HARM REDUCTION IN MENTAL HEALTH: THE EMERGING WORK OF HARM REDUCTION PSYCHOTHERAPY

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Overview

Harm reduction psychotherapy is a term that is being used to describe several clinical models to treat addictions that are based in the international public health movement termed harm reduction. Ours is a biopsychosocial approach- using research and clinical wisdom from the areas of neurobiology, sociocultural forces, psychodynamics, and cognitive/behavioral theory to create a holistic assessment and treatment model. Harm reduction psychotherapy (HRP) represents a radical paradigm shift, one that we believe is necessary if we are to confront our own attitudes towards addiction, as well as those of the society in which we live, and make our clinical interventions more effective.

In this country, we have been fighting about how to help people with drug problems for 200 years. Because of the War on Drugs with its emphasis on zero tolerance, and the widespread use of coercive measures (incarceration and treatment), HRP is an intensely political endeavor. To separate out the politics is to render it just another eclectic bag of techniques, however sophisticated the bag.

It is increasingly common for people to enter psychotherapy with coexisting substance use and psychiatric problems. More and more therapists are confronted with clients about whom they know very little. Most of our training has been seriously lacking in the area of alcohol and drug use and the problems associated with such use. It is not only a lack of training that causes our hesitation in accepting a referral of someone who is alcoholic or heroin dependent. As members of this society, we are vulnerable to the negative attitudes and stereotypes regarding people with alcohol and drug problems. As a result, psychotherapists have traditionally ignored, minimized, or interpreted away alcohol and drug problems in our psychotherapy patients.

Drug treatment in the U.S. is currently based on what is known as the American Disease Model, which states that addiction is a primary disease, not caused by any other condition, characterized by loss of control and denial, and is only treatable by abstinence. Requiring abstinence as a condition of entering treatment and terminating clients who relapse are two examples of setting the threshold for treatment too high. By doing so, we dramatically limit the range of people who can and will come to treatment. Substance abuse is the only field in mental health where the client is required to give up his symptom (drug use) *before* entering treatment.

HRP is founded on the basic principle of the harm reduction movement - respect for peoples' choices, and an active involvement in peoples' lives. One of the clinical principles that derives from this basic stance is to meet clients "where they're at"; and offer "low threshold" treatment. This means removing barriers (such as lack of childcare) or eliminating the traditional hoops (requiring abstinence prior to entry, for example) that people have to jump through in order to access services.

Psychological Theories of Addiction

In contrast to the disease model's insistence that addictions are diseases, many psychological theories offer more complex ways of understanding why people use drugs or alcohol and why they may get into trouble with these substances.

Morgenstern and Leeds (1993) have provided a summary of the major psychodynamic theories: Edward Khantzian was the first person to describe the self-medication hypothesis, stating that people use particular drugs to deal with specific difficult feelings. Leon Wurmser believes that drugs can be used to silence the voice of one's harsh inner critic. Unfortunately, drug use may also silence the nurturing voice that helps us take care of ourselves. Finally, Henry Krystal used the term alexithymia to describe the difficulties with identifying feelings that plague many drug abusers.

One of the most useful models, and one that is at the heart of harm reduction therapy, is Attachment Theory. People develop relationships based on experiences with early caregivers. Problems of attachment in the interpersonal sphere often lead to an attachment to things not human. *Drug users develop complex relationships with the drugs that they use which are reflective of their relationships with people*. Interestingly, Karen Walant (1995) asserts that American's value of autonomy over our need for attachment is a primary cause of the high rates of addiction in our culture, and stands in stark contrast to most non-Western cultures.

Probably the most troubling work has been done in the area of trauma: Up to 80% of people with a history of significant trauma will abuse substances. The sheer numbers of people with substance use problems who have been traumatized as children is staggering and demands that we pay attention to the literature on the psychological and physiological sequelae of trauma. One part of the brain that is damaged by childhood trauma is that which controls emotions. This goes a long way towards explaining why we hear so many chronic drug abusers complain of depression and anxiety and a poor ability to tolerate feelings.

Trauma also damages neurotransmitter systems most affected by street drugs and alcohol: the dopamine system so responsible for pleasure is disabled; the serotonin system may be deranged, leading to problems with mood and aggression: norepinephrine pathways of the fight-flight response become chronically activated, resulting in anxiety: And the endorphin system may also be damaged, leaving the individual unable to tolerate normal physical or emotional adversity.

Both psychological and biological events combine to create clinical depression and anxiety, unstable interpersonal relationships, and general misery. It is no wonder that people with significant histories of trauma are found in the substance abusing population. Trauma and neglect ruin the brains and the lives of our children.

