

# Harm Reduction Model: A Practical Review

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## Learning Objectives

Upon completion, you will be better able to:

1. Describe the main principles of harm reduction.
2. Identify 3-5 risk factors that predict the development of a substance use disorder.
3. Explain 3 therapeutic tasks associated with harm reduction psychotherapy.

This presentation is divided into 3 sections:

- Section I: Pathophysiology and Diagnostic Criteria
- Section II: Clinical Presentations and Assessment
  - Section III: Management Plan

## Introduction

Harm reduction originated in Europe in the 1970s as a public health approach to addressing drug and alcohol misuse.<sup>1</sup> Harm reduction is described as a compassionate and pragmatic way to reduce the harms associated with drug and alcohol misuse<sup>2</sup>. Examples of public health harm reduction interventions include psychoeducation campaigns about the risks of drinking and driving, providing injection drug users access to sterile syringes to reduce HIV transmission rates and naloxone kits to prevent overdose. Harm reductionists acknowledge the reality that people do “and will” continue to use substances, and interventions should be tailored to their specific needs rather than focusing on mandating abstinence or penalizing people for their substance use.<sup>2,3</sup>

Harm reduction has also evolved into a psychotherapy model that embraces client-centered and motivational treatment approaches. Harm reduction therapy emphasizes building a collaborative, supportive, and empowering relationship between clinician and client so that treatment is organized around reducing risk and promoting safe use practices by working with individuals’ needs,

goals, and providing strategies to help them reach their goals. First and foremost is a focus on reducing immediate risk to help people manage their drug and alcohol use, which sets the stage for stabilizing their psychosocial functioning and improving their quality of life.<sup>4</sup> Abstinence is one of many possible goals and outcomes of harm reduction therapy, but it is not seen as the only way to recover and heal as the disease model discussed below advocates.

Harm reduction is a contrast to the disease model, which stresses that a substance use disorder (SUD) is a “primary disease” with no cure and that views psychosocial deficits, and denial and loss of control as central symptoms. The disease model focuses on the progressive nature of SUDs and emphasizes recovery as a lifelong process attained through lifelong abstinence from all psychoactive substances and through working the 12 steps to establish a healthier relationship to one’s “higher power”. Approximately 90% of all drug and alcohol treatment centers in the United States utilize the disease model along with the 12 steps of AA (Peele et al. as cited in Denning & Little, 2012).

While there are tremendous benefits to the free, 24/7 availability of 12 step self-help programs that have saved millions of lives, people need to be provided with options if they don't resonate with an abstinence-only approach. There are many critiques of the disease model, including the strict adherence to total abstinence as a marker of success that categorizes people as either "clean" or "dirty" which can have the unintended consequence of creating more barriers and harm should someone continue using or experience a relapse. In addition, many 12 step meetings begin with members announcing their sobriety day count which can be particularly shameful if someone decides to return to a meeting following a lapse or slip. Moreover, this approach hinges on admitting powerlessness over drugs and alcohol and a willingness to turn towards one's higher power and the 12-steps as the vehicle for recovery. Harm reduction, in contrast, can be characterized as an "empowerment" model that emphasizes choice, agency, and supports clients in the pursuit of the goals and strategies they identify as important and meaningful for them.<sup>5</sup>

Harm reduction therapy is an alternative to this all-or-nothing approach that focuses on joining clients around the goals they wish to pursue in treatment. Many studies have shown that regardless of the severity of symptoms at the onset of treatment, clients are more successful if they are working towards goals they self-select.<sup>6-10</sup> Helping clients establish small, short term goals that feel attainable bolsters their self-efficacy and commitment to making positive changes that can have lasting effects.<sup>7, 9, 11, 12</sup>

The latest National Survey on Drug Use and Health (NSDUH) reported that 20.8 million people (7.8% of the population) in the U.S. met criteria for a substance use disorder (SUD) in the past year. Many who are in need of treatment either don't seek it out or leave treatment prior to completion. The societal stigma associated with the diagnosis of a SUD also poses a challenge as people may be reluctant to identify themselves as an "addict" in need of help. The other barrier impacting treatment-seeking is that when people initially become concerned about their substance use, they may not be ready or willing to commit to abstinence as their goal, and therefore, don't seek treatment as many treatment providers advocate for an abstinence-only approach to SUDs and won't work with clients whose goals include moderation and/or harm reduction.<sup>13,14</sup> These factors pose unique challenges for physicians and other health care providers and suggests that we need to evaluate our current treatment system for SUDs and other problematic behaviors so that its more inclusive and doesn't

stipulate abstinence as the only acceptable goal. Harm reduction principles and practices can bridge this gap and offer a more flexible and integrative pathway towards decreasing the risks associated with SUDs that works in collaboration with clients rather than holding a more dogmatic and authoritarian framework for approaching SUDs requiring a commitment to total abstinence.

