Harm Reduction Psychotherapy

A Case Example

Andrew Tatarksy

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ANDREW TATARSKY

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

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Acknowledgments

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

Most important to this project have been the many clients who had the courage and generosity to invite me into their lives, sharing their stories with me and teaching me about substance use and misuse and how people change and grow. To you whose names may not be mentioned, I am deeply grateful— you have

inspired in me a powerful belief in the strength of the human spirit to overcome all obstacles in its quest for freedom and loving connections.

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

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

Study"), Leon Wurmser (“The Analysis of a Case of Alcoholism, Masochistic Character, and Perversion”), and Elizabeth Zelvin (“Carla: A Case Study").

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

For their insightful comments and criticisms that propelled the development of my work, I especially want to acknowledge my dear colleagues and friends Julie Barnes, Michler Bishop. Antonio Burr, Patt Denning, Armand DiMele, Lisa Director, Jeannie little, Mark Goldenthal, Marc Kern, Robert Lichtman, Deborah Liner, Bart Majoor, Michael Morrison, David Ost, Stanton Peele, Stephen Reisner,

Debra Rothschild, Gordon Rovins, Jeremy Safran, Mark Sehl, Michael Varga, Ora Yemini, Arnold Washton, and Alexandra Woods.

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

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

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

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

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

Most importantly, I am forever indebted to my loving family who have sustained my life. To my mother, Sheindi, who gave me life and planted the seeds that flowered in my discovery of harm reduction; to my fathers, Jack and Dick, who inspired me to think large and believe that anything is possible in love, beauty and truth; to my siblings, Laurie, Miles, and Nikolas, who have been wonderful company in the darkness and light; to my amazing children, Alexandra, for reminding me to stay open to the great mystery of spirit and lightness, helping me to believe in magic, and reminding me of the joys of dance and poetry, and Lucas, for helping me to keep my heart soft and open, enjoy the

interplay of strength and vulnerability in all that is, and for filling my life with delight; and to my wife. Dr. Wendy Miller, you have made my life possible by your warm sustaining love, brought the joy to my life, and supported me in uncountable ways that made this book possible.

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Harm Reduction Psychotherapy

Mainstream abstinence-oriented treatment of alcohol and drug users in the United States today continues to have poor success by anyone's criteria. Clinical observations and empirical studies typically report that a majority of clients seen initially do not successfully complete treatment or maintain their gains after treatment. These poor outcomes are evident in residential and outpatient programs and across different theoretical approaches. The Substance Abuse and Mental Health Services Administration reported that between 1992 and 1997 only 47% of patients completed American drug and

alcohol treatment programs with another 12% referred to other programs (SAMHSA, 1999). Several treatment outcome studies suggest that only 20-40% of patients who complete treatment achieve long-term success even when abstinence and moderation are both considered as successful outcomes (Keso & Salaspuro, 1990; Nordstom & Berglund, 1987). For example, Helzer and colleagues (Helzer et al., 1985) looked at three-year outcomes of four abstinence-oriented programs of patients who met D.S.M. III criteria for alcohol dependence. They found only 15.1% reported total abstinence and 18.4% reported some form of problem-free drinking. Ditman et al. (1967) did a one-year follow up of 301 “chronic drunk offenders" who were randomly assigned to no treatment, Alcoholics Anonymous, or clinic treatment as a

condition of probation. Using re-arrest for a drinking-related offense as the primary outcome measure, they found that 68% of the clinic group, 69% of the AA group, and 56% of the no treatment group were re-arrested; the differences were not statistically significant. And, more recently, a large scale controlled study, Project MATCH (Project MATCH Research Group [1997]) was funded by the National Institute on Alcohol Abuse and Alcoholism to compare patients' responses to different treatment approaches. 1,726 people with alcohol use problems were randomly assigned at sites across the country to twelve sessions of 12-Step Facilitation Therapy (TSF), Cognitive-Behavioral Therapy (CBT), or Motivational Enhancement Therapy (MET). Using complete abstinence during the year after treatment as the

measure of success, 24% of individuals in the TSF group were abstinent, 14% of those in the CBT group, and 15% of those in the MET group.

Standard approaches are not equipped to address serious emotional or socioeconomic problems accompanying substance use problems. These statistics for failure in substance abuse treatment do not include people with drug and alcohol problems who never seek traditional treatment, a group that represents the majority of problem users in this country. The United States Department of Health and Human Services (USDHHS, 1997) estimated in 1997 that about 15 million adult Americans are alcohol dependent or abusing. SAMHSA (1999) estimated that there were 2,207,375 admissions to 15,000 American in- and outpatient treatment

facilities in 1997. Assuming that some of these were multiple admissions by some people, it is likely that approximately two million people were treated in that year. These data suggest that close to 85% of individuals with alcohol problems in 1997 were untreated in this country. This is supported by the Institute of Medicine's (1990) estimate that 80% of American alcoholics have never made contact with self-help or professional treatment, and by the National Institute on Alcohol Abuse and Alcoholism's (1999) estimate of 10 million untreated American alcoholics. I think it is safe to assume that the statistics for other drug users are comparable. For example, researchers at SAMHSA (Woodward et al,, 1997) estimated that 48% of the need for drug treatment, excluding treatment for alcohol problems, is not

being met. If the helping profession of addiction treatment was a Fortune 500 company, it would have gone out of business long ago.

THE “ABSTINENCE-ONLY" ASSUMPTION IN TRADITIONAL SUBSTANCE USE TREATMENT

While these results are related to the complex and challenging nature of substance use problems, I have come to believe that the prevailing assumption that informs most mainstream treatment contributes to this limited effectiveness. Mainstream drug and alcohol treatment has been informed by an “abstinence-only" assumption. According to this model, abstinence from all mood-changing chemicals is the only acceptable goal for compulsive substance users; it must be accepted by the client in order to gain access to treatment and must be quickly achieved and maintained to remain in

treatment. Abstinence is the criterion of success for the client and treatment provider and the prerequisite for continued assistance. People who want to address other issues before they address their substance use are generally said to be rationalizing their substance use and denying their "disease."

This model is based on the assumption that unless problem users are willing to accept total abstinence from all drugs and alcohol, they are not suitable for treatment; active users are assumed to have such impaired awareness and judgment that they cannot engage in treatment or psychotherapy in a meaningful way. The consensus belief is that the user must "hit a lower bottom," that is, suffer more from the assumed negative consequences of their use in order for motivation toward abstinence to grow.

This mandate results in a Catch-22 for the user that results in the denial of any treatment. Substance users seeking help for issues other than substance use are routinely denied psychotherapy and referred to substance abuse treatment, while substance users unwilling or unable to accept abstinence are denied substance use treatment. Clients in treatment who are unable to stop using are routinely terminated from treatment, often with no other treatment recourse, or with a recommendation that is not suitable for the client. Not only does this approach prevent many people from obtaining the help they are seeking, it frequently demoralizes and damages people who come at the depth of their vulnerability and the peak of their readiness to change.

Assumptions are Based on the Ambiguous Disease Concept

These assumptions are based on an ambiguous “disease concept” that sees compulsive substance use as born from a hypothetical and unsubstantiated “addictive disease." The disease is believed to have a life of its own, separable from the complex of issues that influence the life of the user. The disease is deemed a permanent, lifelong condition, dormantly active even when the client isn’t using drugs. The hypothetical addictive disease inevitably causes loss of control over drug use and is generally understood to be lethal if not arrested, that is, if the user doesn’t accept total abstinence. In effect this model isolates the drug-using behavior from the rest of the person and claims that it must be dealt with before anything else in the user’s life.

Biological and Behavioral Reductionism Denies Personal Meaning

While there are often biological and behavioral conditioning factors involved with excessive drug use, this model reduces problem use completely to biology and conditioning. The prevailing abstinence-only approach is not process or depth oriented and denies the importance of the unique personal meanings that drug use carries for people. This model tends to devalue, dehumanize, and objectify drug users and often alienates the user from seeking help rather than examining the insufficiencies of its own assumptions.

Abstinence is sometimes the ideal approach in terms of risk reduction for many substance misusers; however, it may be argued that the majority of users are not willing nor able to accept this as their goal at the beginning of a

treatment process for a wide variety of legitimate reasons. Consequently, they are met with an expectation that keeps them from becoming effectively engaged at the start. This zero-tolerance, “high threshold" approach (the prospective client must jump high to get in the door) simply does not begin where many clients live; rather, it requires that the client come to match a model that is riddled with outmoded assumptions and expectations.