In addition to the above psychodynamic contributions to harm reduction therapy, there are many Cognitive/Behavioral models that increase our understanding of the development and maintenance of habits. Coping skills, assertiveness, and self confidence are important in a person's ability to use drugs without problems.

Concepts of Harm Reduction Psychotherapy (HRP)

HRP defines addictions as biopsychosocial phenomena. A general framework for this comes from Norman Zinberg's *Drug, Set, and Setting* model (1984). Drug refers the class of drug, its cut and the route of administration; Set to the person and her unique physiology, psychology, as well as motivation and expectation of drug effect; Setting is the environment in which the drug is used with whom one uses, and in what cultural context. The relative importance of drug, biology, psychology, and culture and environment varies. In treatment, each person needs to be individually assessed and her unique circumstances understood.

Knowledge about how people make changes in behavior is essential to any treatment process. Prochaska and DiClemente's (1992) Stage Model of Change provides this. *Precontemplation* is the stage that refers to not knowing that one's problems are related to drug use. In the *Contemplation* stage (the "yes, but" stage) the person is aware of certain drug-related problems, but also wants to keep using and has good reasons for doing so. In the stage of *Preparation,* the person decides to make some preliminary changes to reduce harm, while in the *Action* stage, he or she is fully engaged in making major changes in drug using behavior. *Maintenance* refers to the hard work of changing one's life in order to support the change in drug use. Of course people often *Relapse,* hopefully learning important lessons that will help them in the future. Once this hard work has been done, the person exits the addictive process and enters the stage of *Termination.*

The above concepts and strategies are central to HRP and are especially useful when engaging a person whose drug abuse is intertwined with significant emotional problems.

Dual Diagnosis

The term dual diagnosis (co-existing mental and substance use disorders) encompasses a large and complex group of people. It is a group that, for a number of reasons, including the design of our treatment systems, is extraordinarily difficult to serve. Dually diagnosed people usually come to treatment with many other psychosocial problems such as poverty, social isolation, and homelessness. Their need for social and economic support is so great that these clients often overwhelm our treatment resources.

Dually diagnosed people often have difficulty establishing or maintaining abstinence. In addition to using drugs for the same reasons that we all do – to relax, to socialize, to escape reality, to feel more energetic, and so forth – people with serious mental and emotional disorders often use drugs to "self-medicate." (Khantzian, 1985) Even if, in the long-term, one's drug of choice does not improve one's mental health, the short-term perceived benefits can be profound. For example, the same stimulants that can cause acute psychosis can also relieve the negative symptoms of schizophrenia or the side effects of anti-psychotic medication such as emotional blunting, inability to experience pleasure, depression, or social withdrawal. Many individuals with a history of emotional, sexual, or physical abuse or trauma develop dependence on a variety of drugs, especially opiates, alcohol, and marijuana, to relieve traumatic memories and other symptoms of PTSD. Given this, one can begin to see that abstinence poses the potential loss of a supplement to a person's quality of life or to his/her regular treatment regimen.

We have a series of system-based problems in the treatment of co-existing substance abuse and psychiatric disorders. For a number of reasons, especially related to theories of addiction and recovery, we have developed separate treatment systems for substance abuse and psychiatric disorders. In spite of the difficulty of accurate diagnosis, we have attempted to assign the substance use or the mental disorder as primary so that we could then refer clients into the "right" treatment. As a result, mentally ill persons have historically been excluded from substance abuse programs, and vice versa. As many authors have argued (e.g., Drake, 1993, Minkoff, 1989), we must provide *integrated* treatment for dually diagnosed people. Although we have gone some way toward breaking down traditional barriers, we still need to create better marriages between mental health and substance abuse treatment providers.

Arriving at a firm diagnosis is difficult. Intoxication from street drugs or alcohol can exacerbate underlying psychiatric symptoms or mimic various psychiatric disorders. For example, if a person with schizophrenia also uses stimulants, this may either precipitate or present as an acute psychotic episode. Until a detailed history is obtained, it is impossible to know whether this is a drug-induced psychosis or a substance-exacerbated psychotic episode. In the case of a Valium-dependent person, if that person presents in an agitated state, you may be seeing an anxiety disorder, which is not well medicated, or a case of Valium withdrawal. These diagnostic difficulties can make treatment providers reluctant to prescribe treatment, whether medication or therapy.