Harm reduction therapists work collaboratively with clients on what they're motivated to address and embrace a range of goals such as reduced use and moderation in addition to abstinence as acceptable. This model broadens the reach of traditional abstinence-only treatment to engage a wider range of people impacted by SUDs. A misconception about a harm reduction therapy is that it doesn't embrace abstinence as a goal or desired outcome in treatment. In fact, abstinence is considered one of the many paths that comprise harm reduction. What is different about the harm reduction model is that it doesn't presume that abstinence is the ideal or necessary goal for everyone at the onset of treatment. Instead, clients work in partnership with providers to make small, incremental changes to their relationship with substances or other problematic behaviors over time.

The objectives of an abstinence-only approach and a harm reduction approach are actually the same: to reduce risk and keep people alive. The difference lies in how clients and providers work together to reduce the risky consequences of drug and alcohol use. In a harm reduction model, clients work in collaboration with their providers to meet their self-identified goals and the therapeutic relationship is viewed as an integral part of the change process. In some traditional, abstinence-based programs, providers are seen as the "experts" and may adopt a more authoritarian role whereby they are setting goals for clients such as total abstinence that may not be in line with what the client is initially motivated to work on. This mismatch in terms of client and provider goals may lead to premature treatment termination, mistrust, and more harm — especially if a client is discharged from treatment for continuing to use drugs and/or alcohol.

The aim of this article is to present the harm reduction model for conceptualizing, assessing and treating SUDs. Case examples will be provided throughout to illustrate the application of a harm reduction model to addressing a range of drug and alcohol problems. Please note that names and identifying information were changed to protect clients' anonymity.

**Case Presentation: Vanessa**

*Vanessa, an African-American, lesbian-identified female presented for treatment following a referral from her primary care doctor after endorsing heavy drinking, cocaine and marijuana use. Vanessa experienced multiple traumatic events starting in childhood when she was sexually abused by her mother's boyfriend and she began to use alcohol and drugs at age 12. She became pregnant at age 13 and was kicked out of her mother's home and made to live with her grandmother who subsequently cared for her child once she was born. Vanessa would often run away and would spend days out of the house using alcohol and marijuana with older peers. Vanessa had another child prior to age 18 and her drug and alcohol use escalated and she found herself using heroin, cocaine and alcohol on a daily basis. By the time she sought treatment at age 55, she had stopped using heroin on her own in her mid-20's, saying, "I got tired of feeling like crap so I decided to stop- it was the worst thing I ever went through and I will never go back to it". But she continued to binge on alcohol and cocaine on most weekends and used marijuana throughout the day and evening to relax.*

*When she began treatment, she was primarily motivated to address her use of cocaine and alcohol and didn't think her marijuana use was problematic and felt that it helped her relax and unwind. Vanessa also endorsed symptoms of post-traumatic stress disorder such as hypervigilance, irritability, insomnia, flashbacks and intrusive images along with major depressive disorder. She was also diagnosed with hypertension and high cholesterol by her primary care doctor.*

*My initial approach involved understanding the multiple traumas she experienced, which also included the deaths of two of her children plus one grandchild, and the ways in which she felt her substance use helped her cope with overwhelming feelings of grief and sadness. Together, we practiced mindfulness skills to help her notice and accept her emotions rather than reacting to them in impulsive ways or numbing them with substances and building distress tolerance*

*skills. I also provided psychoeducation about the impact of drugs and alcohol on her physical and mental health, which bolstered her motivation for change. It was not until we were able to establish healthier coping skills and process the multiple traumas she had endured that she was able to make lasting changes to her drug and alcohol use. I taught her cognitive-behavioral and mindfulness-based strategies to reduce her consumption of drugs and alcohol. By the end of treatment, she was abstinent from cocaine, used alcohol moderately on weekends and used marijuana a few times per week.*

*My work with Vanessa initially focused on building an alliance with her and working collaboratively on the goals she set for herself. She was clearly interested in reducing her use but the thought of total abstinence frightened her and felt completely unattainable and unrealistic. Since she had been using drugs and alcohol since she was 12, she struggled with basic emotion regulation skills and we began to slowly build her capacity to tolerate feeling distressed and we also focused on helping her process and resolve the multiple traumas and complicated grief she was experiencing. Had I taken a stance that she needed to abstain from all substances, I imagine she would have terminated treatment and perhaps continued to use drugs and alcohol in a risky way for the rest of her life. By using a harm reduction approach that honored her goals as we worked slowly to reduce her use over time, she felt empowered to make changes to her drug and alcohol use. And, her symptoms of depression and PTSD substantially decreased and her relationship with her partner and family also improved as a result.*

This concludes the Introduction. We now move on to Section I.

