

Harm Reduction Therapy Groups: Engaging Drinkers and Drug Users in a Process of Change

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ABSTRACT. Harm reduction psychotherapy is the newest approach to engaging and working with substance users and abusers. It combines public health principles and interventions, motivational interviewing, and psychiatric treatment with psychodynamic psychotherapy to create an integrated model of treating individuals with substance abuse and psychiatric or emotional problems. In groups, harm reduction psychotherapy exposes group members to the continuum of drug use and abuse and to the continuum of motivation to change addictive behaviors. Members are encouraged to work through their impulses to use alcohol or other drugs in the context of a diverse group. This paper focuses on an ongoing psychotherapy group of men and women who use or abuse different drugs and are at different stages of change and is well-illustrated with examples of group interactions. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2006 by The Haworth Press, Inc. All rights reserved.]*

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“The only requirement for membership in Alcoholics Anonymous is a desire to stop drinking.” This oft-repeated phrase is a testament to the low-threshold nature of AA and its sister 12-step programs. Harm reduction therapy and harm reduction therapy groups have developed over the last fifteen years to reach out to the majority of substance abusers in the United States who do *not* have a desire to stop drinking (or using), do *not* avail themselves of existing treatment or self-help resources (SAMHSA, 2002), and who continue to use alcohol and other drugs despite incurring actual or potential harm. Harm reduction therapy thus lowers the threshold for entry into a “treatment” relationship even further than do 12-step groups.

Harm reduction is a “come as you are” approach that welcomes drug users into a helping relationship that allows them to set their own short- and long-term goals. In harm reduction work, a myriad of outcomes, not just abstinence, are considered to be helpful (harm reducing). Harm-reducing as abstinence is, most substance abusers in the United States are not abstinent; moderation is often an outcome of problem drinking (Rotgers, Kern, Hoetzel, 2002; Saladin and Santa Ana, 2004). In harm reduction treatment, which addresses alcohol as well as other drug use and abuse, data has been gathered on the varieties of success in overcoming problems with drugs (Denning and Poon, 2004; Ruefli and Rogers, 2004). For example, one person has quit crack, learned to drink moderately, and continues to use medical marijuana, while another has stopped shooting heroin, goes on methadone maintenance, but still struggles with a long history of alcohol abuse. A third, in danger of losing her job, has quit all psychoactive substances, while a fourth who is HIV positive committed to using condoms during all sexual activity even while still using crystal meth (speed), and a fifth now hands his car keys to the bartender as soon as he enters the bar.

Harm reduction therapy has grown out of the data and common sense of two fields of practice and research—(1) the public health arena of needle exchange and other interventions that interrupt the spread of communicable diseases and prevent overdose, abscesses, and other medical consequences of drug use (Goosby, 2001; Marlatt, 1998; Springer, 1991), (2) the rich cognitive-behavioral research on facilitating motivation for change in addictive behavior (Marlatt, 1998; Springer, 1991; Miller and Rollnick, 1991 and 2003) and the transtheoretical (stage) model of change (Prochaska, DiClemente, and Norcross, 1992).

Harm reduction therapy is an integrated biopsychosocial, rather than a sequential, model of treatment. In other words, clients are treated simultaneously for their drug, psychiatric/emotional, and social issues.

The primary developers and practitioners of harm reduction therapy (Denning, 2000,1998; Denning, Little, and Glickman, 2004; Denning and Little, 2001; Little, 2004, 2002, 2001; Springer, 2004 and 1991; and Tatarsky, 2002 and 1998) have integrated public health and cognitive-behavioral interventions into a framework of psychodynamic treatment that focuses on the meaning of addictive behavior, the transference/countertransference dynamic, and resistance. They offer psychotherapy for any problem a client identifies as worthy of attention, accurate information about drugs so that clients can make informed choices and thus increase the likelihood of avoiding harm, and psychiatric treatment for mental health disorders. Originally established as an individual treatment model, this author has applied the principles and interventions of harm reduction therapy to both drop-in support groups and ongoing therapy groups.

In the short-term, harm reduction therapy encourages people to start where they are and to select goals that they are most likely to achieve in an effort to reduce individual and community harm and to start a change process that supports self-efficacy (Miller and Rollnick, 1992 and 2003). Second, harm reduction therapy addresses any and all of the issues that bring a person to therapy—relationships, emotional pain, work issues, psychiatric and social problems. Third, harm reduction therapy is a psychological approach to helping people identify long-term goals vis a vis change, reduction, or cessation in alcohol and other drug use. Finally, harm reduction therapy uses many strategies to help the user change behavior to achieve those goals at the same time as therapist and client continue the work of overall improvement in psychological well-being (Denning, 2000; Denning and Little, 2001).

Previous psychotherapeutic approaches to working with drug problems naively assumed that drug use and abuse were symptoms of psychological problems. In harm reduction therapy, this is not assumed. The relationship between emotional and psychiatric disorders and drug use and abuse must be explored with each individual and, as long as a person's relationship with alcohol and other drugs is attended to along with the many other concerns that bring a person into therapy, then the work of addiction treatment is being done. What the harm reduction therapist is looking for is to develop and sustain a therapeutic relationship in which the user can understand her own relationship with drugs, tell her own story, and discover and work toward her own goals. Movement in a healthy direction is generally hoped for and all interventions are dedicated to reducing resistance and creating positive movement. The motto of harm reduction is "Any positive change."