When assessing and treating dually diagnosed persons, I find it useful to avoid the diagnostic argument and to look instead at other ways of assessing someone's appropriateness for a particular treatment. Instead, I propose that we ask three questions:

1- *Can* a given client participate in any of the available treatment programs?
2- Does that client *want* to participate in treatment?
3- If the answer is no to both of those questions, we then need to figure out what type of programs we *should* create to accommodate the needs of dually diagnosed persons.

On the question of whether a person *can* participate in (traditional) substance abuse treatment, I would argue first that a person's level functioning is more important than diagnosis. Functioning refers to having the social skills, the emotional capacity, and the interest to cope with group and individual interactions, which may at times be highly personal, if not confrontational. In other words, a person needs to be able to be self-reflective and to be challenged with new perceptions about him or herself without becoming excessively confused or injured.

Regarding the second question, that of someone's *desire* to participate in substance abuse treatment, the real issue is the willingness to be *abstinent*, rather than willingness to engage in treatment per se. The strict requirement that abstinence be a condition of entering or continuing in treatment may be too high a threshold for people who perceive real benefits from drug and alcohol use. Nevertheless, dually diagnosed clients may be interested in other benefits of treatment, such as attending to their psychological and emotional problems, and may also be interested in *changing or reducing* their use of substances.

Dually diagnosed persons help us to understand and remember that people use drugs and alcohol for reasons. Even if those reasons have gotten blurred over time with habitual drug use, drugs and alcohol often still serve a protective and defensive function. Without them, a person may experience overwhelming emotional states or unbearable physical or mental pain. Thus, reasons for continuing to use drugs and alcohol are often more compelling than reasons to stop.

Harm Reduction as an Approach to Treatment

The question is then, how *do* we serve people who need treatment but do not fit into existing programs? Harm reduction offers us a means of conceptualizing and designing treatment that reaches vulnerable populations – treatment that lowers the threshold so that people who are unsure of what to do about their drug and alcohol use, or who have complicating factors such as mental illness, can have access to treatment. The goals of harm reduction-based treatments are flexible and are established in a collaboration between client and treatment provider. Abstinence is never a condition of treatment, and may or may not be a goal of treatment.

Harm reduction principles demand that we negotiate a treatment plan that is congruent with what a person *perceives* his or her needs to be. We should also be careful about expecting abstinence or change in drug use until we can offer something to replace the function of drugs and alcohol, whether it is more effective psychiatric medication, a therapeutic relationship, or relief from social or economic distress. It is important to respond to the problems that a person identifies as priorities, rather than to define all of a person's life problems in terms of addiction. In other words, we must understand and attend to the *client's* "hierarchy of needs". (Denning, 2000)

The best treatment strategy also includes addressing *ambivalence*, or a person's mixed feelings about giving up his or her drug of choice. (Miller, 1991) Ambivalence is a normal state of conscious or unconscious confusion that we all experience when faced with pressure to change something important about ourselves. It is the core of harm reduction therapy – the work that focuses on helping someone resolve ambivalence and make a decision. The decisions could range from using sterile syringes at all times to using condoms in some sexual encounters to quitting alcohol and smoking marijuana instead.

Harm Reduction Psychotherapy grew out of our realization that, for a number of reasons, including complex diagnoses, psychological fragility, and unwillingness to be abstinent from street drugs, many people have been excluded from both psychiatric *and* chemical dependency treatment.

Harm reduction therapy is based on the controversial concept, learned through research and our own experience with clients, that people can and do make rational choices about their drug use, even while in the throes of addiction.

The treatment process can be broken down into four parts:

Engagement

The best way to start treatment is to engage in a relationship in which we acknowledge and understand the compelling reasons why a person continues to use drugs or alcohol. We must join a person where s/he is, move at his/her pace, and identify and engage *his/her* motivation to change. According to Miller and Rollnick (1991), motivation is not a stable trait that exists within the person. It is more usually a product of the relationship between a person and whomever or whatever is demanding change. We do not need to wait for someone to get motivated or hit bottom. We can and should use techniques that create a relationship of trust and collaboration.

The primary tool in the engagement process is to use the five principles of motivational interviewing:

- *Express Empathy* – The therapist must see the world from the client's point of view and communicate to the client, "I get it."
- *Develop Discrepancy* – The client needs to see the discrepancy between her goals and the reality of her current situation in order to create pressure to change. *Note: it is the client's job to gradually see the discrepancy, not the therapist's to point it out.*
- *Avoid Argumentation* – The client has the right to tell his own story and is always right.
- *Roll with Resistance* – Resistance to change is natural – it is the mind's way of saying, "wait a minute, how do I know I am going to be better off if I…?" If you hear "yes, but…", the proper response is to back off, go back to where you were and check out what you did to arouse resistance.
- *Support Self-efficacy* – Self-efficacy is the sense that one can accomplish one's goals. The therapist must take every effort to build self-efficacy in the client by supporting all efforts the client makes toward healthy change, *and* by congratulating the client on the adaptive nature of her drug use.