## SECTION I: PATHOPHYSIOLOGY AND DIAGNOSTIC CRITERIA

Substance use disorders (SUDs) are complex and stem from an interaction of biological, psychological, and social/environmental factors. No one factor can explain why someone develops a SUD and it's important to focus on the cumulative impacts of multiple risk factors across time.<sup>15</sup> Additionally, the specific symptoms and prognosis of SUDs across individuals also varies widely. And, to add to the complexity, some people can use certain substances in non-problematic ways while also experiencing significant distress and impairment due to use of another substance, so there is substantial variability within individuals as well. It's estimated that only about 10% of people who use drugs or alcohol will end up with a SUD.<sup>16</sup> Taking an individualized approach to understanding the causes leading to substance use sets the stage for establishing a treatment plan that captures each person's unique needs.

The DSM-5<sup>17</sup> diagnostic criteria of SUDs focuses on cognitive, behavioral, and physiological symptoms characterized by continued use despite consequences. Diagnosis is based on reports or observations of the following symptoms:

- Impaired control over use
- Use in dangerous or risky situations
- Continued use despite physiological or psychological consequences
- Persistent efforts (or unsuccessful attempts) to reduce use
- Increased cravings
- Impaired social, recreational and/or occupational functioning
- Increased tolerance
- Increased time spent obtaining substances, being under the influence, or recovering from use
- Withdrawal symptoms
- Interpersonal problems resulting from continued use.

It should be noted that drug and/or alcohol use per se is not indicative of a SUD; rather, it is the presence of accompanying maladaptive biopsychosocial consequences that determines whether one has a SUD. Moreover, symptoms of increased tolerance and withdrawal symptoms are not required for one to meet diagnostic criteria of a SUD. Careful consideration should be made if a person is prescribed a medication such as a benzodiazepine or opioid for a psychological or physical condition that results in tolerance and withdrawal symptoms, as those two symptoms are not sufficient by themselves to warrant a diagnosis.<sup>17</sup>

Co-occurring psychiatric disorders, and most notably trauma, place people at greater risk for developing a SUD. The Adverse Childhood Experiences Study examined the relationship between substance use and ten types of adverse childhood experiences such as sexual and physical abuse, household dysfunction, and parental substance use in a large sample of adults in a primary care clinic.<sup>18</sup> Adverse childhood experiences were associated with earlier initiation of drug use along with an increased likelihood of drug use across the lifespan. Experiencing four or more adverse childhood experiences led to a five-fold risk of developing an alcohol use disorder, and those with six or more were 46 times more likely to be an injection drug user.<sup>19</sup> It is estimated that approximately half of those meeting criteria for PTSD also have a SUD.<sup>20</sup> and 30%-60% of people in SUD treatment meet criteria for PTSD in their lifetime.<sup>21</sup>

Given these findings, it is not surprising to find that many people with SUDs struggle with basic emotion regulation, are prone to engaging in avoidance and dissociation, and seek relief through external sources such as drugs and alcohol.<sup>22</sup> Self-regulation deficits and externalizing disorders characterized by executive functioning challenges during childhood are also risk factors for the development of a SUD.<sup>23</sup> Moreover, the self-medication hypothesis focuses on vulnerabilities in four aspects of self-regulation that contribute to SUDs, including emotion regulation (i.e., identifying and modulating emotions), interpersonal relationships and conflict management, identity and self-esteem, and self-care.<sup>24</sup> These deficits in self-regulation contribute to an increased risk of engaging in substance use which works as a negative reinforcer that promotes habitual and ongoing use in a feedback loop.<sup>15</sup> For instance, if an individual drinks alcohol to soothe feelings of anxiety, then over time, they are more likely to rely on alcohol when feeling anxious due to that paired association. In this example, the behavior of drinking alcohol is a negative reinforcer in that it reduces anxiety in the short term and may become an overlearned, more habitual response.

As mentioned previously, people with SUDs tend to have high rates of other psychiatric disorders and a major national survey found that about 50 percent of respondents with a substance use disorder also met criteria for at least one mental health disorder in their lifetime.<sup>25</sup> A recent national epidemiological survey found that major depressive disorder, bipolar type I disorder, specific phobia along with borderline and antisocial personal disorders were positively associated with 12-month and lifetime rates of alcohol use disorders.<sup>26</sup> Past year or lifetime cannabis use disorder is associated with major depression, anxiety disorders, and bipolar type I disorder

in addition to higher rates of antisocial, obsessive-compulsive, and paranoid personality disorders. About 33% of adolescents with cannabis use disorder meet criteria for internalizing disorders like depression and anxiety, and 60% endorse symptoms of externalizing disorders such as conduct disorder and ADHD.<sup>17</sup> PTSD, panic disorder, persistent depression, and generalized anxiety disorder were also associated with lifetime rates of alcohol use disorders.<sup>26</sup> Not surprisingly, those with co-occurring disorders tend to have more severe and enduring symptoms.

