HARM REDUCTION PSYCHOTHERAPY: PRINCIPLES AND PRACTICE – Part 1

By Patt Denning, PhD

Therapists are often at a loss when their clients present with substance misuse. We have mostly been taught to refer them to a 12-Step based treatment program, or at least refuse to see them if they continue to use. This results in many people going without treatment because they cannot or will not comply with those limited options. This two-part series introduces the reader to an alternative to traditional approaches, a model that can be used with all presenting problems because it includes substance abuse treatment within the container of psychotherapy.

Harm reduction psychotherapy (HRP) is a term that is being used to describe several clinical models to treat substance use disorders that are based in the international public health movement termed *harm reduction*. The treatment model described in this two-part article is a biopsychosocial approach to the complex problem of addictions—using research and clinical wisdom from the areas of neurobiology, trauma, epidemiology, sociocultural forces, psychodynamics, and cognitive/behavioral theory to create a holistic assessment and treatment model. Harm reduction psychotherapy represents a radical paradigm shift, one that 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.

Often, when harm reduction is mentioned, it is not clear exactly what one is referring to. The harm reduction movement actually has three distinct but related "arms:" The public health arm has contributed syringe exchange and better access to medical care to active drug users without requiring abstinence as a condition of receiving services. The policy/advocacy arm focuses on changing laws and policies that discriminate against drug users. The treatment arm is the newest. Most discussions of harm reduction use either public health or advocacy language and thus contribute to confusion about the unique contributions of harm reduction *treatment*. The reduction of drug-related harm is still the central goal of any harm reduction intervention, including treatment, but the placement of emphasis is important. In public health and advocacy, the emphasis is on protecting the safety and rights of drug users. In treatment, by contrast, people come because they recognize (or have been told) that their substance use is harmful and they want to explore the options for fixing the problem. Harm reduction treatment, collectively referred to as Harm Reduction Psychotherapy (HRP) by its developers, is client driven, collaborative, holistic, respectful, and empowering. Contrary to the dominant paradigm of substance abuse treatment where abstinence is the pre-ordained goal, *harm reduction treatment does not state that abstinence either is or is not the goal of treatment*, but rather that it is up to the client to choose and pursue appropriate and realistic goals. These might be total abstinence, abstinence from their most problematic drug only, or some combination of reduction in frequency, in amount, or in dangerous behaviors associated with drug or alcohol use. The dichotomous and often contentious question, "*Should I do abstinence or harm reduction?*" is rendered pointless. It is our view of HRP practitioners that *all* treatment should be harm reduction-informed.

Background to Harm Reduction Psychotherapy

The problems of substance abuse are complex and at times seem to be overwhelming our society. Many of us know someone who has suffered harm related to drug use, either self or a family member or friend. However, media portrayal of the incidence and severity of these problems is unrealistic and inflated. For example, while heroin is thought to be a universally addicting drug, only 22% of all users actually become dependent on it (compared to 65% of nicotine users). Of a total of 600,000 drug-associated deaths each year in the United States, most are caused by legal drugs: 450,000 deaths as a result of tobacco, 125,000 from alcohol, and only 25,000 from all other drugs. These statistics do not, of course, minimize the real harm that is done to individuals, their families, and society as a result of substance misuse.

In addition to the numbers of people affected directly or indirectly by drug or alcohol problems, it is increasingly common for people to enter psychotherapy with coexisting substance use and psychiatric problems. Whether this represents a new epidemiological reality or merely that our diagnostic acumen has improved, more and more therapists are confronted with patients about whom they know very little. Most of our training has been seriously lacking in the area of alcohol and drug use and the disorders associated with such use. It is not only a lack of training that causes our hesitation in accepting a referral of someone who is alcohol or heroin dependent, however. As members of this society, we are vulnerable to the negative attitudes and stereotypes regarding people with alcohol and drug problems. The stigmatization of this diverse group of people enters into our professional training and our countertransference. At heart, we may feel that we don't really even *like* "those people."

Principles of Harm Reduction Psychotherapy

- Not all drug use is abuse: people use drugs on a continuum from benign to chaotic.
- People use drugs for reasons, reasons that must be understood, appreciated, and treated, not confronted. In clinical terminology, drug use is an adaptive behavior rather than primarily pleasure-seeking or self-destructive. People use drugs for specific reasons and they continue to use them because they work (at least in the short run). HRP requires us to acknowledge and explore the adaptive reasons for a person's use of drugs.
- Drug use is a relationship between the user, the drug, and the emotional experience that binds them. Just as attachments to people may be more or less pathological, so may a person's attachment to drugs or alcohol.
- Change in addictive behavior is usually gradual, relies on the resolution of ambivalence about one's relationship with drugs, and passes through a series of stages. These stages are best negotiated with the help of motivational enhancement.
- People vary widely in their ability to manage drugs. Many can and do make rational decisions while using drugs, and do not necessarily have to quit in order to do less harm to self or others. In fact, research shows that many people manage formerly abusive or dependent drug use patterns by spontaneous recovery, moderation, or *reduction* in drug use or drug-related harms. There is no way to predict at the outset who will attain which of these goals.
- Each person's relationship with drugs is unique. Therefore, HRP is a collaborative model in which the goals and the pace of treatment are established together between client and the therapist, not pre-ordained by "the program."
- Rather than a disease, we consider substance misuse a biopsychosocial phenomenon in which the relative importance of biology (for example, genetics, health status, age, gender), psychology (mental health/illness, identity, motivation, and expectation), and environment (environmental stressors as well as setting of use) vary from individual to individual. We use the model of drug, set, and setting to work with these interrelated aspects.

This article has introduced the reader to the background and principles of Harm Reduction Psychotherapy (HRP). Part 2 of this article will describe the clinical practices, techniques of HRP, and attend to the many countertransference reactions a therapist will have to cope with when using this unique model.

References and Suggested Readings:

Denning, P. and Little, J. (2012). *Practicing Harm Reduction Psychotherapy*, 2nd Edition. New York. Guilford.

Denning, P., Little, J, and Glickman, A. (2004). *Over the Influence: The Harm Reduction Guide to Managing Drugs and Alcohol.* New York. Guilford Press.

Miller, W., Rollnick, S. (2013). *Motivational Interviewing: Helping People Change,* 3rd Edition. New York. Guilford Press.

Prochaska, J., DiClemente, C., Norcross, J. (1992). In Search of How People Change: Applications to Addictive Behavior. *American Psychologist, 47 (9),* 1102-1114.

Zinberg, N. (1984). *Drug, Set, and Setting: The Basis for Controlled Intoxicant Use*. Yale University Press.

Patt Denning, PhD, is Director of Clinical Services and Training at the Harm Reduction Therapy Center in San Francisco and Oakland: pattdenning@harmreductiontherapy.org