt's influence has touched thousands of lives, and we mourn his recent death.

Today, there is no doubt that harm reduction is a viable and essential part of dealing with health problems related to drugs and drug use. Australian physician, researcher, and drug policy expert Alex Wodak (2007) states categorically, "The prolonged scientific debate about harm reduction is over. Harm reduction is now accepted to be effective in reducing new HIV infections, free of any serious adverse effects (especially increasing illicit or injecting drug use) and is cost-effective. This evidence is overwhelming for needle syringe programmes and methadone or buprenorphine treatment" (p. 60).

HARM REDUCTION PSYCHOTHERAPY

The newest innovation in the treatment of drug and alcohol problems is called harm reduction psychotherapy (Denning, 2000; Denning & Little, 2001; Marlatt, Blume, & Parks, 2001; Tatarsky, 1998, 2002) or counseling (Springer, 1991). Recognizing that traditional approaches to drug and alcohol problems are not very effective, mental health clinicians have been engaged in a search for better treatment strategies (see, e.g., Marlatt, 1996; Marlatt & Tapert, 1993). Several principles guide these efforts: First, the clinician should work side by side with the stated goals of the client; second, access to treatment should be "low threshold," that is, having few barriers to entry. (Requiring abstinence prior to treatment, a typical rule of drug treatment programs, is a considerable barrier for many drug users.) Third, success is *any* reduction of harm in a drug user's life.

For Whom Did We Develop Harm Reduction Psychotherapy?

Joan

The following client, who was seen by Patt Denning for 2 years, represents a large subset of people for whom harm reduction psychotherapy can be useful. Even though this client may be vastly different from other clients, the issues she struggles with and the interacting complexities of her case are a good place to start. This book follows Joan through her treatment based on the harm reduction therapy model.

Joan, a 27-year-old lesbian, was referred by a colleague who did not want to treat her because she was "addicted" to prescribed pain medication. Joan, however, was seeking treatment not for her drug use but for relationship problems. On intake, Joan freely acknowledged taking six to eight Vicodin pills each day for the past 6 years. These pills were prescribed by her orthopedic surgeon for hip pain and subsequent surgery 3 years earlier. Despite improvement in her hip pain, she continued to use Vicodin, often taking more than was prescribed and then asking for more from her physician, who complied with her requests. Joan's main concern, however, was that she could not maintain a stable intimate relationship and was currently in a very stormy relationship. She reported a series of intense, chaotic attachments to women, who quickly tired of her demands for reassurance and constant contact. She became obsessively jealous and at times verbally assaultive if her efforts to control her girlfriend failed. Her history included abandonment by family, subsequent sexual abuse in an orphanage, and a heroic struggle to put herself through both college and graduate school. She worked hard in a professional job and had been employed with the same company for 4 years. Joan's narcotic use was not a concern for her, but she had been terminated by two other therapists because she was an "active drug addict." She was confused and very hurt by these rejections.

After two or three sessions in which Joan focused on her relationship concerns, she volunteered that she thought maybe she "drank too much sometimes," often up to a pint of bourbon at a time. She also said that she used cocaine, but mostly for recreation. I asked her, "Mostly?" My question was not addressed until a few sessions later. Joan explained that once this information came out in her previous therapies, the therapists "freaked" about drug addiction and could not talk about anything else. I had some appreciation of these therapists' dilemma as I found myself silently wondering, "Now what do I do?" My first impulse was to focus on Joan's considerable drug use and her unwillingness to label it as a primary problem. I realized, however, that by doing so I would merely repeat her previous

experiences with therapy (and possibly an important reenactment of her early life). I chose to "do no harm" by doing nothing as an initial strategy.

Joan exhibited clear signs of borderline personality disorder. Her lifestyle of chaotic relationships, impulse-ridden behavior, affective lability, and externalization of problems offered a classic presentation of this disorder. Many of her disruptive behaviors occurred after drinking alcohol, but her use of Vicodin did not appear, during my initial evaluation and impressions, to contribute to either her psychological or her behavioral problems. Because narcotics, in general, do not contribute to disinhibition or moodiness, this was not surprising. Cocaine, on the other hand, with its intense stimulating effects, could easily cause some of the symptoms Joan was exhibiting. Listening to her describe the emotional events that frequently preceded her use of these drugs, it became clear that drug use often formed a protective emotional shield around this vulnerable woman. It seemed, though, that it also disrupted her fragile equilibrium.

What Does It Take to Practice Harm Reduction Psychotherapy?

The practice of harm reduction psychotherapy requires, in addition to solid clinical training, an open-minded attitude toward drugs and drug use, a culturally competent practice, client-centered ethics, and evidence. Chapter 12 focuses on what it takes to practice harm reduction therapy and reviews the ethics and the evidence that support it. In the remainder of this book, we describe what we mean by these components of clinical practice with drug users. In essence, in order to practice harm reduction psychotherapy, one must develop a respectful relationship that explores and permits differences, resists efforts to control clients, and uses proven helpful strategies. The particular harm reduction approach that we have developed, which has so far successfully served thousands of drug users and abusers in our practice and we hope will be of use to the reader, combines the public health principles of harm reduction with psychodynamic and cognitive models of psychotherapy. The result is a holistic psychotherapy, based on both empirical and clinical experience, that allows clinicians to treat clients as people with problems, not as problem people. A reciprocal exchange of practical techniques and conceptual principles enhances the usefulness of this model: Our clients open our eyes to experiences that we could not have imagined and suggest solutions that we would not have considered. This trust in and respect for the client is the fundamental principle of harm reduction psychotherapy.

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