While certain genetic markers have been associated with problematic drug and alcohol use, we can't under-estimate the role that social, cultural, and political factors play in onset, duration, and outcome of SUDs.<sup>15</sup> For instance, genetic factors are estimated to account for 40%-60% of the variance in alcohol use disorders.<sup>17</sup> People who were adopted and whose birth parents had an alcohol use disorder are 3-4 times more likely to develop an alcohol use disorder themselves. High levels of impulsivity predict alcohol use disorders and are associated with increased risk for developing substance use disorders in general. Experiencing trauma and living in a socioeconomically disadvantaged environment with exposure to violence impacts the way in which cortisol is processed and may contribute to underarousal and lower reactivity to risk, both of which are associated with an increased risk for developing a SUD.<sup>15</sup>

Broadly-speaking, SUDs are also associated with deficits in inhibitory control and decision-making as evidenced by behavioral changes and in alterations in the prefrontal cortex and mesocorticolimbic reward system that hinder one's ability to manage their responses to reward-based cues and engage in more effective cognitive-behavioral processes such as inhibiting responses to cravings and anticipating short and long-term consequences.<sup>27</sup> There is a bias in terms of responding to cues and anticipating relief through drug and alcohol use that is then reinforced by the dopamine surge that occurs during this process. Research examining the neurobiology of SUDs has led to a call for conceptualizing addictive issues as a "brain disease".<sup>16</sup> This model differs from the previously mentioned disease model associated with 12-step fellowships focused on psychospiritual deficits and powerlessness. Specifically, the brain disease model points to alterations in brain structure and functioning due to individual differences and/or as a consequence of repeated and habitual substance use as key factors in the development of SUDs. Moreover, the brain disease model suggests that an interaction between several factors such as family history (through both

genetics and social learning), early experiences with drug use, high risk and stressful environments with inadequate social supports, and psychiatric conditions increase the likelihood that a person will develop a SUD.<sup>16</sup> As drugs and alcohol (and other behaviors) yield dramatic increases in dopamine production, associations with cues linked with substance use contribute to neuroadaptations in areas such as the nucleus accumbens and dorsal striatum so that dopamine begins to increase in the presence of anticipatory cues rather than during the use experience itself. In other words, the anticipation of using that arises out of previous experiences and learning leads to dopamine surges and increases in cravings and urges to use. Over time, using a drug or drinking in of itself results in diminished levels of dopamine and people do not experience the same type of euphoria from using as they previously did. And, the pleasure associated with every day, adaptive rewards also diminish with time and people become less motivated to engage in them and life may become organized around drug and alcohol use. The presence of anhedonia maintains ongoing use through the temporary relief people feel in anticipation of using. As these reward cues become more salient, engaging the prefrontal cortex and executive control systems becomes more challenging and people experience difficulties inhibiting their behaviors and continue using.<sup>16</sup> This cycle makes it challenging to effectively engage the executive functioning system to slow down, plan, and consider alternative responses.

The following case example describes a multipronged approach to working with problematic alcohol use that integrates a focus on biological, psychological, and social factors. The use of medications to aid in a harm reduction approach is also illustrated here.

#### **Case Presentation: Eric**

*Both of Eric's parents were from families where there was excessive and problematic alcohol use and he noted that two of his grandparents had died from alcohol-related medical conditions. He remembers alcohol being a ubiquitous part of his life growing up. His parents would have "cocktail hour" each evening followed by a bottle or two of wine. Once he was 18, he was allowed to share in this nightly ritual and by the time he began treatment with me in his late-20s, he struggled to recall a day in the past few months during which he hadn't consumed alcohol. Eric sought treatment after noticing that he was drinking more beer than usual and reported feeling hung over at work several times a week. He was interested in learning*

*how to drink moderately and to not feel like he needed to have alcohol every night of the week. The idea of total abstinence was unrealistic to him and he very much wanted to continue to enjoy moderate drinking with family and friends.*

