

Harm Reduction Psychotherapy: An innovative alternative to classical addictions theory

BY PATT DENNING

The public health system continues to struggle with the challenge of attending to the needs of a drug-using population in the current climate of zero tolerance and the war on drugs. The mental health care system has had a particularly difficult time adjusting to working with individuals with both mental health and substance use problems. Clinicians are often unaware of the different characteristics and special needs of a drug-using psychiatric population. This lack of training in the face of such difficult situations evokes feelings of frustration, anger, and hopelessness on the part of service providers, leading them to view drug users as untrustworthy.¹

This article describes the traditional model of treating addictions and compares it to a new approach called Harm Reduction Psychotherapy (HRP), a holistic method for assessment and treatment based on reduc-

ing drug-related harm. The traditional 12-step, disease model theory describes addictions as a unitary progressive disease that will prove fatal for addicts unless they abstain from all psychoactive drugs for the rest of their lives.² In contrast, HRP is an integrated treatment model that combines the principles of harm reduction with the psychodynamic and cognitive model of psychotherapy. HRP uses a biopsychosocial model that varies for each person and each drug used. This new model is based on the presence of a continuum of drug use that ranges from abstinence to chronic addiction; over time, most people will move toward reducing drug-related harm.³

Traditional treatment: Based on the disease model of addictions

Most research data now available indicate that the 12-step programs of Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous are most helpful for alcohol-dependent and other drug-addicted pa-

tients as they seek to achieve secure, long-term abstinence.⁴ Indeed, the traditional treatment of addiction begins with discontinuing drug use in order to recover and before dealing with other mental problems. In this approach, mental health problems may eventually resolve, or the patient will follow the doctor's orders by taking the medications prescribed. In many cases, medications have been viewed in traditional drug treatment as drugs and thus are seen as prolonging dependency. Because of this, there is a need to break the habit before treatment begins. In essence, physicians should be prepared to work with patients as long as necessary to stabilize their sobriety.

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Traditionally, it has been assumed that drug users are unreliable and cannot be trusted with complex medical regimens, and therefore that drug users should not receive other treatments while still using drugs. Traditional

drug treatment creates a revolving door of treatment, not of patients. In general, drug users are overly stigmatized, but in reality are not necessarily any more impaired in their ability to adhere to medical treatment than those who do not use drugs. For example, in the treatment for depression, only 33 out of 100 patients receive medical treatment and prescriptions; of these, three do not get the prescriptions filled, 10 fail to take them as directed, and 10 drop out due to side effects and/or poor follow-up.

Harm Reduction Psychotherapy

Harm Reduction is a set of principles and interventions arising from standard public health models. Originating in The Netherlands as a direct response to the HIV epidemic in the early 1980s, this philosophy was introduced in the United States by Edith Springer in 1991^{5,6} and by other health advocates on the East Coast. Health promotion and risk reduction are the

major goals, and the inclusion of the target population in designing services is integral to the philosophy. Because communities and the individual drug user are involved in the decisions about what services are needed, Harm Reduction as an orientation changes faces with each new program and each client.

HRP is an Addiction Treatment Alternative approach based on the belief that people can get better even while using drugs, and that not all drug use is drug abuse. In contrast to traditional disease models, the principle of harm reduction is that drug problems are the result of serious life problems as well as a source of harm to oneself and others. Inherent in this approach is that harm can come even to those who use drugs nonaddictively. People can make sensible, life-saving choices while using drugs, including using them more safely.

HRP becomes involved with all problems, starting with the client's hierarchy of needs (start where the client is). This treatment has no punitive sanctions for what people put into their bodies or refuse to put into them. Rather, it encourages individuals to talk honestly so that they can plan and make decisions about their lives, their health care, and their drug use. HRP is not an all-or-nothing process; change actually happens in stages with the overall goal of achieving better health.

HRP treatment protocols: What is done and who does what?

HRP uses the Stages of Change model to help people assess their motivation toward changing behavior.⁷ There are several stages of change:

- Precontemplation stage: At this stage, the person is not thinking about the problem. The person is asking the question, "Who, me?"
- Contemplation stage: At this stage, awareness sets in, but is characterized by ambivalence. The person is saying, "Yes, I have a problem, but..."
- Preparation stage: At this stage, the person starts making a plan.

Most of us are ambivalent about change. Indeed, resistance and ambivalence are normal parts of change. Motivational interviewing (MI) focuses on building a relationship that understands and helps to resolve ambivalence and resistance. Then, it utilizes assessment as treatment rather than using a diagnosis. HRP evaluates and negotiates the hierarchy of health risks and needs with the patient. Medical treatment is not withheld

based on biases and assumptions. For example, one assumption would be that a person who uses drugs surely cannot adhere to a treatment protocol. HRP assumes the best in patients and plans for the worst.