HARM REDUCTION AND THE DIVERSITY OF SUBSTANCE USERS

Substance misusers are a broadly diverse group of people who differ in many important ways, including the severity of their substance use problems, personal goals regarding use (e.g., moderation vs. abstinence), motivation and readiness to change, emotional state, personality

strengths and vulnerabilities, and socioeconomic and cultural variables. It is obvious that any one-size-fits-all model is doomed to fail with the majority of clients. This diversity suggests the need for a more flexible, inclusive, and comprehensive model to increase overall effectiveness at helping this broad spectrum of people.

Harm reduction is an alternative paradigm for approaching the treatment of this diverse population that has many advantages over the abstinence-only approach that make it more acceptable and relevant to a greater number of clients and can increase overall treatment effectiveness.

History

Harm reduction first emerged in the Netherlands in the 1970s as a response to the

limitations of the traditional abstinence- only treatment approach. It has since become the best available practice informing numerous national policies on drug treament including the Netherlands, Germany, England, Australia, and Canada (Marlatt, 1998). In the United States, harm reduction became accepted in the late 1980s and early 1990s as a set of pragmatic public health strategies for reducing the spread of HIV and other risks associated with active substance use (Heather, Wodak, Nadelman, and O'Hare, 1993). These strategies include clean needle exchange, condom distribution, and methadone maintenance.

An Alternative Paradigm

Inherent in these strategies is an alternate philosophical paradigm for helping drug users. Harm reduction is not at odds with abstinence,

but includes it as one possible goal for substance users and for many the best possible harm reduction outcome. But it is a critique of the abstinence-only model I discussed previously. Whereas abstinence-only limits who can be helped and how, harm reduction turns abstinence-only upside down by giving up the presumption that abstinence is the required goal for all clients with substance use problems. In so doing, it opens the door to the possibility of engaging the whole spectrum of substance users.

Alan Marlatt, in his groundbreaking book *Harm Reduction* (1998), has called harm reduction “compassionate pragmatism." As a pragmatic approach, active substance use is accepted as a fact, and substance users are engaged where they are, not where the provider thinks they should be. In effect, harm reduction

follows the client’s nature rather than asking the client to match imposed treatment demands. It recognizes that substance use and its consequences vary along a continuum of harmfulness for the user and the community and that behavior generally changes by small incremental steps. Harm reduction seeks to help the client move along the continuum in the direction of decreased harm. Therefore, any reduction in harm is seen as a step in the right direction. For many users, abstinence is considered ideal in terms of reduction of harmful consequences, but alternative goals that “step down" the negative consequences of substance use are also embraced (Marlatt and Tapert, 1993).

As an approach that emphasizes compassion, harm reduction actively challenges the tendency

in our society to deal with drug users in stigmatized, disrespectful, coercive, and punitive ways. The disease concept that informs abstinence-only treatments denies the complex personal meaning that drug use can have for drug users, which contributes to failure. We also see this in the country's commitment to the criminalization of drug users. Rather than dedicating monies to treatment reforms, education, and other supportive services to meet the various needs of this group of people, our country spends significantly more on punitive criminal justice measures. This clearly speaks to the hypocrisy of the country's commitment to seeing drug misuse as a disease or related to serious psychological or social issues. In what other areas of health care do we terminate people from treatment for continuing to have a

problem and then sentence them to prison for engaging in the behavior in question? Harm reduction challenges us as practitioners and as a society to find more creative and effective means to help drug users.

Harm Reduction Has Treatment Implications

This simple but profoundly important shift in focus has positive treatment implications at two levels. As an umbrella concept, harm reduction suggests the need for an integrated system of treatment with linkages across the full spectrum of treatment modalities that are matched to the needs of the broad diversity of users. Harm reduction also has implications for how treatment is conducted in the moment-to-moment interactions between clients and clinicians at every stage of the treatment process from evaluation and initial engagement through

goal setting and working toward change, that is, moderation, abstinence, or other harm reduction goals. This issue of the *right fit* between client and treatment will be explored in more depth in Chapter four.

HARM REDUCTION PSYCHOTHERAPY

A growing number of researchers and clinicians have broadened the application of the harm reduction approach from a public health strategy to psychotherapy and counseling of active drug users (Carey and Carey. 1990; Denning. 2000; Marlatt and Tapert, 1993; Marlatt, 1998; Peele and Brodsky, 1992; Rothschild, 1995; Tatarsky, 1998). I think of harm reduction psychotherapy as a general category of psychological interventions that may vary in theoretical perspective and clinical approach but share in the commitment to the

reduction of the harm associated with active substance use without assuming that abstinence is the ideal goal for all drug users.

In the section that follows, I describe what I consider to be the essential features of harm reduction psychotherapy and its clinical rationale.

THE INTEGRATIVE MODEL

I will summarize an approach to harm reduction psychotherapy that I have developed in my own practice with a broad range of substance-using clients over the last fifteen years. My approach is consistent with a bio-psycho-social model of drug use problems in that it recognizes that personal meaning, social learning and conditioning, social-interpersonal and biological factors may all play a role in the genesis of these problems, and that the specific

contribution of each for each client must be understood in developing individually tailored treatments that have the most chance of success. This approach begins with the assumption that substance use problems may result from a variety of different psychological, social, and biological factors, the combination of which is unique for each person.

Integrating Strategies for Change

Harm reduction psychotherapy is an integrative approach in that it also recognizes that drug use can be motivated by behavioral, sociocultural, and biological factors that must be understood in formulating effective interventions. A proper understanding of the contribution of all of these factors will inevitably lead to a treatment approach that integrates strategies that target all of the relevant factors

for a given client. Given the diversity of drug-using individuals, harm reduction psychotherapies can look very different depending on the particular client. This dictates that harm reduction psychotherapists be attuned to the unique qualities of each client and flexible in blending different kinds of psychological, behavioral, and biological/ pharmacological intervention depending on the client's needs.

People use substances because they work, at least initially, in addressing some psychologically, socially, or biologically based needs. We may define substance use as problematic or excessive when it compromises or interferes with other important needs and values. But, for any substance use treatment to have a chance at being successful, it must begin with an effort to discover the specific reasons or

motives that have made the substance so compelling in spite of these problematic consequences. As these factors are identified, strategies and modalities can be combined that specifically target them.

THE PSYCHOANALYTIC CONTRIBUTION

For me, the multiple personal meanings that drug use carries, expresses, and reflects that are unique to each user are pivotal in understanding the motivation to use and misuse. Identifying these meanings is essential for creating lasting positive change in drug use. My thinking on this has been largely influenced by the psychoanalytic/psychodynamic contribution to understanding the myriad personal meanings drug use can have for people.

Contemporary psychodynamic writers on substance problems have generally emphasized

the “adaptive” value that substances may fulfill as one possible reason that substance use becomes compelling (Khantzian, Halliday, and McAuliffe, 1990; Wurmser, 1978). According to this perspective, substances may come to serve important psychological functions that help the user cope more effectively. They may be relied on to self- medicate or defend against overwhelming affect states; regulate fragile self-esteem; support interpersonal effectiveness; comfort or soothe oneself; or tranquilize the harsh inner critic (“superego") to allow temporary experiences of pleasure unavailable while sober, among other possible functions.

I discuss the importance of the psychoanalytic contribution to harm reduction psychotherapy in Chapter 2 and look at some of the specific meanings drug use can have for

people and how they can be addressed in psychotherapy in Chapters 5, 6, 7 and 8.

Personal Meaning and the Vicious Cycle of Excessive "Addictive" Drug Use

Over time, chronic substance use may take on multiple functions for the individual as it becomes increasingly integrated into one's psychological functioning and lifestyle. Chronic use is also often associated with psychological, conditioning, lifestyle, and biological changes that compound and can intensify the original motives for using, thus increasing the pressure to use. The interaction between the initial meanings that drugs have for people that make them appealing and the consequences of chronic drug use is a way of understanding excessive drug use is an alternative that to the disease model. As the expression of a complex interaction of personal

and social factors, drug use can be seen as the expression of an interactive process that is more open to change than the more static, reified disease model for which abstinence *now* is the only starting point.