*Eric's case is an example of the intergenerational transmission of drinking patterns due to a combination of genetic, psychological, and social/environmental elements. While he loved that nightly ritual of drinking beer after working all day, he noticed he was unable to go one day without a drink, and had begun to consume more than he typically had in the past; in this case, two beers had now become four beers, and then on weekends, his use increased to between six and eight beers. Eric grew concerned about the long-term impact of alcohol use on his health and was also becoming increasingly more isolated as he would sometimes avoid social situations in favor of going home to enjoy beer alone. There were clear biological, psychological, and environmental triggers propelling his use over time. He reported increased cravings to drink and had trouble following through with the initial plan we had developed which included delay strategies, scheduling other activities in the evening, and practicing mindfulness to notice cravings and the accompanying thoughts and emotions along with relaxation skills to replace alcohol as his primary coping tool.*

*I suggested that he consult with a psychiatrist to consider if medications could compliment the work we were doing. The psychiatrist initially prescribed gabapentin to help Eric reduce his alcohol use and manage the cravings, anxiety and restlessness he felt in the evenings. The addition of disulfiram during a planned 30-day break from alcohol afforded Eric a chance to focus on building new routines in the evenings. He viewed taking disulfiram as a "safety net" that would deter him from drinking during this 30-day period. We treated that month as a learning opportunity so that once he was ready to begin drinking again, he could draw upon these new experiences. For instance, Eric recalled that he felt less anxious and was more focused and energized in the morning when he drank very little or no alcohol. This insight motivated him to continue to practice*

*the strategies we worked on once he concluded his month taking disulfiram.*

This concludes Section I: Pathophysiology. We now move on to Section II.

## **SECTION II: CLINICAL PRESENTATIONS AND ASSESSMENT**

This section describes a biopsychosocial framework for assessing SUDs and other problematic behaviors that emphasizes reciprocal interactions between many factors.<sup>14,28</sup> Rather than exclusively conceptualizing SUDs as primarily stemming from a "brain disease", the American Society of Addiction Medicine advocates for focusing on the unique interplay between biological, psychological and social factors in its definition of "addiction".<sup>29,30</sup>

The American Society of Addiction Medicine has outlined six standards of care for physicians working with clients with SUDs and co-occurring conditions.<sup>30</sup> This section focuses on the assessment part of the ASAM standards of care while the following section details their recommendations for the management plan. The ASAM standards of care are a seamless complement to a harm reduction based approach for working with SUDs. The assessment of SUDs should be multidimensional and address biological, psychological, and social/environmental factors impacting substance use. As such, a comprehensive, multi-component assessment is ASAM's first standard of care and is viewed as an ongoing process that features both a physical exam and mental status exam, a detailed medical and psychiatric history including current and past prescribed medications, and an assessment of substance use across the person's lifespan. Particular attention is paid to assessing and monitoring symptoms of tolerance and withdrawal along with the use of pharmacotherapies and outcomes. In addition, the assessment should also gather information about the client's readiness for change and motivational factors that will help or hinder engagement with the treatment process.<sup>30</sup>

A clinical interview is typically conducted and standardized assessment tools and laboratory measures can also be used to provide a more complete diagnostic understanding. Moreover, assessment should be considered an ongoing part of the treatment process and should not be limited to the first few sessions. ASAM (2014) has created six domains of a multidimensional assessment that will be described here.

1. First, ASAM recommends gathering information about current use patterns and assessing for intoxication and withdrawal management needs. This domain also ideally includes laboratory information such as results from blood tests (e.g., liver functioning data for someone who is a heavy drinker) and imaging studies (e.g., liver ultrasound) as needed to establish a baseline that will be subsequently monitored over time with updated test results.
2. The second domain focuses on biomedical conditions and complications associated with comorbid medical conditions such as diabetes mellitus, HIV, and hypertension with an emphasis on coordinating care among providers.
3. Emotional, behavioral or cognitive conditions and complications comprise the third domain and include an assessment of co-occurring mental health disorders.
4. The fourth domain emphasizes assessing for readiness to change and motivational factors that may impact the treatment process, and recommends that interventions be tailored according to the person's stage of change.
5. The fifth domain focuses on relapse, continued use, or continued problem potential and is again tailored to the client's readiness for change so that interventions and strategies meet clients where they are motivationally.
6. The final domain, recovery environment, assesses for psychosocial factors such as the need for family and childcare service along with housing, financial, vocational, educational, legal, and transportation needs.

Based on the information gathered from these six domains, diagnoses are formulated, and a comprehensive treatment plan is developed based on an individualized conceptualization of the client.<sup>30</sup>

Beginning with open-ended and neutral questions is useful and may help mitigate feelings of anxiety and shame in the patient about disclosing substance use. I often start sessions by asking, "how can I be of help?" or "what would you like to focus on?" Noticing the language we use and how we talk about substance misuse is also important and I frame questions about substance use as neutrally as possible. For instance, I ask, "how would you describe your relationship to alcohol?" rather than, "do you think you have a drinking problem?" I also start by asking what the person enjoys about their substances of choice and what they would like to change about them, if anything. I make no assumptions. I let clients guide the way and encourage them to describe their treatment goals as

clearly as possible in the first sessions.

