



INTEGRATIVE HARM
REDUCTION
PSYCHOTHERAPY

ANDREW TATARSKY, PH.D
MARCH 17, 2017

The Scientific Revolution
in Addiction Treatment:
From Disease Model to
Psychobiosocial Model

Hosted By



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Choopers Foundation & Grace Street Services

Proudly Present
An Introduction to Integrative Harm
Reduction Psychotherapy
March 17, 2017

Workshop Program

8:00 AM – 8:30 AM

Registration & Exhibitor Setup

8:30 AM – 8:40 AM

Welcome - A Poppy is not a Grape: The Myth of “The Addict”

Tim Cheney | Co-founder & President, Choopers Foundation | Partner, Grace Street Recovery Services

8:40 AM – 8:55 AM

The role of Law Enforcement in Maine’s opioid crisis: Advocacy, Intervention, Diversion and Enforcement.

Michael Sauschuck | Chief of Police, City of Portland Police Department

8:55 AM – 9:05 AM

Rumors of a Preferred Future

An overview of the treatment philosophy and practices of Grace Street Services. Grace Street Recovery Services is the largest medication assisted treatment (Suboxone) and recovery program in the state of Maine with facilities in Lewiston, Portland and Sanford. This year they received The Innovative Practice Award.

Martin O'Brien | Founder & CEO, Grace Street Recovery Services

9:05 AM

Introduction – Andrew Tatarsky, Ph.D

Adrian Hooper, Jr. | Co-founder Choopers Foundation | Partner, Grace Street Recovery Services

9:10 AM – Noon

The Scientific Revolution in Addiction Treatment: From Disease Model to Psychobiosocial Model

Dr. Tatarsky will introduce Integrative Harm Reduction Psychotherapy (IHRP), his integration of harm reduction principles into psychotherapy and substance use treatment. IHRP brings together relational psychoanalytic, active cognitive and behavioral skills building and mindfulness techniques in a harm reduction frame to support positive change in substance use and related issues. He will discuss how IHRP has particular power to attract, engage and facilitate positive change in a group of people that has traditionally been thought to be hard if not impossible to treat in psychotherapy.

Andrew Tatarsky Ph.D | Center for Optimal Living

12:00–12:30 PM

Lunch

12:30 – 2:00 PM

Afternoon Session

Describe the many paths to addiction and multiple paths to recovery. Describe how the psychobiosocial process view of addiction the multiple meanings model and the Transtheoretical Stages of Change model best explain this complexity. Present an overview of IHRP's 7 therapeutic tasks with emphasis on therapeutic process and technique. Demonstrate "urge-surfing" and discuss its applications to positive behavior change. There will be time for discussing application to participants' settings.

Andrew Tatarsky Ph.D | Center for Optimal Living

2:00 – 2:15 PM

Break

2:15 – 3:30 PM

Afternoon Session (cont.)

Andrew Tatarsky, Ph.D | Center for Optimal Living

Integrative Harm Reduction Psychotherapy: A Case of Substance Use, Multiple Trauma, and Suicidality



Andrew Tatarsky

Harm Reduction Psychotherapy and Training Associates



Scott Kellogg

New York University

Harm reduction is a new paradigm that seeks to reduce the harmful consequences of substance use and other risky behaviors without requiring abstinence. This article discusses integrative harm reduction psychotherapy, one application of harm reduction principles to psychotherapy. Seven therapeutic tasks are described with attention to clinical process, skills, and strategies. A case is presented that illustrates the application of this approach with life-threatening substance use that was related to multiple trauma and suicidal depression. © 2010 Wiley Periodicals, Inc. *J Clin Psychol: In Session* 66: 123–135, 2010.

Keywords: harm reduction; substance abuse; integrative psychotherapy; trauma; co-occurring disorders

Harm reduction is a philosophy and set of interventions that seek to reduce the harmful consequences of substance use and other risky behaviors without requiring abstinence (Marlatt, 1998). Harm reduction has been successfully applied to public health, substance use treatment, and psychotherapy. In this article, we discuss the therapeutic process of integrative harm reduction psychotherapy, our approach to the application of harm reduction principles to psychotherapy.

Integrative harm reduction psychotherapy is based on the assumption that substance abuse and other potentially risky behavior are best understood in the context of the whole person in his or her sociocultural context. Integrative harm reduction psychotherapy has the goals of identifying the psychological, biological, and social currents that contribute to the addictive process, clarifying the multiple meanings of the substance abuse, and individually tailoring psychotherapy to the unique needs of each patient. Integrative harm reduction psychotherapy can facilitate the delivery of other modalities, such as syringe exchange and substitution

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treatment. The process can be adapted for workers with differing levels of education, training and job tasks, as well as to others who come into contact with the patient, such as the security guard, receptionist, outreach worker, nurse, and peer educator.