HARM REDUCTION PRACTICE IN GROUPS

Not surprisingly, harm reduction groups are designed as a low-threshold treatment option. Harm reduction groups welcome members who want to work on a myriad of issues in addition to their relationship with drugs. Members are supported for their strengths and are encouraged to prioritize and talk about whatever concerns them. They are protected from perceived attack by a strong culture of acceptance, a culture which begins by welcoming people who have not given up using drugs, who typically have not decided to do so, and who may at times come to sessions intoxicated. In fact, members are encouraged to show up, even and especially when they have used (as long as they do not drive to get there)!

Unique characteristics of actively using clients, in this author's experience, are difficulty managing strong affect, especially their own and others' aggression, extreme vulnerability to narcissistic injury (often experienced as shame), and difficulty managing relationships. These observations correspond with Khantzian's (2002, 1990) assertion that affect tolerance, self-care, self-esteem, and relationships are the four key vulnerabilities of substance abusers. To avoid the possibility of treatment drop-out due to difficulty tolerating stress, these vulnerable individuals are welcomed into groups "as they are" and are not expected to change anything as a condition of treatment. Prospective group members are told that the goals of treatment are (1) to learn more about their relationship with drugs; (2) to understand the interaction of drug use with other life issues of concern to them; (3) to make decisions about change; and (4) to use the group's help to make changes. There is no time frame for this process. If no change in drug use occurs, that is accepted and the treatment continues.

Members of harm reduction groups have very diverse goals regarding future drug and alcohol use. Typically, prospective members have reached a point of chaotic drug and/or alcohol use, and they are not happy with either the quality or the consequences of their use. Some are clear that they want to quit the use of one or all of their drugs of abuse or they want to achieve successful moderation of use. A minority of prospective members are less clear about what they want and are eager to join a group where the outcome is not pre-determined, where they can attend to their many concerns in the order that they deem most important, and where they can explore their relationship with drugs and make decisions about change later. The result is that harm reduction groups

have members with widely divergent goals about future use, from harm-reducing changes to moderation to abstinence.

Harm reduction groups provide an excellent opportunity for group members to witness the continuum of drug use and abuse without having to experience it all themselves! Members also get to witness the varieties of progress and success. Just as drug use occurs on a continuum from benign to useful to problematic to lethal, a continuum that for most people takes a long time to develop, so does the undoing of problematic patterns of drug use occur on a continuum that is much more gradual than the often hoped-for dramatic conversion to abstinence after a person “hits bottom.” Abstinence is one of many valuable harm reduction solutions to the problems people encounter with drugs, but it is not the only one. The emphasis of harm reduction practice is on the *process*, not on the *outcome*.

Because of the tension aroused by such diversity in harm reduction groups, learning to tolerate tension is a key developmental task for members. Welcoming diverse drug use patterns, emotional difficulties, and goals regarding future use into harm reduction groups is not only a humane and welcoming approach to treatment, it also, not coincidentally, offers group members a developmental opportunity. If one assumes, in accord with the author’s and of Khantzian’s observations about drug abusers, that tolerating tension is another difficulty, then why not create the conditions in treatment that offer group members the opportunity to develop greater tolerance and flexibility by bringing them into heterogeneous rather than homogeneous groups.

CHARACTERISTICS OF THE LEADER OF A HARM REDUCTION GROUP

First and foremost, the leader of a harm reduction group is challenged to practice in certain ways that are antithetical to traditional addiction treatment. The harm reduction group leader must:

- accept the reality of drug use and tolerate intoxication comfortably.
- be able to encourage people to talk about the details of their use and trust that the group will develop tolerance for anxiety-provoking problems.
- focus on behavior, not necessarily the drug use itself.

- not expect or demand change—the client is the ultimate director of his treatment.
- accept that ambivalence and resistance are perfectly normal and work with them.

True adherence to the principles of harm reduction—starting where the client is, respecting client choice and autonomy throughout the treatment, and accepting that there are many ways to reduce drug-related harm—helps clinicians break away from the abstinence vs. non-abstinence dichotomy. This dichotomy leads to the dramatic language and interventions of traditional recovery programs where the correct outcome (abstinence) is predetermined and the treatment is conditional on the user stopping all use of intoxicants before entering the treatment. In harm reduction treatment, by contrast, if the therapist becomes attached to a particular outcome such as abstinence, she remains part of the dichotomous paradigm of abstinence vs. non-abstinence. As a matter of fact, if she holds out for *any* particular outcome such as safer sex, use of clean needles, reduction of pot smoking, abstinence, or any of a myriad of harm-reducing changes, she risks encountering resistance from the client, simply because she has declared her own agenda! The most important contribution of harm reduction to the development of addiction treatment is not the growing literature on successful interventions and outcomes that lead to abstinence or to the many useful alternatives to abstinence, but a paradigm-shifting departure from the dualism that colors our thinking about drugs, drug use, and drug users.