It's important to focus on the timing of symptoms as a way to clarify whether more than one disorder may be present or if the symptom picture is limited to substance use, intoxication or withdrawal. For instance, anxiety symptoms can increase or decrease as a function of drug or alcohol use and may be associated with alcohol withdrawal. Panic attacks can result from cocaine intoxication or opioid withdrawal.<sup>4</sup> In addition, symptoms of psychosis and/or mania often accompany stimulant use or misuse and a longitudinal assessment in conjunction with a period of abstinence is optimal in terms of being able to parse out the symptom picture and make an accurate diagnosis. Substance use disorders in general (and alcohol and opioid use disorders in particular) are associated with an increased risk of attempting or completing suicide, so conducting a suicide risk assessment is essential.<sup>17</sup> Chronic alcohol, cocaine, and cannabis misuse can also lead to anhedonia and lower motivation which can resemble symptoms of major depressive disorder or persistent depressive disorder.<sup>17</sup>

Carefully assessing for a client's stage of change is essential and helps determine the appropriate treatment recommendations and level of care. Clients who are in the pre-contemplation stage of change typically do not identify themselves as having a problem and do not feel motivated to make changes. Those in the contemplation stage may be experiencing ambivalence about their use and whether they feel ready to make changes. In this stage, it's helpful to ask clients to describe both the benefits and consequences of their use along with what they imagine the benefits and consequences of changing their level of use might be. This is called a decisional balance and it can be a useful tool to gather information about where a client might be stuck and what might serve as a motivator for change. As clients progress from a place of ambivalence towards making changes, they go through a preparation stage where we can work together to establish a plan, develop strategies and techniques and then establish clear goals for change. In the action stage, clients are in the process of change and we may need to revise or refine the plan according to how it's going. The maintenance stage is when changes have been made and sustained for a period of time and the nature of our clinical interactions may change from being more action-focused to addressing other lifestyle issues and enhancing other domains of their functioning to ensure that the gains are sustained over time.<sup>31,32</sup>

It's useful to divide the assessment process into the following categories: drug, set, and setting.<sup>4</sup> Gathering information about the type of substance(s) used (including current and past compliance with prescribed medications and over the counter drugs) and assessing the frequency, amounts, route of administration, and patterns of use over time helps establish a substance use profile. In addition, assessing for the person's level of control and where they fall in terms of severity, distress, and impaired functioning is useful. Focusing on the "mind-set" or psychological factors impacting use, such as level of motivation, treatment expectations, and self-efficacy are also critical. Understanding where clients are in terms of the stages of change allows the clinician to tailor interventions and treatment strategies according to the client's motivational state.<sup>31</sup> It is useful to distinguish between different substances because an individual may not be at the same stage of change for each substance they are using. For instance, when I was working with Vanessa, when she began treatment she made it clear that she was ready and willing to focus on reducing cocaine use, but did not feel it was important to focus on her marijuana use. We adjusted our approach accordingly and the changes she made in her alcohol and cocaine use eventually translated to a new understanding of her marijuana use and she gradually began to use less of it as well.

Gathering data about past treatment experiences and attempts to change substance use patterns with or without seeking professional help or self-care resources can help provide a roadmap for what to focus on in treatment based on what was or wasn't effective in the past. Carefully assessing for other psychiatric conditions and the timeline of the development of mood and anxiety disorders can aid in the clarifying differential diagnosis issues. In addition, given the high rates of comorbidity between trauma and substance misuse, it's important to assess for past trauma and also gather information about current relationship issues in the event that a client is in an abusive relationship. Understanding the contextual and social variables linked with substance misuse can provide essential information about potential triggers and areas to address in the treatment plan. Learning about a client's social support system and quality of life also helps us identify areas to address in treatment.

The following case presentation will highlight the nature of co-occurring conditions and the need to provide integrative treatment to address the many factors impacting substance misuse.

#### **Case Presentation: John**

*John, a 35-year old Caucasian male, was referred to me by his couple's therapist after repeated instances of excessive and risky alcohol use that led to conflict with his husband. John reluctantly engaged in treatment with me and presented as anxious, reserved, and difficult to engage. During the initial assessment, John endorsed symptoms of social anxiety and generalized anxiety along with mild symptoms of major depressive disorder. He reported difficulty controlling his alcohol use on the weekends and would drink anywhere between five to ten drinks per occasion on most weekends for the past few years. He didn't drink during the week as he didn't want it to affect his work. He said he was motivated to drink less in order to improve his relationship with his husband, feel less anxious, and to be more productive at work.*