Integrative Harm Reduction Psychotherapy

Integrative harm reduction psychotherapy (Tatarsky, 1998, 2002) draws on the contributions of the psychodynamic, cognitive-behavioral, humanistic, and biological traditions to address the unique vulnerabilities and consequences related to each patient's substance use. The abandonment of the abstinence requirement enables the therapy to begin with whatever brings the patient for help. The form, focus, and timing of interventions must emerge out of the ongoing therapeutic dialogue and negotiation between therapist and patient. This places the relationship and collaborative nature of the work at the forefront of the therapy. A good therapeutic relationship facilitates the other therapeutic activities: skills building and active strategizing to support positive changes in substance use, exploration of the multiple personal and social meanings of problem substance use, and the discovery of new, more effective solutions to related vulnerability factors. These broad focuses are addressed in seven therapeutic tasks: managing the therapeutic alliance; the therapeutic relationship heals; strengthening self-management skills for change; assessment as treatment; embracing ambivalence; harm reduction goal setting; and active strategies for positive change.

The Therapeutic Alliance

Our clinical experience and the empirical research lead us to believe that the most important consideration in the effective psychotherapy of this group of patients is a good therapeutic alliance (Safran & Muran, 2000). The therapeutic alliance is the ability to work purposefully together in agreement about goals, tasks, and quality of the bond. This is consistent with harm reduction's fundamental principles: to start where the patient is and begin the treatment around the patient's goals. Research has shown that the alliance is a key contributor to positive outcomes in substance abuse treatment (Dearing et al., 2005).

How the initial contact is handled is often critical to whether the patient returns and becomes engaged in therapy. Initial meetings are designed to find out what the prospective patient wants and agree on a focus of treatment. The patient's reason for coming must be the issue around which the initial alliance is formed. The therapist's ability to meet the patient with respect and empathy and without a preconceived set of assumptions enables the therapist and patient to collaborate on finding an approach that is right for each patient.

It is essential to maintain the alliance throughout the course of therapy. As the patient changes in therapy, the therapist must change her approach accordingly. A stance that may have felt safe and supportive initially may come to be experienced by the patient as no longer helpful. Inevitable ruptures in the alliance will need to be addressed and repaired if the therapy is to proceed. Being misunderstood may leave the patient feeling unsafe or abandoned and activate self-protective reactions such as withdrawal or increased substance use. The therapist's attention to these ruptures and willingness to inquire into them may enable the alliance to be repaired.

Therapists enhance and maintain the alliance with a series of skills: active listening, collaborative inquiry, empathy, reflection, and management of countertransference.

Active listening is listening with the goal of accurately capturing the experience of the other without interpretation, judgment, or commentary.

Collaborative inquiry refers to the therapist and patient working together to clarify an aspect of the patient's experience. The therapist looks to join with a part of the patient that is curious about the nature of something.

Empathy is the capacity to understand the experience of the other (Kohut, 1982). It includes intellectual understanding but also includes an affective resonance that enables the therapist to imagine and feel what the patient may be experiencing.

Having arrived at an assessment of the patient's experience, the therapist can reflect back to the patient what he has heard. The patient may need to clarify some of what the therapist has said until she can agree that the therapist has accurately understood her.

We are using countertransference here to refer to all of the therapist's personal reactions to the patient. If recognized and not acted upon, the therapist's reactions can provide an understanding of the patient that can be used to help the patient understand himself and his relationships. Active listening and empathy depend on the therapist's capacity to distinguish between empathic feelings that are accurate reflections of the patient's experience and personal reactions of the therapist's that may interfere with her capacity to empathize. This underscores the importance of personal therapy and ongoing supervision to support the therapist's self-knowledge and ability to identify countertransference reactions of which she may be unaware.

The Therapeutic Relationship Heals

A good therapeutic relationship is itself potentially healing in several ways. It creates a sense of safety that may decrease anxiety and enable greater self-reflectiveness. This supports people in clarifying the harmful aspects of substance use and the feelings, wishes, and needs that are related to substance use and a consideration of new ways of using and new ways of expressing or caring for these aspects of oneself. The therapeutic relationship can also support the integration of self-regulation or self-management skills as the therapist both models and teaches these skills and gives the patient permission to use them. To the extent that relationship difficulties are often at the heart of problematic drug use, these issues are likely to emerge in the therapeutic relationship. The therapeutic alliance enables the therapist and patient to discuss these difficulties when they arise and experiment with new solutions. Resolving problems in this relationship demonstrates that relationship difficulties can be resolved, that people may be trustworthy, and that the patient is worthy of the therapist's efforts.

Instances of drug use may reflect or express something that is occurring for the patient in the therapy and should be considered in this light. For example, the patient may use drugs to manage uncomfortable feelings that arise in therapy rather than talk to the therapist about them. The therapist's interest and inquiry into the possible meaning of the drug use may signal to the patient that the therapist is truly interested in understanding the patient's experience and what the drug use may have expressed. This may signal both that the therapist is interested and have the more important implication that people may be more interested and trustworthy than the patient believes because of early experience.

Enhancing Self-Management Skills for Positive Change

Changing addictive, self-defeating behavior is often related to healing self-regulation deficits through the acquisition of a set of self-management skills. These skills are

also necessary for addressing the other tasks of integrative harm reduction psychotherapy. We look to form an alliance with the part of the patient that wants to feel better and actively participate in the therapeutic process. This aspect of the patient is related to what has been called the “healthy adult mode” in Schema Therapy (Young et al., 2003), that is, the capacity to navigate, negotiate with, nurture, or neutralize.