This letting go of the therapist's agenda in harm reduction therapy is supported by the self-determination theory of Deci and Ryan (2000), who posit that motivation is healthiest if it is intrinsic (self-generated) or integrated into a person's sense of self. These healthy states of motivation, as opposed to motivation that is externally driven by rewards or punishment, optimize a person's interest in accomplishment and well-being. The needed ingredients that support intrinsic motivation and/or encourage the integration of extrinsic motivation, they assert and have demonstrated through their research, are feelings of competence, autonomy, and relatedness. Competence is developed in the context of praise and admiration from significant others. Autonomy refers to the sense that one is self-driven. It derives from the non-controlling stance and respect for choice of significant others. Relatedness can be established in infancy by secure attachment to primary caregivers and fostered later in life by the interest and support of significant others—parents, teachers, coaches, and therapists (Deci and Ryan, 2000).

Harm reduction therapy, while not derived by this author directly from self-determination theory, embodies an appreciation of each person's competence and autonomy by recognizing the attempt by the client to adapt to life by using drugs, an attempt that is often better than the alternative, especially in the case of trauma survivors. Harm reduction therapists actively accept client choice by reinforcing the possible adaptiveness of the choice to use drugs, even if that drug use also incurs negative consequences. By reinforcing the effort to adapt through drug use, the therapist is supporting self-efficacy (Miller and Rollnick, 1992 and 2003). The range of therapist interventions that facilitate self-exploration, decision-making, and behavior change include asking such questions as "Why do you use? How is it of use to you? What experience do you hope to have?" These questions can and should lead to assisting each member to work a "decisional balance" (Miller and Rollnick, 1992 and 2003), an elaborate pros and cons consideration that includes evaluation of the meaning and importance of each item on the list. The group then is in a position to help each member evaluate and reevaluate his decisional balance and to suggest and support various strategies for behavior change. The context for this work is a virtually unconditional relationship with the therapist. (It is not completely unconditional because the client must show up when the therapist is there and, in some cases, must pay a fee to contribute to the continuation of the relationship.)

Following are descriptions of three group sessions that will illustrate in much greater detail the type and style of interventions used by this author in harm reduction groups. These sessions occurred in an ongoing harm reduction therapy group that has been meeting since 1998. This group is one of five ongoing therapy groups that meet weekly at the Harm Reduction Therapy Center. Three others are also groups for drug users and the fifth is a group for family and friends of problematic drug users. This group meets in a private practice setting. Group members pay fees as in any other therapy group. The following sessions took place over the course of four months. The six members who were present at these sessions have been in the group from three months to six and a half years at the time of writing. In each session, a conflict emerged, followed by some sort of resolution. The leader's specific interventions demonstrate the principles of motivational interviewing, self-determination theory, and harm reduction. Names and defining characteristics of group members have been changed.

GROUP #1***On the Value of Talking About Drugs and Uncovering Differences***

In this session, John had had difficulty hearing Allan, who speaks softly, often drifts off in mid-sentence, and has word-finding difficulties. Allan is a heavy marijuana user, and although he often speaks in this hard-to-follow fashion whether using or not, John is new to the group and does not know this. John is typically agitated and has difficulty sitting still. He has a history of impulsiveness, parasuicidal behavior, and violence toward others for which he has spent four years in prison. He also has a 20-year history of membership in Narcotics Anonymous so is from a culture of abstinence. He has joined this harm reduction group following a relapse to methamphetamine and GHB, which contribute to unsafe sex and many missed days of work. He wants additional support to regain abstinence from those substances, but wants help to moderate his medical marijuana use, which disturbs his wife. He feels that a harm reduction approach will help him with these disparate goals, while NA, which he continues to participate in, focuses only on abstinence.

John could no longer stand to wait for Allan to get to his point and burst out, "Are you high? I mean, have you smoked in the last 24 hours?" Allan froze, as did the other group members. Allan believes in harm reduction as an advocacy movement for the right of drug users to use without punitive sanctions. He finds any hint that group members should be accountable for their drug use offensive. Margaret, a new member, asked, "Is it a rule that we say? Should we disclose our drug use every week?" The group debated the pros and cons of regularly reporting the details of their use. Margaret thought it important to "count" the frequency and amount of her drinking (a common harm reduction activity) and to report back to the group. Allan, on the other hand, experiences such reporting as punitive.

John, despite a long habit of reporting abstinence and relapses at NA meetings, was surprised to find himself getting upset that he should "report" to the group. He has much more fear of judgment than he had ever thought. At the beginning of the session he had mentioned using speed a couple of nights ago. Margaret had asked him many detailed questions about how much he bought, how many hits he took, how high he got, and how much money he had spent. John had erupted with anger. At first he explained his outburst as a defense against encouraging someone else to use a new drug. He told a story about introducing someone to

speed who subsequently had a heart attack. When Margaret reassured him that it was not John's responsibility to protect her against drugs, John became reflective about how ashamed he is when he has to talk about his drug use in detail. While inclined to agree that reporting represents "being real" and doing the work he came to group for, he became confused by his lack of desire to be open.

To bring attention to the core therapeutic challenge, the group leader questioned the usefulness, or lack thereof, of talking freely in group about thoughts, feelings, and impulses. John talked about his shame about his self-destructive impulses and behaviors and about feeling stupid when others find out about them. He feels different than the other group members—particularly because he is the only African American member of the group and has been in prison. He is proud of his years in "recovery" and is impatient with other members' naiveté about "addiction," but he is also ashamed of his hard life. Allan spoke up about his own shame. His disastrous history with relationships and intimacy, his history as a scapegoat, and his deep loneliness since he was a young child are very painful. When he talks about these things, he gets deeply sad—it makes talking in therapy a stressful experience. The group quieted and softened during these self-revelations.