Assessment

Using the *Drug, Set, Setting* models, the therapist and client must identify detailed information about the *extent* of a clients use of each drug and then about the *interaction* of each drug with the client's physical, psychological, and environmental conditions.

Using the *Stage Model of Change*, the therapist must accurately assess the stage of change the client is in *for each identified problem.* For example, the client may be in the preparation stage for quitting crack cocaine or for stopping the practice of sharing needles to shoot speed, but in the precontemplation stage for smoking marijuana on a daily basis. Likewise, the client may be contemplating not pairing sex and speed because he realizes that when he uses speed he is less likely to use condoms – he is HIV+ and is becoming uneasy about endangering sex partners. On the other hand, he is in a physically abusive relationship, which he does not even want to discuss with the therapist.

Finally, the therapist must assess the psychological issues in order to understand where he will meet resistance in the therapeutic process and to know what psychological work will need to take place in order for the client to reliably make and maintain behavior change.

The result of this assessment process is the creation of a hierarchy of needs that becomes the treatment plan to which client and therapist can both refer.

Ongoing Treatment

The *Decisional Balance* is the primary tool used to explore a client's ambivalence about drug use and behavior change. This is a version of a cost/benefit analysis, which involves listing the pros and cons of change and the pros and cons of maintaining the same behavior unchanged. (Looking at change from both points of view increases the complexity and shows more the reality of the change process.) The most important thing to know about this decisional balance work is that the *length* of each pros list and cons list is irrelevant to the ultimate decision. It is the relative *weight* of each item that is important. For example, losing one's children to Child Protective Services as a result of unresolved drug problems may be one person's "bottom" that swings the balance in favor of radical change. For another person, who is overwhelmed at the thought of child-rearing responsibilities, stopping drug use is also overwhelming; it will be other factors that influence her in the direction of positive change. For someone who avoids social contact, the isolation that comes with solo drinking is a blessing. For someone who is depressed, on the other hand, solo drinking soothes the pain of social isolation, but maintains isolation in ways that are also uncomfortable. Once the pros and cons lists are developed, the therapist must help the client explore the importance of each item. As might be imagined, this is a very delicate and often painful task – one that can take months or even years.

The therapist *must* remain neutral in the decisional balance. The client's own life issues and investment in each issue will provide sufficient weight to give the therapist plenty to explore. It is *not* the therapist's job to weigh in with her ideas of the costs and benefits of the client's drug use. One exception to this rule is that, when the client lacks information about drugs and their effects, the therapist has an obligation to provide such information. This information must be balanced, correct, and not based on generalizations about all drugs, on myths about drugs, or based on the therapists wish to frighten a client into abstinence.

There are many areas for specific intervention in HRP such as stress reduction and coping skills training, nutrition, psychiatric medication, relapse prevention, family therapy, and drug substitution (methadone, marijuana). The most important is *Substance Use Management (SUM).* This refers to any effort to manage one's drug use to increase safety, control, or to decrease negative consequences of drug use. SUM techniques are useful in themselves for obvious safety reasons, but are also useful in information-gathering to determine the extent to which a client will be able to manage his use of drugs or will need to eventually consider complete abstinence as the only way to ensure safety and successful functioning.

Attention to Therapist Pitfalls

Therapist pitfalls fall into the category of countertransference. The most common reactions to watch out for:

- Bringing a moralizing tone to the therapy based on one's own attitudes toward drug use, especially illegal drugs
- Being overeager to capitalize on client's wishes to change without giving due attention to his attachment to drugs and resistance to change
- Not eliciting enough detailed information about drug use for fear of producing craving or of appearing to support pathological drug use (i.e., enabling)

- Colluding with the client's resistance to change. In an effort to develop or protect the therapeutic alliance, being afraid to be challenging enough
- Underestimating the negative aspects of a client and his life. In an effort to support the client's strengths and self-efficacy, not acknowledging and giving space for the depth and extent of his hopelessness and despair

  By combining theory and technique, and by being wary of our own biases, we can create treatment that will be both acceptable to the client and successful *in whatever way she or she defines success*. It's obvious that HRP can take as many forms as the clients it serves.

In Conclusion

We offer these ideas to inspire others to join in the development of Harm Reduction Psychotherapy and to acknowledge the debt we owe our clients and colleagues for years of support and patience as we find our way to more humane treatments.

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