GOALS OF TREATMENT

The goal of this work is to engage clients in a relationship that will support them in clarifying the problematic aspects of their substance use and work toward addressing these problems with goals and strategies that are consistent with who they are as individuals. The ideal outcome of this approach is to support the user in reducing the harmfulness of substance use to the point where it has minimal negative impact on other areas of one's life. Whether the outcome is moderation or abstinence depends on what is practically realistic for the client and emerges

out of the treatment process. Ultimately, this is accomplished by identifying the various bio-psycho-social factors that initiated and contribute to ongoing substance use and discovering alternative, more effective drug-free solutions. However, the harm reduction principle places the value of engaging clients in treatment around their own initial goals as the starting point, with the ultimate goal of treatment emerging out of the process of the therapy.

ENGAGEMENT/ASSESSMENT PHASE

The cornerstone of all effective treatment is the therapeutic alliance between client and clinician around shared goals. Thus the focus of therapy must be on the client's definition of the problem and goals. By starting with an attempt to understand the client's reason for coming, an alliance can form around a mutual exploration of

the client's concerns and how, if at all, the substance use impacts on them. Without preconceptions about the substance use, we are free to join the client in the exploration, keeping open the question of how the substance impacts on other areas of the client's life. This puts us on the same side as the client, avoids power struggles about what the client "should" do, and conveys a respect and empathy for the client that is conducive to the client feeling safe and supported in our presence.

The nature of the problem is explored through a detailed consideration of the client's reason for coming, the current substance use pattern, history of use, and the impact of the substance on other important areas of life. It is acknowledged that the substance has some positive value to the user and that this must be

weighed against the negative consequences of use. Identifying the positive function of the substance opens up the issue of whether other, more effective, and less harmful ways of meeting these needs may be discovered.

Clients are taught a self-observation strategy for developing a clear picture of how substances fit into their lives in relation to situational triggers, thoughts and feelings, and positive or negative consequences of use. The strategy consists of paying close attention to physical sensations, thoughts, and sense perceptions in the present moment and describing them in detailed, nonjudgmental language as fully as possible. Then, clients are asked to use the technique whenever they become aware of thoughts or behavior that are related to using drugs or alcohol in order to identify the thoughts

and feelings that immediately precede and follow the substance-related behavior. This may be assisted by having clients keep written records of these observations that can be brought into sessions to be reviewed with the therapist.

GOAL SETTING

As the problematic aspects of substance use and other issues of concern to the client become clear, it becomes possible to establish goals and agree on a treatment plan to work toward them. I take my lead from what is most pressing to the client, whether this is working toward moderation or abstinence, clarifying the motivational obstacles to addressing the substance use directly, or addressing some other non-substance-related issues. Rather than beginning with my assumptions about how realistic these goals are, I state my experience

with similar clients, where appropriate, and suggest a pragmatic approach to determining if the client's goals are achievable. We can discover together what is practically possible by working together toward the client's chosen goals. Goals and strategies can be revised as difficulties are encountered along the way.

For many clients whose substance use continues to serve some positive function, the question of whether they can moderate their use must be answered before they will consider stopping. This is more likely answered by a supported, direct attempt that includes learning ways to achieve moderation. If clients are unable to achieve moderation in this context, they are more likely to have a clear recognition of why it has not been possible for them based on their

own observations and are more likely to consider stopping altogether.

WORKING TOWARD CHANGE

Out of this process, an “ideal substance use plan" is developed that is designed to maximize the positive value of using substances for the client while minimizing the negative impact of using *to the point where the client is presently ready to go*. Ideal route of administration, amount, and frequency of substance use are arrived at empirically by examining the client’s experience with using. As the client attempts to put the plan into effect, how well it achieves the desired goals can be assessed in an ongoing way and the plan can be fine-tuned to more effectively achieve the goals as therapy proceeds.

Difficulties encountered in successfully implementing the plan are “micro-analyzed" to identify the situational and psychological issues that are driving excessive use. These difficulties may be related to conditioned environmental or emotional triggers, social pressures, emotional states that substances are used to cope with, or motives about which the client may be unaware (e.g., the passive, self-destructive expression of anger through substance use that hurts oneself). The identification of these motives leads to the exploration of alternative ways of coping. These may include the full range of coping skills such as relaxation training, anger management, assertiveness training, and identifying and verbalizing feelings in constructive ways. The therapist teaches these coping skills and invites the client to practice them in therapy sessions

and out in the client's life. This permission-giving stance may challenge clients' early messages that caring for oneself is unacceptable and help empower them to use their innate capacities to care for themselves effectively. When they become aware of the variety of motives for using substances, the compulsive need to use them may abate somewhat as it now becomes possible to make alternative choices. At this point, a discussion of other ways to manage, express, or resolve these broader emotional or characterological issues becomes possible. The envisioning of alternative possibilities is a prerequisite for many people to feel motivated to consider giving up their familiar, habitual ways of coping. Over the course of therapy, the focus of the work broadens from substance use to a whole set of

larger issues related to getting to know oneself better, learning to listen to and accept oneself more deeply, and discovering more effective ways of caring for oneself.

Because this approach does not begin with preconceived goals, it is applicable to a broad variety of people with substance use issues. With some clients, this work is relatively simple and straightforward and may consist of a small number of contacts of evaluation and recommendations resulting in dramatic, long-term positive changes in use. With many others, however, the work is very complicated, uncertain, and difficult for both client and clinician. This is often what is required for the resolution of substance problems that exist in more complex psychological and sociological contexts. This reality, which is avoided by the

abstinence-only approaches, is embraced by harm reduction psychotherapy.

Tom: Harm Reduction to Moderation

by Andrew Tatarsky

Tom called me four years ago because he was concerned about “drinking too much and at the wrong times," and he wanted “to get it under control." He called me specifically because he had heard of my reputation as an alcohol treatment specialist who will work with problem drinkers who do not want to stop drinking.

Tom appeared at my office for our first meeting looking scared and shaking. The faint odor of alcohol accompanied him as he entered my office. I found myself feeling somewhat anxious and wondered if this would interfere

with our work. As it turned out, this first meeting ended with us feeling optimistic about the possibility of doing some valuable work together, a feeling that has grown and strengthened over the past four years of weekly psychotherapy.

Tom is a somewhat heavy man, at that time looking his 43 years of age, wearing a neatly trimmed mustache and a hoop earring in his right ear. Along with his neat, casual style of dress, he projected the image of a hip, downtown, arty man trying to look younger than he was. His initial wariness and guarded manner melted quickly in response to my interested, accepting stance. He seemed painfully lonely and hungry for contact, and he expressed intense gratitude for my willingness to help him on his terms, that is, while he continued to drink. This

also seemed to reflect a desperate need for validation of his adequacy as a person. He was exploring whether I might be able to offer that to him. As Tom talked, I also quickly formed the impression that he was a very bright, honest, emotionally vulnerable, and talented man. I immediately liked him and felt optimistic about embarking on a psychotherapeutic journey together.

Tom described himself as a 43-year-old single Italian-American gay man who lived alone in New York City. He said that he was glad to be gay, although there were certain changes in the gay world that had become increasingly problematic. While he was vague at this point, these problematic changes would become clear over the course of our work together; they were powerfully related to his

drinking problem and a number of other emotional and lifestyle problems.

During the next few meetings, Tom revealed himself as sensitively attuned to the nuances of my reactions to him, belying both a keen attention to detail and a particular sensitivity to the emotional responses of others. He expressed a strong need for emotional support and reassurance, frequently asking if I thought he was “doing it right," showing me things that he had done to address his problems and asking for my approval. He didn’t actually want my opinion but rather my approval for the decisions that he had already made. These aspects of him revealed a very fragile sense of self and an intense reliance on the approval of others to maintain a positive self-image. I felt as if I was being invited to play the role of mother,

applauding and feeling proud of his baby steps toward learning to take better care of himself in the world. Not only did it seem to me that he wanted my approval to maintain a good feeling about himself, but as a kind of mother/father, he wanted me to help him to construct a more firm and more effective self. I wondered if this vulnerability in his sense of self might be directly related to his drinking, a suspicion that was to be supported in several important ways.

Tom said that he indeed saw his drinking as a problem, though the most important factor motivating him to seek treatment was pressure from his job. Tom had a responsible position as curator at an art museum. Prior to his visit, Tom's supervisors had given him an ultimatum: go in for alcohol treatment as the condition for keeping his job. Tom was in a crisis in his

workplace. He was extremely disturbed by the way his co-workers had responded to his excessive drinking and felt that he was being misjudged and misunderstood. Our session was Tom’s second attempt at seeking help for alcohol use. His first experience was a coercive intervention that occurred nine months prior to our meeting. Tom's colleagues had staged a semi-theatrical intervention to get him into an intensive treatment program, assuming for him that he had no other options. As Tom spoke, he was controlling strong feelings of anger and sadness. Without warning, his colleagues had confronted him publicly, at the start of the workday, and told him that they had made arrangements for him to be evaluated by a well-known alcohol treatment program that morning and that a car was waiting just outside to take

him there. At that moment Tom realized that he had no choice but to go, unless he wanted to risk losing his job of twenty-three years.