After a pause, Margaret asked the group to help her work on her alcohol problem—she wanted to drink the last of her wine that night after the group and try a period of abstinence. She made it clear that she was not going to dump it down the sink, so the group attended to the task of helping Margaret plan drinking the rest of her wine, which consisted of a half a bottle in the refrigerator. They discussed the many opportunities to buy more, avoidance strategies, the risk that her girlfriend will buy more, the dilemma of having a drinking partner who is not committed to stopping, and options for other activities to distract her and to soothe her considerable anxiety.

At this point, another conflict ensued. Sally insisted that Margaret meditate to calm her very evident anxiety and wouldn't hear that Margaret *can't* meditate because she is so anxious. She jiggles her legs, worries about everything, and can't stop cleaning her house, and can't sleep unless she is drinking. While many group members say in awe, "No WONDER you drink!" Sally is painfully reminded of her own anxiety, which she views as the source of her crack smoking and drinking. For her, treating anxiety is her top priority. Margaret, however, would prefer to focus on her relationship with alcohol as a top priority. They went back and forth, essentially explaining themselves to each other, for several minutes. With the help of the group (someone finally shouted,

“You’re not hearing Margaret. She *can’t* meditate!”), Sally was able to see that she was projecting her own priorities onto Margaret. She apologized and each came closer to seeing that both concerns are important, neither more than the other.

What Happened in This Group?

This group session illustrates the tension aroused when active users are asked to openly discuss their use, the tension aroused by cultural as well as goal differences between group members, and the stages of change, a phenomenon studied and described by Prochaska and colleagues that identifies addictive behavior change as an incremental process that progresses through a predictable set of stages, stages that will be described later in this section.

Talking about drug use is both tantalizing and embarrassing. In groups, people talk about drugs a lot and many complain about this in both harm reduction groups as well as in AA and NA meetings and other treatment programs. Since people often harbor fantasies about drugs and impulses to get high anyway, it is useful to encourage bringing those fantasies into the open and then talking them through. This process is the verbal equivalent of “cue exposure” (Drobes, Saladin, and Tiffany, 2001; Sitharthan et. al., 1997), the cognitive-behavioral technique of exposing people to various stimuli related to their drug/s of choice, either in films or by bringing drug paraphernalia into the room which elicits a psycho-physiological response, and then talking through the experience. Likewise, by verbally eliciting fantasies and projections, group members can talk through and thus forestall acting on their impulses to use.

As John so poignantly told us, revealing the details of his use is shaming. In this group, the leader could have been active, but chose to simply ask the group to talk more about the difficulties of exposing their impulses in a group. John and Allan were truly pained; their conflict was important for the group because it raised existential issues about the pain of being different. Despite their seeming similarities, group members feel more different than similar. *This* is what they have in common.

Disarming shame and making difference tolerable can be done by reinforcing the *adaptiveness* of each person’s drug use (e.g., “no wonder you drink!”) and by supporting self-efficacy (“alcohol does a wonderful job of suppressing anxiety”). For example, at one point when Margaret and Sally were going at each other, the leader said, “Sally, you have done an excellent job of coming to terms with your relationship

with crack and its connection to your anxiety. Margaret is at a different stage. What's bothering you about that?" and "Margaret, you are doing an excellent job of clarifying to Sally the difference between her and you." These sorts of interventions support members' sense of competence, one of the ingredients that helps people to integrate motivation (Ryan and Deci, 2000).

The addictive behavior model that best helps harm reduction group members understand and benefit from diversity is the transtheoretical model of change (Prochaska, DiClemente, and Norcross, 1992), more commonly known as the stage model of change. Knowledge about how people make changes in behavior is essential to any treatment process. According to Prochaska and colleagues, change in addictive behavior typically proceeds through a predictable series of stages. The action stage, in which a person makes a change in behavior, is the *fourth* stage. Before that occurs some very important decisions must be made and preparatory work accomplished. Unlike in many treatment programs where the work of becoming "ready" occurs *before* the person enters treatment, harm reduction programs welcome people into treatment well before they have decided to change or give up their addictive behaviors in order to support the decision and preparation phases.

1. *Precontemplation* is the stage when a person doesn't know that her problems are related to drug use or that she even has a problem with drugs. Many people who are thought to be in denial are actually in precontemplation, which is characterized by ignorance about drugs and their consequences, not denial. The idea that one has a problem and should do something about it is a new concept ("who, me?"). It is possible that there also arises resistance to acknowledging a problem in this stage. This resistance is generally best handled by offering information in a non-demanding way and by expressing curiosity about the individual's history and relationship with drugs.
2. In the *Contemplation* stage (the "yes, but" stage) a person is now aware of drug-related problems, but also wants to keep using and has good reasons and arguments for doing so. In this stage, a person might decide to make a change, or not. The therapist's job is to help the person weigh the pros and cons of changing so that any decision made is authentic.
3. In the *Preparation* stage, the person has decided to make some behavior change and begins a process of planning and practicing. This stage can take some time as the person goes back and

forth trying to figure out what will work best for her. The therapist should be very active in proposing options, making sure the pitfalls of a plan are foreseen, and for suggesting that they together make a plan B and perhaps even a plan C.

4. In the *Action* stage, the person makes hopefully sustainable changes in drug using behavior and begins to put structures in place that will support the changes.
5. *Maintenance* refers to the hard work of changing one's life in order to support changes in drug use. Traditionally, this would be the time that psychotherapy on other issues would start. In harm reduction therapy, of course, this work has been integrated all along the process.