*When I explored his symptoms of social anxiety, he said alcohol helped him cope with feeling insecure and anxious about his social skills and it helped him "loosen up and relax" so he could be "more fun and interesting". During work happy hours, his work colleagues had also noted the change in him and made reference to "Party John" who was a stark contrast to the John they knew from the office. This became a central focus of our work as we began to unpack the thoughts and beliefs he had about himself that prevented him from being at ease and comfortable in social situations. He also began to notice the physical tension and discomfort he felt in social settings and how alcohol allowed him to relax and disinhibited him so he became more comfortable engaging in small talk. Alcohol quieted the negative and self-critical talk he engaged in during social situations and allowed him to have fun and be spontaneous.*

*Understanding the history of his symptoms of anxiety was also crucial and I learned that he was a shy and reserved child and felt isolated in his small, more rural community. He said he realized he was gay in late childhood and felt anxious about coming out to his family and friends. Although his parents were supportive and loving, they did not realize that he was dealing*

*with significant anxiety and feared how others would react once he told them about his sexuality. He eventually came out to his parents in college and they were very supportive. While in college, John began to drink excessively and it became a way for him to bond with friends and also meet men he would date. His peer group also engaged in heavy drinking so his use was normalized and accepted. He quickly discovered that alcohol helped him manage his anxiety and loosen up at clubs and bars so he could meet new people and enjoy himself.*

*In order for us to help him with reducing alcohol use, we had to first understand the nature of his symptoms of anxiety and the ways in which alcohol helped and also got in the way. We worked on having him identify the thoughts, sensations, and behaviors that would lead him to over-drink and then established a treatment plan to address those factors. Not surprisingly, John had very self-critical and perfectionist beliefs and held himself to high standards. This contributed to his anxiety about social situations and how he interacted with others. He would feel tense and have difficulty engaging in conversations with others because he felt so anxious and self-critical in the presence of others- especially new people and work colleagues. We also examined the relationship between his alcohol and tobacco use and how one would reinforce the other.*

This concludes Section II: Clinical Presentations and Assessment. We now move on to Section III.

### **SECTION III: MANAGEMENT PLAN**

This section will start with a brief description of the ASAM (2014) Standards of Care for managing SUDs. Following a multidimensional assessment and with an understanding of the client's motivation for change, we can begin to determine the most appropriate level of care. ASAM has established four levels of care which include outpatient services, intensive outpatient or partial hospitalization, residential and inpatient services, and medically-managed intensive inpatient services. Based on ongoing assessments of clients, we may need to refer them to a higher level of care depending on their current symptoms and need for stabilization and risk management. ASAM (2014) recommends placing clients in the least restrictive level of care based on their clinical presentation.

In terms of treatment planning, ASAM (2014) recommends focusing on coordinating medical care, providing therapeutic alternatives, evaluating safety, addressing comorbidity, involving social supports, and clearly documenting clinical decisions that includes measurable treatment goals. The treatment management process should include an assurance of quality of care that is clinical indicated based on an ongoing assessment, determining clinical progress and making appropriate referrals and recommendations based on that, and providing adequate social support referrals if needed. These recommendations are in line with a harm reduction approach as well.

Somatic treatments for SUDs include medications to address acute intoxication states, withdrawal symptoms, agonist and antagonist maintenance therapies, along with medications to promote abstinence and promote relapse prevention and medications to address co-occurring psychiatric disorders.<sup>33</sup> Research has shown that medications to address SUDs are more effective if integrated with psychosocial interventions which can enhance medication adherence, treatment engagement, retention, and outcome. For instance, a study demonstrated that the addition of psychosocial treatment for methadone maintenance was associated with decreased heroin use when compared to methadone maintenance alone (Amato et al. as cited in APA, 2010).

The remainder of this section focuses on the principles and essential therapeutic tasks of harm reduction therapy. Developing an alliance and building rapport with clients is seen as the key to successful treatment. Harm reduction therapy draws on principles of motivational interviewing with its focus on active listening, expressing empathy, offering feedback and providing clients a chance to reflect on the nature of their use and the goals they wish to work towards.<sup>1,32</sup> The beginning stages of treatment consist of self-monitoring and assessment as clients are encouraged to track their substance use patterns, notice what contributes to cravings and how they are responded to, and what may lead to subsequent drug and/or alcohol misuse. As we consider this information together, clients develop short- and long-term goals that are attained incrementally at their pace.<sup>4,32,34</sup> Non-judgmental psychoeducation about the physiological effects of certain substances may lead to a consideration of additional goals and treatment options to include consultation with a medical provider and/or addiction psychiatrist.<sup>33</sup> Harm reduction interventions draw on a range of therapeutic models including mindfulness-based practices (e.g., Bowen, Chawla, & Marlatt, 2010), psychodynamic principles (e.g., Rothchild, 2015; Tatarsky, 2007), cognitive-

behavioral therapy (e.g., Marlatt & Witkiewitz, 2005), and dialectical behavior therapy (e.g., Linehan, 2014) that are tailored to each client's needs.

