State of the Art in Harm Reduction Psychotherapy: An Emerging Treatment for Substance Misuse

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Harm reduction psychotherapy is an exciting and emerging treatment for a broad spectrum of substance use problems. This article introduces an issue of the *Journal of Clinical Psychology*: *In Session* devoted to the state of the art of harm reduction psychotherapy. We describe the harm reduction paradigm, the context for and history of the development of harm reduction psychotherapy, and its clinical principles. We then outline and frame the contributions to the issue. Our goal is that this issue will encourage psychotherapists to employ more harm reduction principles in practice and will provide many evidence-based methods to do so. © 2010 Wiley Periodicals, Inc. J Clin Psychol: In Session 66: 117–122, 2010.

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Harm reduction, a framework for addressing substance use and other potentially risky behaviors, aims to reduce the harmful consequences of these behaviors without requiring abstinence as a goal or a prerequisite of treatment. It is an alternative to traditional treatments that require abstinence and extends the reach of treatment to substance users who are unwilling or unable to embrace abstinence. We believe this is the majority of substance users.

Harm reduction has been called "compassionate pragmatism" (Marlatt, 1998) because it begins with the pragmatic acceptance that people are and will use drugs in ways that pose threats to themselves and their communities. Its compassionate and understanding view of these users allows for collaboration between consumers and professionals, which creates effective interventions. Harm reduction has a human rights agenda in that it is committed to bringing effective treatment to marginalized

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groups that have traditionally been denied quality care. It is scientific in that it is committed to discovering and implementing interventions that are empirically supported. We believe that harm reduction is riding the crest of a global paradigm shift in our understanding of drug users, drug problems, how these problems change, and how clinicians can help facilitate these changes.

Harm reduction is most widely applied globally as public health interventions designed to help substances users stay alive and healthy. The best known of these are needle exchange programs, whose goals include the prevention of HIV transmission and other blood-borne infectious diseases, as well as overdose prevention, including naloxone distribution and opiate substitution treatment.

Harm reduction psychotherapy applies the principles and methods of harm reduction to the practice of psychotherapy specifically. This journal issue is devoted to disseminating and illustrating the state of the art of harm reduction psychotherapy and features contributions by many of the innovators of harm reduction psychotherapy. Our hope is that this issue will encourage psychotherapists to employ more harm reduction principles in practice and will provide many evidence-based methods to do so.

In this brief introductory article, we provide a brief history of harm reduction psychotherapy, outline its clinical principles, and then overview the subsequent articles in this issue.

Brief History of Harm Reduction Psychotherapy

The heart of the problem is that traditional treatment continues to attract and fully help only a small fraction of problem substance users. Data from 2007 reveal there are 22.2 million people in the United States with substance abuse or dependence diagnoses, but only about 2 million are treated annually. A survey of ''treatment as usual'' outcomes from contingency management studies (Kellogg, 2007) found that only 15%–35% of patients were still in treatment at 12 weeks and substance-free urine samples were below 40%. Thus, the overwhelming majority of problem users are not being attracted, retained, or effectively helped, if we use abstinence as the measure of success.

Many, if not most, substance users are unable or unwilling to embrace abstinence for a variety of reasons. Some data suggest that many substance users avoid seeking help altogether because they do not have life-long abstinence as their objective (Rotgers, 1996). According to one survey, abstinence is the only treatment goal offered by 75% of drug and alcohol treatment programs in the United States (Roman & Johnson, 2009). Many problem substance users are concerned about their use, but they want to attempt to moderate it or get it under control before they consider stopping altogether. By accepting goals other than abstinence as reasonable starting places for treatment, harm reduction opens the door to this group of people in a way that traditional abstinence-oriented approaches cannot.

Perhaps out of a concern that it represented a form of denial or grandiosity, traditional addiction treatments were unsympathetic or even hostile toward patients' claims that their experiences were different than others. Such antitherapeutic statements as ''addicts suffer from the disease of terminal uniqueness'' have epitomized this. Harm reduction psychotherapy, in contrast, is based on a deep appreciation for the uniqueness of each patient's journey.

Substance misusers are a diverse group who vary widely in almost every possible way: severity of substance use, goals regarding substance use (e.g., safer methods of

using, moderation, or abstinence), motivation and readiness to change (Prochaska, DiClemente, & Norcross, 1992), psychiatric status (Carey & Carey, 1990), personality strengths and vulnerabilities (Khantzian, 1985, 1986), and socioeconomic variables. This diversity suggests the need for a flexible, inclusive, and comprehensive treatment that can address the myriad needs and desires of this diverse group of people.