Of course people often *Relapse*, learning important lessons that will help them in the future. It is important that a person not sustain any damage caused by shame at relapsing. The therapist is instrumental in this by suggesting that if a plan didn't work, it just wasn't quite the right plan, or the preparation process was insufficient. Blame the plan, not the person! As a client once said, "Shame don't change anything." Once this hard work has been done, the person exits, or *Terminates*, the addictive process. Whatever change he had wanted to make, be it abstinence, moderation, or safer use, has been accomplished and the drugs have lost their power in his life. It is crucial that individuals negotiate each stage of change only when they are ready. Otherwise, unsustainable new behaviors might fail.

Using the stage model of change, therapist and client must accurately assess the stage of change the client is in *for each identified problem*. For example, John is in the preparation stage for reestablishing abstinence from speed and GHB and in the contemplation stage about what to do about marijuana. Allan is in the early contemplation stage about heroin. Margaret is in the preparation stage for a trial period of abstinence from alcohol, while Sally is in the contemplation stage regarding crack and alcohol but in the action stage of treating her anxiety. The harm reduction therapist or counselor, in response to discovering the variety of motivations and readiness to change, will help each client develop a *hierarchy of needs*. The hierarchy of needs is essentially a goal or goals that reflect the *client's* priorities.

Groups provide a wonderful setting in which to develop goals because they expose members to the varieties of problems and of solutions. They offer a three-dimensional experience of being surrounded by different priorities and different options for resolving problems, ex-

emphified in the above group by Margaret's and Sally's differing approaches and priorities regarding their drug use and anxiety. While some stages of change groups (Velasquez et al., 2001) divide clients into pre-action and action stages, guide them through the change process using a combination of cognitive techniques and experience, and presuppose abstinence as the most common goal of group members, harm reduction groups challenge individuals to tolerate the tension of each members' different goals and an individualized pace of incremental change, to solidify their own identity, and to consider various options for change.

GROUP #2

Disarming Aggression, Surprising People Out of Compliance with Expected Outcomes, and Using the Group to Debate All Sides of Ambivalence

The three group members in this exchange have each at various times raised serious concerns about their suicidal thoughts and parasuicidal behaviors. They are three of the four members of this group most prone to hopelessness and despair. Because of concerns about the rage being expressed by one member, the group leader resorts to seemingly radical interventions. She is attempting to shock him out of false avowal of abstinence, an avowal that, when he fails, adds to his self-loathing and feeds his self-destructiveness.

Robert, a group member with a twenty-year drinking and drug history, opened the group by raging. "No f---ing doctor will help me!"

Sally: What kind of help?

R: Valium

S: What for?

R: To get off alcohol.

S: Why Valium?

R: I can't go f---ing cold turkey or I'll die. It would be easier to get my nuts cut off in this city than to get Valium to quit drinking.

Leader: I agree, you probably shouldn't go cold turkey if you've been drinking heavily. You might not die, but on the other hand, you don't want to risk having a seizure, so you're smart to think about medical detox. [*This affirmation of his stated motivation for Valium had the effect of cooling Robert's temper somewhat.*] How much have you been asking for?

- R: At least a week's supply.
Leader: My goodness, it only takes three days to detox, maybe four.
R: No way—at least a week!
Charles: Have you gotten Valium before from the doctor? [*All of these group members use the same psychiatrist.*]
R: Yeah.
C: What happened?
R: I blew it.
C: [*not missing a trick*] How many times?
R: Four or five.
S: Oh, well then, there you go—that's probably too many.
Silence.
Leader: You know, you do have the means to detox yourself.
R: What?
Leader: Alcohol.
R: [*blowing up at the leader*] What, are you kidding?
Leader: I guess that was an outrageous suggestion.
S: Yeah, no kidding—you gotta get away from it. How can you detox using the same thing you gotta get away from? [*There followed affirmation from C that she had gotten away to residential treatment and had detoxed with only two days of Librium.*]
Leader: Sure, it would be great for Robert to get away from it; I'm just suggesting that he *could* detox without dying if he wanted to badly enough. But what I really want to know is why he wants to quit drinking, anyway?
S: What kind of question is that? [*She was practically shouting.*]
Leader: Well, Robert has been drinking for so long, I just wanted to hear him talk about why he wants to give it up now. [*The leader is pretty certain that Robert is ambivalent about detoxing. She is trying to tease out his internal conflict and his possibly false compliance to a goal of abstinence by arousing a debate in the group. She is also trying to draw some of Robert's anger toward her because she is concerned about his potential for self-destructive acting out of his frustration.*]
S: Well, he just should.
Leader: [*pushing harder for the ambivalence but making it less personal in the hope that someone else will join Robert in a subgroup*] But we know how much he likes drinking. Anyway, we humans have been getting high for 8,000 years. Why stop now? Why all of a sudden are we supposed to be abstinent?
S: [*mouth agape*] Well, that's what *I* think, but what are we doing here then?

R: *[interrupting the leader before she answers]* Because I'm killing myself. *[Robert's initial rage and externalization are now spent. His tone is quite "sober" and he is much more serious about his situation with alcohol. He has moved beyond the question of Valium.]*

C: How much have you been drinking anyway?

R: A fifth a day of vodka.