The core of the treatment is resistance reduction, working with barriers. HRP seeks to determine whose job it is to treat the patient. Is it the MD, RN, researcher interviewer, or case manager? It then defines the best treatment under optimal conditions. These conditions include the identification of specific barriers, absolute contraindications, and necessary adherence. MI develops strategies to overcome one barrier at a time; HRP works with the patients' strengths. For instance, heroin addicts may be ideal patients for complex, scheduled medical regimens since they are accustomed to timing, dosing, preparation, and side effect management.

HRP and motivational interviewing

Motivational interviewing⁷⁻⁹ employs techniques designed to reduce resistance and increase motivation for change. This view holds therapists as responsible as clients for changes in the level of motivation and resistance to change. Motivational interviewing stresses the importance of eliciting and reinforcing clients' statements of self-efficacy and problem recognition, while refusing to engage in confrontation or arguments. The use of open-ended questions and summarizing a patient's history by using a on-the-one-hand/on-the-other-hand balancing technique stresses that the therapist appreciates the complexities of the client's drug-associated problems: "On the one hand, I can tell that you are really worried that your alcohol use is getting out of control, but you also seem to really enjoy the beers that you have with friends after work." This type of statement allows the patient to explore fully his or her ambivalence.

The definition of success is radically changed in Harm Reduction Psychotherapy. Instead of abstinence from all psychoactive drugs, success is defined as any reduction in drug-related harm, a step in the right direction. A treatment plan is mutually constructed along several lines. Does the person hope to abstain now, later, or never? Does he or she hope to abstain as soon as possible from one drug, but not another? Or, from another dimension, does the patient want to make sure that he or she does not get fired from a good job? What changes will he or she have to make to prevent that adverse event?

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Summary

Harm Reduction Psychotherapy is an innovative treatment for people with alcohol and other drug problems. Unlike the traditional disease model of addiction, HRP uses a biopsychosocial approach to understand the complexities of drug use, abuse, and addiction. In other words, in the context of HRP, addiction is not the primary issue. Rather, it is an interactive phenomenon in which the relative weight of biology, psychology, and social factors varies for each person and for each drug he or she uses. HRP allows us to assess each person individually and to plan treatment that is tailored to the individual's relationship with alcohol and other drugs. It also incorporates other important problems: emotional disorders, family problems, social alienation, and medical complications. These issues are discussed at the beginning of consultation, without patients having to focus solely on their alcohol or drug problem. The unique aspect to HRP is that patients do not have to commit to abstinence as a condition of, or even necessarily as a goal of, treatment.

HRP seeks to identify and work with the barriers to treatment adherence in any patient. It is clear that most medical patients have some difficulty understanding and adhering to medical recommendations and treatment protocols. However, drug users have particular problems that must be identified. HRP helps people create individual strategies to decrease harmful alcohol and drug use. It uses a nonjudgmental and collaborative approach to actively encourage individuals to explore their own barriers to change and to choose among a range of options such as abstinence, moderation, or other short-term goals.¹⁰ Motivational interviewing can be used to motivate behavioral change with the goal of reducing the effects of adverse consequences.

References

1. Denning P. *Practicing Harm Reduction Psychotherapy: an alternative approach to addictions*. New York: Guilford Press, 2000.
2. Room R, Greenfield T. Alcoholics anonymous, other 12-step movements and psychotherapy in the US population, 1990. *Addictions* Apr 1993; 88(4):555-62.
3. Peele S. What works in addiction treatment and what doesn't: is the best therapy no therapy? *Int J Addict* 1990-1; 25(12A):1409-19.
4. Chappel JN, DuPont RL. Twelve-step and mutual-help programs for addictive disorders. *Psychiatr Clin N Am* Jun 1999; 22(2):425-46.
5. Clear A, Springer E, Lanier C. The Harm Reduction Coalition. *Newsline People AIDS Coalit NY* Jun 1998:27-34.
6. Springer E. Effective AIDS prevention with active drug users: the harm reduction model. In: Shernoff M, ed. *Counseling chemically dependent people with HIV illness*. New York: Harrington Park Press, 1991:141-57.
7. Miller JH, Moyers T. Motivational interviewing in substance abuse: applications for occupational medicine. *Occup Med* Jan-Mar 2002; 17(1):51-65.
8. Miller WM, Rollnick S, eds. *Motivational interviewing: preparing people to change addictive behavior*. New York: Guilford Press, 1987.
9. Carroll KM, Libby B, Sheehan J, Hyland N. Motivational interviewing to enhance treatment initiation in substance abusers: an effectiveness study. *Am J Addict* Fall 2001; 10(4):335-9.
10. Denning P, Little J. Alternatives to traditional drug treatment. Presentation, 14th National HIV/AIDS Update Conference, Mar 19-22, 2002. San Francisco, CA, session #204.

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