Harm reduction first emerged in Amsterdam, Holland and Mersyside, England in the 1970s and 1980s as a response to rapid increases in illicit drug use in those cities and the limited success of traditional abstinence-based treatments to engage, retain, and help the majority of those users. The door was opened to public health harm reduction in the United States in the midst of the HIV/AID epidemic as American practitioners and the government recognized the need for nonabstinence-oriented interventions to stop the spread of HIV to intravenous drug users and the community at large.

The development of harm reduction psychotherapy has been a uniquely American phenomenon. Alan Marlatt and Edith Springer are credited as two of the trailblazers who visited Europe in the early 1990s and introduced harm reduction to the United States. It was on this soil that a number of psychotherapists from a variety of theoretical orientations and professional disciplines began integrating harm reduction into their work. The result of these efforts was the creation of harm reduction psychotherapy.

Harm reduction psychotherapy is now formally 12 years old. It was named as such (Tatarsky, 1998), fittingly, in an issue of the *Journal of Clinical Psychology*: *In Session*, and edited by one of the current editors, Marlatt, and contributed to by three of the contributors to this issue, Denning, Rothschild, and Tatarsky. Tatarsky (1998, p. 11) defined harm reduction psychotherapy as "psychological interventions that seek to reduce the harm associated with active substance use without having abstinence as the initial goal." This definition brought together many nonabstinence-based interventions that existed before and constitute the prehistory of harm reduction psychotherapy (e.g., Sobell & Sobell, 1973; Miller & Marlatt, 1984; Peele & Brodsky, 1992; Hester, 1989).

On the global level, harm reduction is now part of the national drug control policy of most developed and many developing nations. Harm reduction primarily takes the form of public health interventions in these countries, but there is a growing recognition of the need to facilitate the delivery of public health interventions with harm reduction psychotherapy. Despite long-standing governmental opposition to harm reduction in the United States, there are now a number of ongoing developments that support the spread of harm reduction and harm reduction psychotherapy, as follows: (a) an increased interest in treating drug users rather than incarcerating them; (b) a growing recognition that substance use problems often exist in the context of serious cooccurring psychiatric, medical, and social problems; (c) an escalating promotion of "evidence-based" practice rather than the traditional favoring of ideological treatments; and (d) a new administration that has pledged to support science over ideology regarding the treatment of substance use disorders. The latter is reflected in the selection of A. Thomas McLellan, PhD, as Deputy Director of the White House's Office of National Drug Control Policy.

We believe that these political and professional developments will result in a growing embrace of harm reduction psychotherapy. In fact, over the last 5 years, we have witnessed an increased interest in harm reduction psychotherapy in the United States and around the world. Harm reduction psychotherapy has developed into a distinct wing of the harm reduction movement and is gaining increasing acceptance in the addiction treatment community.

Clinical Principles of Harm Reduction Psychotherapy

The clinical principles of harm reduction psychotherapy constitute a new paradigm or set of assumptions about drug users and their treatment. The principles provide a clinical lens in which to see the patient, create the treatment relationship, and guide the selection of interventions. They also serve as a clinical framework that can guide the delivery of other interventions and modalities. A dozen of such clinical principles are as follows.

1. *Substance use problems are best understood and addressed in the context of the whole person in her social environment.*
2. *Meet the client as an individual.* People with substance use problems vary widely on every psychosocial variable; thus, each substance user must be recognized as a unique person with a unique blend of strengths, vulnerabilities, and needs.
3. *The client has strengths that can be supported.*
4. *Challenge stigmatization.* Substance users are commonly subjected to negative, devalued, and dehumanized images. These frequently include beliefs such as "addicts" are weak, manipulative, criminals, exploitative, lazy, and liars. This is problematic in a number of ways. First, the concepts of addiction and "addict" are loaded with assumptions (i.e., permanence, progressive, terminal) that are not necessarily borne out by data and experience. Second, the qualities frequently attributed to these concepts may apply to some substance users but certainly do not apply to all.
5. *Substances are used for adaptive reasons.* Serious substance users often, if not usually, use substances in the service of adaptation, such as coping with challenging inner or outer circumstances.
6. *Drug use falls on a continuum of harmful consequences.* Substance use varies along a continuum of severity from relatively safe to imminently life-threatening.
7. *Not holding abstinence (or any other preconceived notions) as a precondition of the therapy before really getting to know the individual.*
8. *Engagement in treatment is the primary goal.* Many clients are lost in the initial engagement phase of treatment due to failures to respect and empathize with their concerns and problem definitions. By accepting the client's definition of the problem as the necessary starting point, harm reduction seeks to join with that which motivates the client to seek help, meet the client's need and, facilitates a positive treatment alliance. For example, exchanging a clean syringe for a used one may be the beginning of a positive relationship with helping professionals for many disenfranchised substance users.
9. *Start where the patient is.* Interventions that are relevant to the entire spectrum of substance users can be designed to literally begin where a patient is geographically and in terms of his or her motivation, goals, strengths, values, culture, and social group.
10. *Look for and mobilize the client's strengths in service of change.* Harm reduction assumes that many substance users have strengths and motivations that can be enlisted in the service of positive change at every point.
11. *Developing a collaborative, empowering relationship with the client.* Professionals and consumers must collaborate in negotiating goals, strategies, and treatments. This principle redefines the nature of authority in psychotherapy from a top-down model to one that is more equal. Inherent in this principle is the assumption that clients may have a clear understanding of what they need.