C: What? You said you had quit!

R: I did, for about three weeks. I relapsed.

C: Really?

R: Well, not really. I did quit when I was in the hospital for my knee.

C: And?

R: I started right up again.

Leader: So you DID detox.

R: *[becoming wary again, because the leader had jumped too quickly on proof that he doesn't really need a week of Valium]* Well, yeah, but I was in the hospital.

Leader: So anyway, I still didn't get my question answered.

S: *[irritated now]* He said it, he's killing himself.

Leader: *[raising the heat even more in attempt to extract even more of Robert's anger and irritation]* But he tells us all the time that he wants to die. He seems to be doing an excellent job, so how's he going to accomplish that if he stops drinking? *[Silence for several seconds. The outrageousness of this interpretation mirrored the aggression expressed by Robert's demands. Such mirroring often has the effect of stopping the client's aggression in its tracks.]*

S: *[in a very toned down voice]* Well, what you need to do, Robert, is find something else to do.

[Some discussion about other activities ensued, none of it of great interest to Robert.]

Leader: *[now offering a problem-solving compromise]* I'll say it again—I agree you can't go cold turkey, but you could detox yourself. I can't represent the doctor, but you would stand a better chance of her helping you detox if you took some action that showed you really want to quit.

S: How would he do that?

Leader: He would drink a little less alcohol each day. We could help him work out a schedule that would be realistic.

R: But when I get up, I feel like shit and have a bigger drink.

S: Well have a smaller one, for god's sake!

[The leader interrupted a potential rift between Robert and Sally and described the practice of a former group member who used a measuring cup]

each day, and reduced his intake by an ounce a week. Robert then said he has actually been doing something like that—he buys half gallons of vodka because they're cheap, but then pours it into a pint bottle—twice a day.]

Leader: See, Robert's got the hang of it. He just has to decide whether he wants to use his method to cut down.

R: Well, I could pour just one a day.

Leader: No way. That's too dramatic a change, you probably won't do it, then you'll have a great excuse to beat yourself up.

C: You could keep pouring two, but just pour them below the shoulder. OR, don't fill them all the way, but add water to the top, then add more water every day. Actually, you should put the water in first, just in case [*again, thinking of everything*].

R: That's a great idea. Then I could really taste it. Vodka tastes like shit—I really hate it.

[*This is a first—an admission that he doesn't actually like alcohol.*]

R: [*his self-efficacy on the rise*] I did go from 70 mg of methadone to 2.5-5 mg a day. I just can't get any damned Valium. [*He had been forced into what is called a "feetox"—a rapid detox due to lack of ability to pay for methadone.*]

S and C together: Guess you don't get any of those Internet ads [*referring humorously to the many ads for online sales of prescription drugs*].

Leader: Do you guys know how amazing it is to manage a methadone detox like Robert has just had?

[*Robert beams, an unusual occurrence, his affect usually so irritable.*]

C: You know, you know, you look so much better; I really did think you weren't drinking.

R: Look at these bags [*pulling at the red bags under his eyes*].

C: Yeah, but your memory is so much better. [*The group had had serious concerns about Robert's mental status and the extent of neurological damage he had sustained from alcohol.*]

R: Wow, you're right. And when I stopped drinking in the hospital, people said I looked ten years younger.

C: There you go.

What Happened in This Group?

In this group session the leader first attempted to disarm Robert's potentially self-destructive aggression by drawing his anger and outrage to her by arguing that he didn't seem to have a convincing enough reason to change. The leader's second aim was to draw out Robert's ambivalence about change, in this case about quitting drinking. By bringing up

what he wasn't talking about, that he doesn't really want to quit and that he has "adaptive" reasons to keep drinking, the leader forced attention to both sides of his feelings about his relationship with alcohol. With the leader arguing the "no change" side, the group worked well with Robert to problem-solve and Robert ended up having to argue for change. Eventually the group and the leader worked together toward solutions. Finally, the leader and Charles complimented Robert on his successes in an effort to build self-efficacy and to cajole him into more authentic concern for himself.

Ambivalence, according to Miller and Rollnick (1992 and 2003) in their groundbreaking work on motivational interviewing, is a common state of mind of the substance abuser. People tend to avow their desire for abstinence when they arrive at the door of a treatment program or an AA meeting. While that desire may be true in the moment, it is far from the whole story. One doesn't want to end a long relationship with drugs any more than one wants to end a bad marriage with someone one still loves. How many times do we hear, "If I weren't running out of money/getting sick/getting in trouble, I wouldn't be quitting"? The work of motivational interviewing and of harm reduction therapy are to bring to the surface all sides of a person's ambivalence about her relationship with drugs and about change so that a real decision regarding change can eventually be made and realistic, sustainable movement can take place. In the above group, Robert was not acknowledging his ambivalence about alcohol, so the leader acted it out for him. In other words, she played the other side of the decisional balance.

The decisional balance (Miller and Rollnick, 1992 and 2003) is a key tool for working with ambivalence. A decisional balance is simply an elaborate pros and cons list that explores reasons for and against change and reasons for and against maintaining the same behavior. When the client protests his desire for change or abstinence, the therapist says, "but what about . . ." reminding the client of all his attraction to and reasons for using drugs. In this back and forth struggle, the client ends up arguing more and more convincingly for change. Arguing the "no change" side also has the effect of slowing down the pace of change and circumventing the dramatic abstinence-relapse-guilt cycle. Two things happen by the leader's coming to the defense of Robert's drinking and the "no change" side. When relieved of the need to secretly hang on to his drinking, he is able to more objectively evaluate its pros and cons.