Tom said that he felt “shell-shocked." He said that he had never been approached by anyone about his drinking or job performance before this and felt utterly humiliated and betrayed. He wondered aloud why no one had spoken to him if they had concerns. He said that he would have willingly gone for an evaluation if he had been consulted and included in the process. Stricken with shock in front of the others, he felt he had no choice but to submit to their thoughtless suggestion and went for the evaluation.

At the evaluation, Tom was told he was an alcoholic. The interviewer said that he believed that Tom was minimizing the nature of his

problem and that he believed that Tom needed to stop drinking altogether. He recommended that Tom enter the program's four- night-per-week intensive outpatient program. Thinking that he had no alternative, Tom entered the program under pressure.

During the course of that six-month treatment, Tom did not drink at all. He had had questions that he wanted to raise about whether he could drink safely in the future, but was not able to explore these options because they were taboo in the program. Tom quickly learned from the staffs automatic, seemingly presumptuous responses to his questions with proclamations of his minimizing and denial and "inability to accept his disease." His treatment experience left him feeling traumatized and waxy of entering therapy again. Later on in our work together.

Tom described that this first treatment experience had contributed to his feeling worse about himself than when he began.

Shortly after completing that treatment program, Tom began to drink again, this time with a vengeance. His drinking quickly came to the attention of his superiors at work after he made some phone calls to co-workers while intoxicated. He appeared at a work function obviously drunk. Tom's supervisors again required Tom to seek treatment or risk losing his job.

Tom now felt nervous on the job, afraid that expressing his feelings might further jeopardize his relationships there. These feelings distracted him; they interfered with his concentration at work and on a book-writing project. As a result of this rupture in his relationships within his

workplace, he felt more lonely than ever. He saw his most recent drinking as his way of handling his feelings of anger and loneliness. He said that his “co-workers’ attempt to help had not helped at all” and had left him with feelings that compounded the more long-standing problems that contributed to his drinking.

At first I was unclear about the nature of Tom’s drinking problem or whether he could successfully achieve his goal of moderation. My initial impression was that his heavy drinking was a meaningful reaction to a number of painful emotions, the emotionally charged present as well as the ongoing, more chronic situations in his life.

Tom felt quite depressed much of the time. As background to the recent betrayal at work, his depression had grown over fifteen years with

the gradual loss of several primary sources of support for his fragile sense of self. Tom had managed his vulnerable self-esteem by depending on external sources of positive feedback from others. His relationships were preserved by an overly friendly, nonconfrontational style of relating to others. He had long ago traded away any freedom to express anger or sexual desire in a direct and assertive way.

The harm reduction approach was used to set up a therapeutic context for evaluating Tom's problems and establishing a therapeutic alliance with him while he continued to drink. The integrative aspect of this approach enabled me to explore the various meanings and functions of Tom's drinking while actively supporting the use of specific coping strategies for addressing his

needs in more direct, effective, alcohol-free ways.

COURSE OF TREATMENT

Engagement/Assessment Phase

I agreed to work with Tom to explore whether he could successfully moderate his drinking. We planned to meet once weekly for 45-minute sessions. I told him that I did not believe that it was possible to know whether he could successfully make this change in his drinking, and I suggested that we adopt an experimental attitude toward this question. Tom said that he liked this framework as a starting point for our work together. He said that he was aware that it might not be possible for him to learn to control his drinking but that he needed to give it a serious try before he could ever

accept that he would need to stop drinking entirely.

Our initial alliance was quickly formed around the shared goal of exploration in the area of moderation management. My initial stance conveyed an understanding and respect for what was important to Tom and contributed to an atmosphere of safety in therapy. Tom quickly developed a very positive feeling about working with me and said that he felt optimistic about being able to get what he needed. My interest in supporting him to discover whether he could achieve his desired drinking goal also had some value in relation to some of the particular aspects of Tom's character problems, vulnerabilities that are often present in clients with substance problems. Tom's compliance with his prior treatment despite feeling that it did

not address his needs was characteristic of his relational tendencies generally. His self-esteem was so dependent on the approval of others that he generally went along with their wishes even when it might be in stark contrast to his own. This was shown by his passive acceptance of what he felt to be mistreatment at work as well as a pattern of personal relationships in which he was physically or verbally abused and taken advantage of in one way or another. Rather than change the pattern of relating, he became increasingly isolated in his life. Like many problem drinkers, his drinking expressed his anger passively rather than in words or appropriate assertive actions. His reticence to claim his needs and express his voice eroded his self-esteem. The critical inner voices contributed to depression over a ten-year period, assisted by

drinking, which numbed his pain. My willingness to support Tom in investigating what he needed to clarify for himself was a good step in the direction of self- expression. As I helped him to identify what was important to him, he began to find the resources to commit to a program that suited his own emerging nature.

The first phase of the treatment focused on clarifying the nature of his drinking. This assessment was designed to identify the problematic aspects of his drinking, to discover how his drinking was meaningfully related to his emotional and external life issues, and to get a baseline level of drinking to develop clear behavioral drinking goals. To this end, I suggested several behavior therapy strategies. I taught Tom self-observation techniques to identify the relationships between external

events, thoughts, feelings, and thoughts or feelings related to alcohol. I describe this to clients alternately as “self-monitoring,” “awareness training,” or “mindfulness,” and think of it as related to the psychoanalytic concept of the “observing ego." I suggested that between sessions, Tom try to practice observing the accompanying thoughts, feelings, and circumstances whenever he noticed the desire for a drink and to keep a mental or written record that we could review together in sessions. I suggested that the initial purpose was to get a clear picture of his current drinking patterns and that he not change anything until he could identify specific goals for himself.

This examination included both written and mental notes over the first several weeks. It revealed that the current pattern of Tom’s

drinking was between two and six drinks daily and occasionally as many as twelve. His drinking mainly occurred in bars where he met with his bar friends, as well as sexual partners. He said he had been generally drinking in this way for the last ten years. The quantity had slowly increased over this period of time. He said that he did not experience blackouts, alcohol withdrawal, or medical problems as a result of his drinking. He identified negative consequences of drinking, including lapses in judgment leading to engagement in inappropriate and risky behavior such as unsafe sex while drinking. Another lapse was the occasional appearance at work with alcohol still on his breath from the night before, the morning after leaving him in a semi-intoxicated state in which he worked at half his capacity. While

intoxicated he had called co-workers from time to time and expressed dissatisfaction with people's work and attitudes. These intoxicated calls made the listeners understandably ill at ease. His assessment of character was impacted by alcohol; he took several strangers home from bars who ended the evening by robbing and beating him.

Tom believed that his drinking was excessive, inappropriate, and self-destructive, but he did not want to see himself as an alcoholic who could never learn to control his drinking. He said that he had never really tried to control his drinking and that he thought there were a number of emotional issues causing him to drink excessively. He said that he wanted to try to learn better control.

We reviewed Tom's drinking history in depth to understand together how drinking fit into the larger context of his life. It became clear that the escalation in Tom's drinking was a response to two major issues that reflected older and deeper emotional and characterological problems. When these were identified, they became the focus of our ongoing and current work together.

Tom had felt a gradual loss of social support that had once given him a sense of belonging, self-esteem, and possibilities for intimate and sexual relationships. In his twenties and thirties, Tom had been a well- respected popular artist in the downtown scene. He was actively involved in the gay community during the 1960s and 1970s when there were many opportunities for social and sexual contact. These communities gave Tom a sense of belonging, pride in his

artistic and social accomplishments, and opportunities for intimate relationships of which he had two important, long-term lovers and many brief but exciting sexual encounters.

As Tom grew older and heavier, and as the AIDS crisis hit in the early 1980s, he gradually withdrew from these worlds: he was no longer as desirable and the opportunities for intimacy disappeared with the changing times. Tom began to satisfy his need for social contact with the pseudo-contact available in bars but stopped having casual sex because of his fear of AIDS. He drank more as a way to blot his feelings of sexual frustration and loneliness. Then in the 1980s, Tom's career at the art museum took off and he gained another support system to replace those he had lost. He advanced progressively into responsible positions and developed a

highly respected status with coworkers and artists in the art world.