12. *Goals and strategies emerge from the therapeutic process*. The patient's needs, motivations, goals, and strengths will dictate the focus of the therapy. The therapist's challenge is to create a space in which both patient and therapist collaborate in the exploration of not only what the patient needs, but also how the therapist can best use herself in ways that support the patient's positive change.

These umbrella concepts link the full range of interventions matched to the range of patients. Psychotherapists can use these principles to work in ways that suit their theoretical orientation and clinical style in pursuing all of the therapy tasks, such as cultivating the alliance, making the assessment, setting the goals, and working toward change.

This Issue

This issue of the *Journal of Clinical Psychology*: *In Session* explores harm reduction psychotherapy from many vantage points and gives practitioners examples and evidence-based methods of harm reduction psychotherapy applications in a variety of clinical setting and a multitude of different populations. Each article provides a case illustration.

Following this introduction, Tatarsky and Kellogg describe their approach to harm reduction psychotherapy, integrative harm reduction psychotherapy. The article describes a harm reduction treatment that integrates biological, psychoanalytic, cognitive-behavioral, and humanistic therapies. They show how the flexibility of this approach and its emphasis on a negotiated, collaborative therapeutic relationship make it applicable to the broad spectrum of patients suffering from substance abuse. The approach is illustrated by the treatment of a woman who with life-threatening substance use and a history of multiple trauma and depression came to treatment with a goal of alcohol moderation.

Next, Rothschild explores the intersection between harm reduction psychotherapy and relational psychoanalysis. The article describes how the recent advents of harm reduction in substance abuse and the relational orientation in psychoanalysis have brought the two traditions closer together. Her article illustrates the effective integration of these approaches in the treatment of a woman with a long history of serious drinking who had the goal of moderating her drinking.

Whiteside, Cronce, Pedersen, and Larimer describe new developments and research on brief motivational harm reduction interventions for college students and adolescents. Their article discusses why harm reduction interventions are particularly appealing to young people and reviews research that demonstrates its efficacy. They provide a case illustration of a heavy-drinking college student who was treated successfully with the Brief Alcohol Screening and Intervention for College Students.

Denning presents a new model for working with families and friends of drug users using harm reduction principles. The model involves learning decision-making processes based on self-care and love for the substance abuser. Denning applies the model to a long-term family therapy group and two family consultations.

Little and Franskoviak present their work bringing harm reduction psychotherapy into community-based settings, such as drop-in centers, community centers, housing with colocated support services, food pantries, and employment resource centers. The article highlights the particular ways in which harm reduction therapy has been adapted to attract and engage substance users in treatment who have been considered untreatable by most program settings and providers.

Blume and Lovato describe and illustrate the use of harm reduction psychotherapy with minority clients. They conceptualize both the entire community and the actual client as the client. This view leads to a deep sense of responsibility to serve the best interests of client and community simultaneously through harm reduction. It also acknowledges the more collectivistic worldview of many ethnic minority clients.

Finally, Logan, and Marlatt summarize the growing body of empirical research on harm reduction psychotherapy with an eye toward implications for clinical practice. Their review describes the empirical support for the spectrum of harm reduction psychotherapy applications for youth, college students, and adults as well as for nicotine replacement, opioid substitution, syringe exchange, and safe injection sites.

Each of these articles describe trailblazing work at the cutting edge of harm reduction psychotherapy and substance use treatment. We trust that upon reading them you will be inspired and encouraged to explore this new treatment in more depth.

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