In a group, the many sides of ambivalence are usually well represented by the thoughts and behaviors of multiple people. This creates a much richer picture of the dilemmas and challenges faced by any given

individual in the group. By taking each side of Robert's decisional balance, both the leader and Sally provided Robert with the experience of being understood. Not only was Robert's unspoken attachment to alcohol being voiced and understood by the therapist, Robert also found himself in an alliance with Sally, who offered much ego support to him and ran interference with the leader's more outrageous suggestions. The leader and Sally managed to have a lively debate about Robert's decisional balance. Robert felt emotionally understood by Sally on a conscious level and by the leader on an unconscious level. When he felt understood, he became more flexible and cooperative. In various ways, the leader and Charles supported Robert's self-efficacy. The leader acknowledged the adaptiveness of Robert's drinking. Despite the many consequences of his years of drinking, Robert is quite attached to it because of the relief he gets from his unremitting self-loathing. Drinking for him is also a convenient and effective way of acting out his suicidal feelings without actually having to kill himself by more dramatic means. Reframing drug use as adaptive is a way of supporting self-efficacy, another key principle of motivational interviewing and a necessary ingredient for sustainable change (Miller and Rollnick, 1992, 2003). By asserting that he has not been entirely foolish in his drinking career because he is in fact achieving his goals (unhealthy as they may be), the leader competes with the critical voices in his head that tell him he has been an idiot and a wastrel his entire life. Finally, Charles contributed to Robert's self-esteem by complimenting him on his improved looks and memory. This well-timed positive regard, which Robert would have rejected earlier in the session, completed the job of softening him up.

GROUP #3

On Developing Tolerance for Pain and Restraining the Impulse to DO Something

In this group session where four members were present, Robert talked extensively about feeling extremely depressed and hopeless, a common theme for him when he isn't irritable. He had joined the group the previous year, drinking heavily and in danger of losing his relationship, which did end shortly thereafter. He had, however, been on methadone maintenance and had not used heroin for several years. A couple of months later, unable to continue methadone maintenance because he

could not pay the \$210 monthly fee, he was put through a “fee detox.” A few months after this, he became quite ill and was diagnosed with pancreatitis. He has now stopped drinking.

During the session, he reported a relapse to weekly heroin use and the fear that he is moving toward a regular habit. He bemoaned the many losses he has incurred in his thirty-plus adult years—dropping out of college, not pursuing music and writing, losing dozens of friends to AIDS—and berated himself harshly for his laziness, lack of effort throughout his life, and proneness toward addiction. Margaret and Charles peppered him with questions about the details of his current situation and about his options for hope, a process he described as “people digging around in an open sore.” He was, however, willing to persist in being the focus of attention. Eventually M exploded at him. “You’re having a pity-party over there and I’ve been working so hard to encourage you.” To which he replied, “I knew I should have shut up and never told it the way it really is. I’ll just come and bullshit you all next time so you’ll all be happy.”

At the leader’s suggestion, the group discussed how hard it is to sit with their own or others’ pain and hopelessness without DOing or SAYing something to change it. Charles commented that he had especially found this to be the case with Robert, that he usually feels helpless when Robert is talking. They discussed the difficulty of being in a group where each person is at a different stage of change in their efforts to move out of problematic drug use and the tendency to judge each other by their own success or lack thereof. Margaret and Robert then apologized to each other.

This led Margaret, the group’s newest member, to say that she had been thinking of leaving the group because she has so far made three people angry and she feels like a misfit. She feels awkward because her drug problem (moderate drinking by the standards of other group members) is far less severe than the others’. (She seems not to remember that Charles has been abstinent for over two years and continues to use the group to support his abstinence and to develop social skills.) As we explored her impulse to leave, it became obvious that Margaret has never found it easy to be a member of a group. She is often disliked for her directness, then scapegoated and excluded. The group made very strong suggestions that, in this group, Margaret has an opportunity to practice being herself and then learning to modulate her interactions with others if needed. They acknowledged the very real cultural issues that Margaret, an outspoken Jewish woman from New York, has in the more laid-back culture of San Francisco. Allan said, “That’s really the key in this

group—we are all very different—the drugs we use, what they mean to us, who we are as people, our f—ed up relationships.” He capped it off by saying, “And it’s not like you’ve resolved your problem with wine yet, right?” Margaret laughed and the impulse to leave had faded.

Allan, who is pretty debilitated by heroin use and a chronically abusive relationship, and who is affectively unstable, often passively suicidal, underemployed, and dependent on his parents, became reflective about his own differences and his cultural identity. To Margaret he said, “I’d love to have your drug problem instead of mine, but then there are other things you suffer from that I might not be able to handle.” He then talked about the beginnings of his relationship with heroin and her attempts to find belonging in a group. He had been an isolated, bullied, and lonely child and has always been unsuccessful at finding stable membership in a social group. From New York City, he met some heroin using artists on the Lower East Side who he thought were cool and started hanging out, including shooting heroin, with them. “I never thought I would get to this point. I thought I could stay an ‘injection drug user.’ I wasn’t thinking about addiction.” As with all of his other relationships, he eventually found himself isolated from the injection drug using community too, shunned because of the severity of his habit. He said he would be very sad if Margaret left the group.