During this period, Tom's social life diminished but he derived great satisfaction from his working relationships. In the several years prior to entering treatment, there were major changes in the administration's support of Tom's interests and the social environment at work. Support staff were let go, the physical plant was allowed to deteriorate, raises became smaller, and his input seemed less valued. The existing staff became more competitive as a result and the earlier sense of community was fractured. These changes left Tom feeling powerless and "unloved." Tom's drinking became more frequent and intense. It was in this context that the intervention was staged, which was temporarily devastating. Tom gained fresh

clarity and relief by understanding the link between the change in his social milieu and his escalating depression and self-esteem issues.

Goal Setting

I wondered aloud with Tom if the occasions of his drunken, inappropriate phone calls to colleagues from work had coincided with the intervention or had increased since the intervention had taken place. Tom was realizing that he had long felt unsafe expressing anger in general and particularly now at work after his job had been threatened. I then posited whether he was using alcohol to free himself to express these feelings that he was unable to express when sober as well as to defy other people's efforts to control him by flaunting his drinking at them. Tom felt his feelings confirmed and recognized as we followed these trails. As his

feelings were clarified he became more aware of the underlying messages carried by his drinking.

This raised another question in my mind: Why would Tom express anger and defiance in ways that would risk his job which had been so important to him in terms of social life and status? Tom was self- reflective and curious enough to actively engage in this question. Our exploration that followed led to a series of associations taking him back to a sequence of interpersonal conflicts with parents and other loved ones; he was always more prone to blame himself than to criticize others. His fear of losing their affection and acceptance, as well as his guilt about hurting those that he loved, seemed to explain the conflict that led him to feel inhibited about expressing anger and other assertive feelings. The self-destructive aspect of

his drinking was self-punishment for guilt provoked by his anger at his colleagues, the most important people currently in his life. Drinking soothed and numbed the pain associated with recent losses. It was also a means to express anger at the worlds that had abandoned him, as well as anger at himself for having let it happen that way.

This interpretation had a dramatic impact on Tom and led to a broadening of the focus of therapy from simply on the drinking behavior and the immediate crisis at work to include his conflicts about expressing anger and other self interests, including sexual and romantic needs, and the character vulnerabilities and relational/interpersonal issues in which these conflicts were rooted.

I suggested that Tom describe his ideal pattern of drinking. This pattern would enable him to enjoy what he defined as the benefits of drinking without the negative consequences. This required that Tom do a cost/benefit analysis of his drinking based on what he found to be the self-affirming benefits of alcohol compared to the ways in which alcohol conflicted with things that were important to him. Tom decided that he wanted to limit his drinking to a level at which he felt somewhat relaxed without impairing his judgment or losing control. He would cease drinking on evenings preceding three morning meetings weekly. He would try not to drink when he was upset and thus more vulnerable to overdoing it.

He wanted to develop other skills for managing these feelings. We agreed to establish

drinking limits for the times he would drink and evaluate them over time to see whether they accomplished his stated goals. Based on his experience and some reading that I suggested, Tom decided on a limit of two drinks per day. For events lasting more than three or four hours, he was allowed four drinks maximum. He also decided to stick with wine rather than vodka, because he could better regulate his intake with wine.

Working Toward Moderation

By the end of the second month of therapy, Tom had dramatically cut down his drinking to his target ideal drinking plan. By examining the external circumstances historically associated with heavy drinking in the past and identifying the internal feeling states and external triggers currently associated with drink thoughts and

urges, Tom developed an active plan to support himself in achieving his drinking goals. This plan included lifestyle changes that would support moderate drinking and alternative ways of addressing the painful issues.

Tom lacked opportunities for alcohol-free socializing, and this vacuum needed to be filled with alternative ways of meeting people. As Tom considered this problem, he recognized that his lack of social contact was, in part, avoidance motivated by a fear of being hurt and disappointed as he had been in the past. Tom recognized the value of social support for facilitating the changes he was making as well as giving him a context for tackling these fears. I suggested a group with a harm reduction orientation run by a colleague of mine. The group assisted attempts at moderation, helping

members to find out whether this was a viable option for them. Tom joined the group immediately. He was able to use the group effectively as a source of information and learned coping strategies used by other group members. The group served Tom as an interpersonal laboratory for working on the fears that kept him from socializing in his life.

As Tom monitored his drinking and witnessed related thoughts arising spontaneously, he was examining his feelings more now that he was drinking less. He clarified and separated the relationship between drinking and angry, depressed withdrawal at work and in relation to his art career. Tom realized how he had experienced a loss of support, first in the art world and gay community, and later at work, which was translated into withdrawal of support

from his sense of self. He witnessed that his passive-aggressive approach expressed by excessive drinking at inappropriate times compounded his deflated self-esteem.

I pointed out that this other-orientation was related to a childlike sense of himself as dependent on the encouragement of others and fearful of risking further loss or retaliation if he expressed himself in a powerful, autonomous way. The strength of our therapeutic alliance that had been built during the course of our work together enabled me to feel that I could risk making such a direct confrontation to Tom, and he accepted it in the helpful spirit in which I meant it. Tom thought about my comments and became interested in exploring the fearful fantasies that had kept him trapped in this powerless state. The museum might fire him for

making waves; he decided that if he couldn't get the support that he needed at work that he would never find a better job; if he tried to reinvigorate his career in the art world through writing, teaching, public speaking, and so forth, he would never be accepted by his peers. He was able to see that all of these concerns were unrealistic and more likely based on echoes of past relationships, mainly those with father and mother.

Tom's father had been a hard-working, uninvolved, distant man who died when Tom was in his early twenties. Tom felt like they never really knew one another. Tom said he always wished they had been closer and wondered whether he could have done more to make that happen. He could see how he had actively avoided conflict with his father in the

hope that they might be closer. On the other hand. Tom experienced his mother as too involved. She was always criticizing him and was very reactive to his successes and failures. With her, he always tried to perform perfectly to avoid her disapproval, yet he secretly resented the pressure and wished to be free of her. These relational binds set the stage for Tom's fragile self-esteem and later patterns of relating to others. Tom began to recognize how his drinking fit into these issues in several ways.

These insights seemed to reinvigorate Tom. He felt validated in his anger and sadness about his past losses and current difficulties at work yet felt optimistic about expressing himself in an active, assertive way. He made plans to present at a major international conference in his area of expertise, became re-energized in his work on

his book, and began to address problems at work. Eventually Tom went to his supervisors and spoke with them about his drinking problem, from his perspective, as he now identified it. He explained to them about his moderation goal and plan for maintaining the changes by addressing the other issues in his life. Over the next few months, Tom was able to get his associates' active support for his plan and began to bring ideas for new projects to them in a way that elicited their encouragement. This helped rebuild a sense of teamwork. Now Tom could see his own contribution to the old patterns of losing, and how his renewed participation could turn that around.

In the fifth month of treatment, Tom decided to attempt thirty days of abstinence from alcohol. This came from him with no direct

recommendation from me. He wanted to prove that he could do it, in part as a way to symbolically show the prior treatment program that they had been wrong about him. He had also become deeply interested in what he might learn about himself off alcohol when he was not doing it as a response to pressure from others or fear.

The thirty days went by in a rather uncomplicated way, although some very important work went on around the problem of how he might fill his time and what he might drink as alternatives to alcohol. He discovered several alcohol-free bars and became more active in the art world of gallery openings and other art-related events. After this period, he gradually reinstituted his drinking plan.

He told me about one minor “slip” that occurred a month later, about seven months into

the treatment. He had violated his two-drink limit by having four drinks in a two-hour period. As he described the situation, he was not upset because nothing inappropriate or risky had happened. He had internalized the value of examining his drinking to understand what fueled it and was eager to talk about it with me. He had been out at a bar to see the bartender who worked there. He was very attracted to the bartender although he knew nothing would happen between them; the man was in a monogamous relationship. In talking about the slip, it became clear that his drinking helped him entertain a fantasy about something between them and, at the same time, was a response to sadness that was evoked by his awareness that nothing could happen. The slip had been a useful doorway to important issues not yet fully

addressed in the therapy. This event brought the issue of Tom's intense wishes for sexual and romantic relationships into the therapy and the conflicting feelings that had kept him frustrated and lonely.