In the early phases of treatment and throughout treatment, clients are encouraged to take note of their drug and alcohol use patterns by identifying the "drug, set, and setting" factors that are unique to them. For instance, under the "drug" category, clients detail their use patterns including the type of substance/behavior, frequency and quantity, route of administration. Under "set", we notice personal variables like mood and anxiety disorders, sleep/eating patterns, reasons for substance use, coping skills. The "setting" component helps us identify the social/environmental aspects linked with use such as whether a person drinks alcohol alone at night or binges on crystal meth with a group of people at a party. Making changes to one of those domains will reciprocally impact the others.<sup>4</sup> For instance, if we identify social anxiety as a factor that leads one to overdrink like in the case of John, we may use relaxation skills training and cognitive-behavioral strategies to address anxiety and establish moderation practices such as drinking water, not drinking on empty stomach, and maintaining safe blood alcohol levels.<sup>36,37</sup> Clients can then report back the results of their efforts so we can continue to revise and reformulate our plans and strategies.

Working with cravings in the moment and integrating mindfulness skills is also useful. Mindfulness skills promote self-regulation and distress tolerance, and allows for the non-judgmental observation of thoughts, feelings, sensations, and emotions to gain awareness into habits and patterns.<sup>27,35</sup> As clients examine the role of substances or other problematic behaviors in their lives, they can experiment with "unwrapping the urge" to gain awareness of what important needs and information is being conveyed through the experience of the urge.<sup>28,35</sup> Questions such as, "What do you notice in the body during a craving; what thoughts and emotions are there?" can be helpful and give us information into the multiple meanings and functions of their use.<sup>28</sup>

By gathering information and noticing the cycle of events leading to problematic use and having a clear sense of their goals, clients can utilize cognitive-behavioral strategies to establish an optimal relationship with drugs and/or alcohol that is based on their values. Addressing lifestyle imbalances that may have contributed to problematic substance use can also include increasing self-care, relaxation training, improving physical health, managing relationships, and building pleasurable activities.<sup>28,38,39</sup> Together, we

can establish a specific plan that identifies the parameters under which substance use is acceptable and details the amount and frequency of use, and risk reduction strategies.

#### **Case Presentation: Amy**

*Amy began treatment to work on reducing her alcohol use and to address the long-term impact of trauma and anxiety symptoms. She struggled with symptoms of generalized anxiety and also had a history of complex trauma stemming from childhood sexual abuse by a step-sibling. Amy had an overbearing boss at work who often led her to feel anxious and on edge and, once she got home, alcohol allowed her to relax and turn her mind away from work. When Amy started treatment with me, she was drinking about a bottle of wine per night, most nights of the week. Her drinking took place as soon as she got home from work and she described the pattern as automatic and habitual. We worked on identifying the triggers that led her to turn to alcohol as a coping tool. Her goal was to drink only a few times per week, to learn new skills to manage anxiety and to process her history of trauma and understand its current impact on her functioning.*

*Our approach to addressing her alcohol use consisted of identifying the thoughts, feelings, and behaviors associated with over-drinking each evening and devising a plan to address each of those elements. Amy developed a new mindfulness practice before she left work so that she was more present and attentive to alcohol-related cues and triggers. And, she experimented with taking a new route home, developed a self-soothing ritual that she practiced each night and made sure to have less alcohol available at home each night. She was also prescribed 50 mg. of naltrexone by her psychiatrist in addition to the antidepressant she had already been taking. She noted that the addition of naltrexone helped "quiet" her cravings to drink at night and allowed her a chance to begin to establish new routines. With time, Amy was able to reach her goal and established a healthier relationship to alcohol and was more confident in her ability to manage anxiety and work-related stressors due to the new routines she developed.*

This concludes Section III: Management Plan. We now move on to the Conclusion.

## ***CONCLUSION***

My hope is that this article provided useful information about the harm reduction therapy model for people struggling with substance use disorders and other problematic behaviors. This article's objective was to describe an alternative approach to working with active drug and alcohol users that is collaborative, compassionate, and empowering. By meeting clients where they are and working with them on the goals they wish to pursue in treatment, we clinicians will be able to engage more people and contribute to reducing the risks associated with active substance use. Many clinicians refuse to work with clients with active drug and alcohol use, and I hope this article provides a framework for conceptualizing, assessing, and treating substance use disorders so that clinicians are more willing to work with clients to reduce the risks associated with their use.

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