Charles, a quiet member of the group who interacts very little, said that he often thinks about Allan and had noticed a job opening he thought Allan might do well to apply for. Allan and Charles have the weakest connection of any two people in the group, so this was a poignant moment. The group came full circle when Robert, who had softened considerably as Allan talked, said a few comforting words to her as the group ended.

What Happened in This Group?

In this session, the group is able to stay with painful affect without any overwhelming impulse to act. Such tolerance is a necessary adaptation in our stimulating world. Group members are also able to describe their dilemmas regarding differences in drug problems, culture, and belonging with little intervention from the leader. Finally, this session illustrates the group’s growing skill at maintaining its integrity despite differences, thus working through the problem of duality that riddles conflicts about drugs and drug use.

Over the course of the four months represented by these group examples, this group of people has been able to articulate their dilemmas

much more clearly and to soften toward each other, and therefore toward themselves. They are better able to take in kindness and empathy from others. The group members have become able to explain their processes themselves, and the group leader was called upon to do very little work.

OUTCOMES

At the time of writing, all of the group members in the above vignettes except one have changed their use of drugs and alcohol, two by establishing abstinence as they had desired, a third by reducing his use and attending additional treatment activities, a fourth becoming less anxious and more flexible and thus more amenable to change, and the fifth (already abstinent) by becoming more interactive and emotionally connected to the group.

COUNTERTRANSFERENCE CONSIDERATIONS AND CONCLUSIONS

Practicing harm reduction is not easy. The therapist has to hold certain principles and beliefs:

- Drugs are not bad. Nor are drug abusers diseased. Problems with drugs are the consequence of an interaction between properties of the drugs used, the unique physiological, psychological, and motivational characteristics of a person, and the setting and context in which the drugs are used (Zinberg, 1984).
- Mixing using and non-using people in group is an opportunity for learning and creativity.
- People know what they need, and they can and do make rational choices, even while using drugs. The therapist must allow each group member to present issues in the order in which they need to be addressed, must follow his lead, and must trust that addressing simultaneously environmental, psychological, and physical complaints will lead to the reduction of problems with drugs.
- There are many solutions to problems with drugs. Many people find their way to abstinence (over 40% of clients of the Harm Reduction Therapy Center have done so), but the route is rarely straightforward.

- The role of harm reduction therapy is to reinforce people's strengths, wisdom, and right to self-determination. The therapist has to trust that in the context of such a relationship, the group will learn to practice tolerance, and each client will make healthier rather than less healthy choices.
- Change has greater integrity if internal motivation is discovered and unlocked through a process of starting where the client is and staying with the client throughout her own pace of change.

The group leader has many challenges in a harm reduction group. It is important to trust that each member has some interest in becoming healthier and that the group, if properly facilitated, has sufficient wisdom and answers to help each person. Most difficult is to restrain one's own impulse to DO something in the face of all but life-threatening behavior (Unger, 1978). Because of their potential lethality, drugs and drug using behaviors arouse powerful countertransference feelings. It is tempting to make rules that forbid certain behaviors. It is probably fair to say, however, that active drug users are sufficiently rebellious, that they will simply go underground if they are not interested in following the rules. The therapist ends up in the difficult position then of having to "catch" people and do something about rule-breaking. The only rules that are useful in a harm reduction group are rules regarding potentially group-destructive behaviors. The rules in *this* harm reduction group are that people show up regularly, pay their fee, and do not develop relationships with each other outside the group. For ideas about rules in drop-in groups, see Little (2002).

The therapist's job in a harm reduction group is to practice neutrality and to help group members debate the many sides of a dilemma. Sometimes the leader is quiet, sometimes she brings up the unspoken, sometimes she reframes apparently problematic behavior as adaptive to increase self-esteem and self-efficacy, sometimes she does her duty by providing education, when appropriate, in a neutral manner, to help members make informed and safe choices and to neutralize stigma about drugs. The harm reduction group leader must explore what it would/will be like to make changes, but tolerate a lot of non-changing behavior on the road to change. She must be absolutely accepting—of every person and every story.

Some people need more structure, instruction, and externally imposed limits than harm reduction practice offers. Such structure is most typically found in abstinence-based treatment programs. This has been changing, however. Cognitive behavioral programs, such as behavioral

self-control training (Hester, 1995), targeted toward moderation, can be quite structured and goal-oriented. The moderation management program described by Rotgers, Kern, and Hoetzel (2002) is also quite structured. Anecdotally, however, this author has found that once group members have been taught the principles of harm reduction work and have been exposed to a group leader who makes room for all client behaviors and goals, group members overwhelmingly opt to join or remain in a diverse harm reduction group.

Practicing harm reduction is not for all therapists or counselors. Harm reduction removes from the therapist the role of prescribing a particular outcome to the client. And it removes from the client the predictability inherent in abstinence-based programs. It requires that the therapist be able to manage a large degree of tension and anxiety as the client wends his way toward greater health, with many diversions along the way. It requires that the client be dedicated to developing an ability to tolerate tension and anxiety when the answers to her dilemmas are not always clear. Despite its complexity and challenges, harm reduction is a useful approach for people who need acceptance for who they are and the freedom to explore their relationship with drugs, to prioritize their problems, and to change their addictive behaviors as and when they choose.

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