This issue was also revealed in two instances when Tom had come to sessions while somewhat intoxicated, once early on in the therapy and a second time close to the slip described above. In both instances, soon into the sessions, Tom mentioned that he had had two glasses of wine before coming. In the first instance, Tom said that he had wanted me to see him in that state. He was more spontaneous and lively than usual. I stated the obvious, that alcohol seemed to loosen him up, and said that I also wondered whether there were particular aspects of himself that he found easier to discuss

after having had something to drink. He giggled and said, "Absolutely! It has to do with sex. I don’t think I could have said that if I hadn’t been drinking." Our discussion revealed that his drinking had enabled him to bring up a subject that he had otherwise been too inhibited to discuss with me. It also led me to wonder whether he was aware of any conflict or anxiety about his sexual wishes. He denied feeling conflicted and the subject was dropped for a while.

It re-emerged during our discussion on the second occasion that he came to a session after drinking. Now, several months later, he was able to recognize that he had a whole set of uncomfortable concerns about talking about sex with me. Would I become uncomfortable and withdrawn or criticize him? Would we be able to

talk about sex and maintain our professional relationship, that is, not act out together sexually? He also began to recognize that he did feel some shame about his sexuality related to self-critical attitudes that he had not acknowledged as his own, instead projecting them onto others. This process had been reflected in his worries about my criticizing him. This exploration of his feelings about discussing his sexuality with me led to our looking at how these issues contributed to his avoidance of close personal relationships in his life that had the possibility of becoming romantic.

In the following months, Tom's drinking stabilized in the ideal pattern that he had envisioned for himself. His relationships at work continued to improve and his career seemed to open up again with opportunities for consulting

and the professional acceptance that he had longed for. He began to seek out social opportunities in his professional world as well as through gay organizations that held activities of interest to him. During this period, he began to widen his circle of friends and began to date.

At this point in the therapy, ten months into the work, Tom's drinking was no longer an active issue, although he was aware that he needed to be ever mindful of his vulnerability to fall back into his earlier patterns of drinking. We discussed a relapse prevention plan that included an identification of the emotional and lifestyle triggers that had been associated with heavy drinking in the past. We discussed specific cognitive and behavioral strategies for managing them in alcohol-free ways. For example, Tom had identified sexual frustration and loneliness

as two main precipitants of heavy drinking. However, the more important trigger seemed to be when he began to tell himself that it was hopeless for him to think that he could ever have a healthy, satisfying relationship and that the best he could hope for was whatever contact was available, regardless of how demeaning it was to his sense of self. Excessive alcohol use could then be justified as a necessary way of assuaging the feelings of shame and self-degradation accompanying these pursuits. Anticipating these feelings and depressing thoughts as heavy drinking triggers enabled Tom to come up with an alternative way of thinking about his loneliness and frustration when it arose. He discovered means to tolerate these feelings while he developed the social skills and socializing opportunities necessary for him to meet an

appropriate partner. He would also actively affirm to himself the actual steps that he had taken and progress that he had made toward successfully meeting these needs in his life. The plan contained specific goals for continuing to modify his lifestyle in ways that would further support moderate drinking. It continued therapeutic work on the self-esteem and relationship issues that kept him vulnerable to relapsing to his earlier problem drinking.

Outcome

Because the focus on alcohol receded into the background at this point, I will end the detailed description of Tom's treatment here. The treatment is still alive and productive at the time of this writing. During this period, he has generally maintained his moderate drinking with a few minor slips similar to those discussed

previously. These occurred around emotionally charged interpersonal situations and were used as opportunities for further learning that deepened Tom’s work in therapy. The central focus of therapy has been on strengthening Tom’s ability to maintain his self-esteem in more autonomous ways. He thinks differently about these insecurities and is able to take constructive actions in the world that give him direct feedback about his value as a person. A related focus has been on working through the threatening fears and fantasies that have kept Tom from freely expressing his emotional needs in relationships. Therapy has helped Tom to feel more confident about and successful at pursuing satisfying relationships in his life. During this period his depression has not returned.

Tom has demonstrated an ability to cope without alcohol with many challenging situations that had been triggers for excessive drinking in the past. These strategies have become familiar tools in his repertoire of coping skills. This, in conjunction with his awareness of his emotional vulnerabilities and continuing commitment to his emotional growth, suggest a very good prognosis for the future.

Commentary

Tom's case is representative of the experience of many problem drinkers in several important ways. Many are coerced into unnecessary, expensive, and inappropriate abstinence-oriented treatments. Tom's experience of being unnecessarily "intervened" at work and coerced into treatment are

unfortunately very common. These dangerous tendencies reflect society's attitudes toward problem drinkers and other drug users. These attitudes inform typical treatment approaches available for these clients. This often results in a jump to the kind of drastic intervention that Tom experienced, which may actually increase a potential client's unwillingness to work on the substance problem.

Secondly, his experience reflects a tendency to lump all excessive substance use in the category of addiction with the generally accompanying assumption that abstinence is the only acceptable goal. Tom's first treatment experience did not allow for an open discussion of moderation of his drinking as an alternative goal to be considered. As a result, he had no way to explore in depth whether this might be

possible for him and to learn the necessary skills to seriously attempt this change in drinking behavior. The overwhelming majority of all forms of substance use treatment and training programs in this country require that participants begin with a willingness to work toward complete abstinence as the only acceptable goal. These limitations in thinking and treatment options prevent many people, like Tom, who wish to explore the moderation option, from getting the support that they need to see whether this is possible for them. This lack of appropriate treatment may set people up to intensify their substance use because the actual problems do not get addressed. They become compounded by feelings of resentment, frustration, and anxiety caused by the negative messages given to them. That experience, as in Tom's case, can

exacerbate the issues related to the problem drinking, contribute to intensified drinking, and set up both client and clinician to fail. This problem may explain much of the failure reported by the substance use treatment field.

By beginning with an attempt to join with the client around his or her view of the problem and desired goals, the harm reduction approach has a better chance of creating a therapeutic atmosphere of safety in which the client can begin to meaningfully address the drinking *where the client is ready to begin*.

With Tom, this approach did lead to a strong alliance early on in the treatment, which supported him in achieving his goal of moderating his drinking while successfully addressing the depression, self-esteem problems, conflicts about constructively expressing anger,

and other relational needs, as well as the lifestyle deficits that needed to be modified to support continued moderate drinking.

Tom is representative of many problem drinkers whose drinking is secondary to powerful emotional issues driving the heavy use of alcohol. Many, like Tom, have the motivation and psychological-mindedness necessary for making good use of psychotherapy while successfully moderating their drinking. Many others recognize through their attempt at moderating their drinking that this is a practical impossibility and become more willing to accept abstinence as the most reasonable goal for themselves. The context created by this approach allows this awareness to arise from an examination by the client of his own direct

experience rather than from the judgment of someone else.

The approach described and illustrated here is an example of harm reduction psychotherapy for active substance users that is based on an integration of psychodynamic and social learning theories in its understanding of substance use problems and in the combining of cognitive and behavioral self-management strategies with psychodynamic interventions in the treatment process. The case illustration demonstrated its effectiveness in helping a client whose excessive drinking was secondary to depression achieve stable moderation of drinking while addressing a range of other emotional and lifestyle issues related to the drinking problem. This approach is also effective with clients whose ultimate goal is

abstinence, as both the initial choice of goals and the outcome of the therapy emerge out of a therapeutic process that clarifies what is ideal for each individual rather than being prescribed in advance by the clinician.

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Harm Reduction Resources

PSYCHOTHERAPY AND COUNSELING SERVICES

Addiction Alternatives

Marc Kern, Ph.D., Executive Director
Los Angeles, California
phone: 310-275-5433
www.AddictionAlternatives.com
E-mail habitdoc@msn.com

Individual and group therapy using harm reduction psychotherapy, consultation, and training. Moderation Management and Smart Recovery meetings available to the public.

Addiction Treatment Alternatives

423 Gough Street San Francisco, CA 94102
445 Bellevue Ave. Oakland, CA 94610
Patt Denning, Ph.D., Director
phone: 415-252-0669
www.addictiontreatmentalternatives.org

Individual and group therapy using Harm Reduction Psychotherapy, consultation, and training.

Behavior Therapy Associates

3810 Osuna Rd. NE Ste. 1 Albuquerque, NM 87109
Reid Hester, Ph.D., Director
phone: 505-345-6100 fax: 505-342-2454
www.behaviortherapy.com
E-mail rhester@ behaviortherapy.com

Behavior Therapy Associates is an organization of psychologists providing scientifically based treatments to individuals, training and consultation to treatment providers, and clinical research in substance abuse problems. We have developed moderation training software and are currently evaluating the efficacy of a computer based brief motivational intervention, the Drinker's Check-up (DCU). The DCU is designed to help individuals look at their

drinking, get objective feedback, and decide whether or not to change.

The Harm Reduction Psychotherapy and Training Associates (HRPTA)
Andrew Tatarsky, Ph.D. Co-director
31 West 11th Street. #6D
New York, NY 10011
phone: 212-633-8157
Mark Sehl, Ph.D. Co-director
59 West 9th Street
New York, NY 10011
phone: 212-228-3467
www.harmreductioncounseling.com
E-mail info@ harmreductioncounseling.com.

HRPTA helps potential clients find appropriate therapists who are selected by HRPTA based on their harm reduction approach to psychotherapy and substance use. HRPTA also offers education and training in harm reduction to professionals, paraprofessionals, and community organizations.

The Harm Reduction Therapy Center (HRTC)
Jeannie Little, LCSW, Executive Director

Patt Denning, Ph.D., Director of Clinical Services and Research
423 Gough Street San Francisco, CA 94102
phone: 415-863-4282
www.harmreductiontherapy.org

A new, nonprofit agency that will provide low fee individual and group alternative treatments as well as train mental health and chemical dependence professionals in Harm Reduction Psychotherapy. Projected opening: May, 2002. Currently in the fundraising stage of development.

Practical Recovery Services

A. Thomas Horvath, Ph.D., President
8950 Villa La Jolla Drive, Suite 1130 La Jolla, CA 92037-1705
phone: 858-453-4777 (4PRS) fax: 858-455-0141
www.practicalrecovery.com
E-mail info@ practicalrecovery.com

AA not for you? We offer an alternative to traditional addiction treatment. The core of our program is customized, intensive, individual psychotherapy to address fundamental issues such as motivation, problem-solving, lifestyle balance, identity, self- control, connecting to others, strength in adversity, and goals and meaning in life. Groups available. Family sessions available, in person or by phone. Our addiction services are described in *Sex, Drugs, Gambling, and Chocolate: A Workbook for Overcoming Addictions,* by A. T. Horvath, Ph.D. (outline and Chapter One at www.practicalrecovery.com). Moderation or abstinence plans (your choice). Referral available for the entire range of adjunct services (medical, wholistic health, dietary, spa, exercise, etc.). Clients from out of town stay in hotels and

walk/drive to our offices daily. Psychiatric admission or inpatient detoxification is available if needed.

Stanton Peele, Ph.D.
27 West Lake Blvd. Morristown. NJ 07960
phone: 973-538-0430
E-mail speele@earthlink.net
www.peele.net

Stanton Peele is unique in combining a long career as a harm reduction therapist—he defended controlled-drinking therapy when to do so was to endanger one's career—with a more recent one as an attorney who defends against misdiagnoses of alcoholism and coercion into 12-step programs. The Stanton Peele Addiction website is one of the most invaluable resources available in identifying the problems of traditional therapy for substance abuse, presenting alternative techniques, and

guaranteeing the right to choose between them. Stanton lives and works in New Jersey, but also is a member of the New York Bar.

HARM REDUCTION CENTERS

Chicago Recovery Alliance

Dan Bigg
PO Box 368069 Chicago. IL 60636-8069
phone: 773-471-0999 pager: 312-797-2223
www.anypositivechange.org
E-mail cra@ mcs.net

Chicago Recovery Alliance operates: 21 sites of Harm Reduction Outreach with syringe exchange, three sites of storefront-based exchange, and five areas of cell phone and pager access to sterile syringes. There is also an overdose management training program to empower drug users, especially opiate injectors to successfully avoid and cope with overdose situations. This program incorporates the

medically appropriate use of naloxone as an opiate overdose antidote. We have developed a pictorial guide to safer injection and better vein care for cross-cultural utilization in harm reduction programs around the world. This program addresses specific injection practices which can greatly reduce infections/disease, tissue damage, and scarring. We also conduct educational sessions on various aspects of Harm Reduction for diverse audiences (physicians and addiction treatment staff to drug users and the general public). Conducting and/or cooperating with various research projects studying the effectiveness of Harm Reduction outreach with syringe exchange or utilizing the attractiveness of Harm Reduction outreach to study other drug-related issues. Current or planned research projects include collaboration with the Chemical

Dependency Institute of Beth Israel Medical Center, Yale University School of Medicine, Loyola University, and DePaul University. CRA believes “Recovery Is Any Positive Change.”

CitiWide Harm Reduction, Inc.

Executive Director: Daliah Heller, MPH
226 East 144th Street, 3rd Floor Bronx, NY 10451
phone: 718-292-7718 fax: 718-292-0500
E-mail: citiwidehr@aol.com

CitiWide Harm Reduction challenges the stigmatization of drug use, homelessness, and HIV within the larger context of society through tireless advocacy as we build partnership and community among homeless People with AIDS. We are an inclusive, cooperative community committed to innovating quality harm reduction models and proactive strategies that promote awareness, education, acceptance, and self-empowerment.

Home delivery services at Single Room Occupancy (SRO) hotels include: Syringe exchange: Toiletries: First aid supplies; Referrals: HIV primary care; and Transportation to our drop-in center. At our drop-in center, participants are invited to access: Coffee; Couches; Clothing; Comfort; Mental wellness counseling; Case management, referrals, and service coordination; Psychiatric care; Acupuncture; Massage; Educational and cultural forums; Support groups; More syringe exchange; More transportation; Hot meals; Showers; Peer education and training; and Advocacy and other volunteer opportunities.

The Lower East Side Harm Reduction Center

Drew Kramer, Executive Director
25 Allen Street New York, NY
phone: 212-228-7734

Full service harm reduction center offering syringe exchange, coffee, couches, comfort, mental health counseling, case management, referrals to drug treatment, acupuncture detox, support groups, peer education and training, advocacy, and volunteer opportunities.

New York Harm Reduction Educators, Inc.

Vanessa Brown, Deputy Director
903 Dawson Street Bronx, NY 10459
phone: 718-842-6050 fax: 718-842-7001
www.nyhre.org

Founded in 1990 by AIDS activists and injection drug users as an underground exchange program, NYHRE is now the largest harm reduction/syringe exchange program in New York City, providing services at six street-side service delivery sites in six zip codes throughout the South Bronx and Harlem. It is one of the six

largest programs in the nation, and the largest documented program in the nation.

The program provides the following; outreach services, harm reduction services, supportive services, and stress reduction. Mental health services provided are; sidewalk psychotherapy, one-on-one counseling, substance user counseling, and group psychotherapy.

Positive Health Project, Inc.

Jason Farrel, Executive Director
301 West 37th Street, 2nd Floor New York, NY 10018
phone: 212-465-8304 fax: 212-465-8306
www.positivehealthproject.org

Founded in 1993, Positive Health Project's (PHP) primary mission is to reduce the spread of HIV and other life-threatening infections by providing a range of health and prevention

services to a traditionally underserved population: people who engage in behavior known to cause HIV and other infections, including injection drug use and high-risk sexual behavior. As a harm reduction agency, PHP does not make its services contingent upon abstinence from drugs. Instead, they work with substance users “where they’re at” on the continuum of addiction and recovery. PHP links harm reduction, recovery readiness, and relapse prevention into a cohesive, continuous model of service delivery through its redefinition of recovery and its focus on peer-driven support. PHP also advocates for the needs of substance users and for those who are HIV-positive, while providing a safe environment in which to obtain and develop skills in accessing services. Additionally, PHP serves as a bridge to other

services, such as detoxification, drug treatment, health care, housing, and education.

St. Ann's Corner of Harm Reduction (SACHR)

Joyce Rivera, Executive Director
Cypress Ave., Bronx, NY 10459
phone: 718-585-5544 fax: 718-585-8314
E-mail sachr@ aol.com

SACHR is a culturally diverse, community based outreach agency committed to reducing the spread of HIV among injecting drug users, their partners, and family members. SACHR works to minimize the potential for harm associated with unsafe drug use and unprotected sex. SACHR recognizes that there is a continuum of levels of drug use that lead to a continuum of harm; accordingly we work at developing a continuum of intervention levels for both the individual and the community.

SACHR is grass-roots and community based. We're located on Cypress Ave., situated above a group of shops. SACHR has been operational for over eleven years. The program is open Tuesday through Saturday. We provide a range of services within a harm reduction model. Some of the services that are offered are: a community gathering space, prevention case management, bodywork/massages, ear and full-body acupuncture, counseling, homemade lunch, referrals, HIV counseling and testing, showers and hygiene kits, syringe exchange, condoms, dental dams, bleach kits, health and community education workshops. Syringe exchange is conducted both indoors and at outdoor locations. The program is grant-funded and charges no fees to clients. All are eligible to participate. Particular attention is given to the special needs

of drug users, the homeless, people living with HIV/AIDS, and sex workers. We welcome diversity.

The Streetwork Project of Safe Horizon

Senior Director: Angela Amel
Site Director (Midtown): David Nish,
Assistant Director (Midtown): Ines Robledo
Site Director (LES): Stacey Rubin.
545 Eighth Avenue (between 37th and 38th streets),22nd Floor New York, NY 10018
phone: 212-695-2220
33 Essex Street New York, NY
phone: 646-602-6404

The Streetwork Project of Safe Horizon was created in 1984 in response to the growing number of homeless and disenfranchised youth in the Times Square area. We offer the young people we work with respite from hunger, cold, loneliness, and fear, as well as the opportunity to reclaim for themselves a sense of dignity and self-worth.

Streetwork Project is grounded in a Harm Reduction philosophy that focuses on building trust and fostering self-esteem, empowering youth to change their high-risk behaviors. Our long-range goal is to help these young people find permanent housing and employment. Last year, 1,302 homeless youth visited the Streetwork Drop-In Center and over 4,000 youth were contacted on their own turf by our outreach workers.

We offer the following services to youth up to age 22: Showers, food, medical and legal services, HIV/AIDS counseling, laundry/ clean clothes, and needle exchange. We also provide individual and group counseling in a nonjudgmental manner. Wellness activities such as meditation, acupuncture, and nutritional counseling are also provided.

MUTUAL HELP SUPPORT GROUP

Moderation Management Network Inc.

C/O HRC
22 West 27th Street New York, NY 10001
www.moderation.org
phone: 212-871-0974

Moderation Management (MM) is a behavioral change program and national support group network for people who have made the healthy decision to address a drinking problem, and make other positive lifestyle changes. MM empowers individuals to accept personal responsibility for choosing and maintaining their own path, whether moderation or abstinence.

HARM REDUCTION INFORMATION, DRUG POLICY, AND COMMUNITY ORGANIZING

Addictive Behaviors Research Center

University of Washington, Seattle
Alan Marlatt, Ph.D., Director
phone: 206-685-1395

The University of Washington, Department of Psychology, established the Addictive Behaviors Research Center in 1981. Our primary mission is to provide research, training, and evaluation in the development and dissemination of interventions to prevent and treat addictive behaviors. In pursuing this mission, we are guided by the following principles:

- Our approach reflects a commitment to evidence-based practices designed to reduce harm and promote health.
- We recognize the commonalities among addictive behaviors as well as the diversity of individuals who engage in these behaviors.
- We are dedicated to increasing our awareness and sensitivity toward sociocultural issues and to bridging boundaries that traditionally separate the university from the surrounding community.

Will send selection of articles on harm reduction.

Harm Reduction Coalition

New York Office:
Allan Clear, Executive Director
22 West 27th Street, 5th floor New York, NY 10001
Phone: 212-213-6376 Fax: 212-213-6582
E-mail: clear@ harmreduction.org
Oakland Office:
Marla Chavez-King, Regional Director
3223 Lakeshore Avenue Oakland. CA 94610
Phone: 510-444-6969 Fax: 510-444-6977
E-mail: chavez-king@ harmreduction.org
http://www.harmreduction.org/

The Harm Reduction Coalition (HRC), a national organization promoting strategies for reducing the harm related to drug use and sexual behavior. HRC began in 1993 in Oakland, California as a working group of leading syringe exchange providers and advocates from around the country seeking to define the principles and

newly emerging methods for working with the drug- using members of their communities. In 1994, the Working Group was incorporated in California as a 501©(3) nonprofit organization under the name Harm Reduction Coalition. Along with its Bay Area office. HRC opened a New York City office in 1995.

HRC is committed to reducing drug-related harm among individuals and communities by promoting regional and national harm reduction education and community organizing. HRC fosters alternative models to conventional health and human services and drug treatment, challenges traditional client/provider relationships, and provides resources and support to health professionals and drug users in their communities to address drug-related harm. HRC believes in every individual's right to

health and well-being as well as in their competency to protect and help themselves, their loved ones, and their communities.

HRC promoted change through the following national programs:

1. The Harm Reduction Training Institute— In 1993, with seed money from the Open Society Institute, HRC created the only national harm reduction training curriculum. Since then, it has offered hundreds of courses and in- service trainings in 20 states.

2. Community Organizing— HRC provides unique resources and technical support to organizations and regional coalitions seeking to support community health and wellbeing through harm reduction.

3. Bilingual Educational Publications— HRC creates, designs, publishes, and disseminates state-of-the-art information on harm reduction, as well as current

information on regional and national activities, in our brochures, manuals, and newsletters, and on our website. These publications are also available in Spanish.

4. Regional and National Conferences— HRC hosts the only national conference on harm reduction. HRC's third national conference, "Communities Respond to Drug Related Harm: AIDS, Hepatitis, Prison, Overdose and Beyond," was held in Miami, October 22-25, 2000. Attended by over one thousand, this was the largest-ever single gathering of harm reduction advocates, and offered over 200 presentations by speakers from the United States, Canada, South America, Asia, Africa, and Europe. In the last four years, HRC has also hosted eleven regional conferences, held in San Francisco, New York, Denver, Atlanta, Seattle, Green Bay, and Chicago.

Lindesmith—Drug Policy Foundation

Ethan Nadelman, Executive Director
925 Ninth Avenue New York, NY 10019
phone: 212-548-0695

Glenn Backes Director, Health and Harm Reduction
1225 Eighth Avenue, Suite 570 Sacramento, CA 95814
phone: 916-444-3751
www.drugpolicy.org
E-mail nyc@drugpolicy.org.

Lindesmith—Drug Policy Foundation is an activist thinktank working in the United States and abroad to advance drug policy reform through public education, public servant education, research, publishing, conferences, trainings, and media awareness. Lindesmith-DPF is working with other organizations toward a public policy regarding drugs based on harm reduction, a policy that seeks to reduce the negative consequences associated with drug use and drug prohibition.

Just Say “No More Drug War!” Join TLC-DPF Today.

PROFESSIONAL ASSOCIATION

Mental Health Professionals in Harm Reduction

Andrew Tatarsky, Ph.D., Chairperson
c/o Harm Reduction Coalition
22 West 27th Street New York, NY 10001
phone: 212-633-8157
E-mail: Atatarsky@aol.com

An organization of case managers, front-line workers, counselors, and other mental health and substance use professionals committed to articulating and promoting the clinical application of harm reduction. Since 1995, through regular meetings, workshops, and conferences, we have provided a forum for this discussion and peer supervision and support for the clinical harm reduction work.

About the Author

Andrew Tatarsky, Ph.D. holds a doctorate in clinical psychology from the City University of New York. He has a private practice in New York City specializing in harm reduction psychotherapy with drug and alcohol users and he is co-director, with Dr. Mark Sehl, of the Harm Reduction Psychotherapy and Training Associates, a treatment and training organization. His perspective on the treatment of substance use problems has evolved over twenty years of experience working in the area as psychotherapist, supervisor, program director, teacher, and public speaker. Dr. Tatarsky has presented widely in the area of substance use and harm reduction. He has taught at The New School University, The City University of New

York, and the Alcoholism Council of New York. He has directed outpatient substance use treatment programs at the Washton Institute on Addictions, the University of Medicine and Dentistry of New Jersey, the DiMele Center for Psychotherapy and Counseling, and the Division of Drug Abuse Research and Treatment of the New York Medical College. He is a founding member and past president of the Addiction Division of the New York State Psychological Association and chairperson of Mental Health Professionals in Harm Reduction, a professional training and support group. His publications include: “An integrative approach to harm reduction psychology: A case of problem drinking second to depression." In *Session: Psychotherapy in Practice,* 4: 9-24 (1998); “Harm reduction in clinical practice with active

substance users." *The Addictions Newsletter,* the American Psychologist Association, issue 50, 5 (3): 4-5 (Summer 1998); and “Harm reduction psychotherapy with active substance users." *Harm Reduction Communication,* 6: 33-37 (Spring 1998). E-mail: Atatarsky@ aol.com