Three key capacities support the process of changing: curiosity, self-reflective awareness, and affect tolerance. Curiosity about one’s suffering motivates self-awareness and self-inquiry. Self-awareness enables the exploration of moment-to-moment experience such that connections can be made between perceived events, thoughts, feelings, impulses, and choices. Self-awareness also supports greater affect tolerance, the capacity to sit with feelings. Uncomfortable and frightening feelings are rendered more tolerable when they can be identified as a set of body sensations and thoughts that can be modulated by various cognitive and behavioral strategies such as dialoguing with them and slow breathing.

Awareness and relaxation training (Tatarsky, 2003) supports the development of self-reflective awareness and affect management. It integrates mindfulness training (Witkiewitz, Marlatt, & Walker, 2005), relaxation training (Benson, 1975), and positive self-talk (Burns, 1999) into a simple set of techniques.

Assessment as Treatment

Assessment is both the initial basis for the therapeutic alliance and initial treatment plan and the heart of the ongoing therapeutic process. Our assessment deepens our understanding of the patient and is geared toward promoting the patient’s deepening recognition and understanding of the difficulties that bring her to therapy. The therapist’s inquiry engages the patient’s curiosity and self-reflection on his experience. In the process of attempting to communicate his experience to the therapist, he formulates his experience in words that can now be integrated into his experience of himself.

Increased self-assessment of what is troubling makes it possible to consider harm reduction goals and strategies for reducing suffering. Topics to be assessed are as follows: substance use severity, relationship of the problem behavior to psychobiosocial variables, the multiple meanings of the behavior in question, stage of change, and other important life issues. Problems should be addressed in the order in which they are most pressing to the patient from most important to least important.

Charting the problem behavior that is the focus of inquiry helps patients get a clearer picture of their behavior and how it impacts other aspects of life. Patients can chart the day and time the behavior in question occurred and what the behavior is: a beer, one line of cocaine, one Klonopin. They can also include additional information such as preceding circumstances, feelings, thoughts and expectations, and resulting consequences and effects. Feedback alone can motivate change in some people as they get a clearer picture of how their behavior is in conflict with their values and expectations of themselves. Charting also strengthens self-reflective awareness. Forgetting or not following through on a commitment to chart may also highlight a conflict or other difficulty maintaining awareness that can be explored in therapy.

Microanalysis is a strategy for getting a full picture of the patient’s pattern of use and its relationship to other psychobiosocial issues, the personal and social meanings and functions of the substance, and the stage of change for each substance. Working from the record the patient has kept between sessions a detailed description of the substance use pattern is generated. It is important to get as detailed as the patient is

comfortable with while respecting and being sensitive to the possibility that the patient may be unwilling to discuss certain aspects of her use. The patient is asked to describe the pattern of using in a typical day, week, and month. When? How much? What route of administration? Under what circumstances? With whom? What is the patient feeling when deciding to use? What precedes using? What follows in terms of drug effects, the total experience, behavior, impact on health, emotional state, job, school, relationships? How does substance use fit in with other aspects of life? How does it help? How does it hurt? What does the patient want and expect from the drug and how does it work out? Did use meet the patient's expectations? Does the patient ever regret it? Explore the severity and quality of the use pattern: does it enhance a social situation? (recreational); is it an intermittent problem? (abuse); does it have a compulsive quality with loss of control and craving? (addictive/dependent); and, finally, what might the patient like to change about using?

Embracing Ambivalence

Ambivalence plays a central role in resistance to changing problematic substance use and needs to be addressed to facilitate positive change (Miller & Rollnick, 2002). The psychobiosocial and the stages of change models suggest that there are many possible reasons that serious substance users would remain deeply invested in using substances, despite a growing number of negative consequences. Substances may continue to be experienced positively at times, and different aspects of the person may have their own unique relationships to the substance based on how they meet the values, needs, wishes, and interests of that part of the person.

Another way to understand addictive behavior is to see that when the conflict between using in a problematic way and not doing so becomes too uncomfortable, the part of the person that does not want to use gets split off and dissociated and the user is left with the impulse to use that is acted upon. To the extent that the patient is able to tolerate the ambivalence and reflect on the dilemma, the patient can consider alternative ways to resolve it. Many patients are aware that their use helps them deal with uncomfortable feelings like anxiety, rage, and grief, despite the risks associated with their using. When they can see or achieve alternative solutions to their emotional difficulties, they become more motivated to stop the risky drug use. The therapeutic goal is to bring the ambivalence into the therapy room so the patient can have the experience of sitting with it and consider new ways to resolve it with the therapist.

Many techniques have proven effective for embracing ambivalence. Here, we summarize two of them: empathizing with both sides of the ambivalence and conducting a decisional balance.

Empathizing with both sides of the patient's ambivalence is a way to invite all aspects of the patient into the therapy room (Rothschild, 2007). If the therapist is only interested in hearing from and supporting one part of the patient (usually the part of the patient that wants to stop or use more safely), then there is a danger that the therapist will form an alliance with one part, potentially against the other. The consequence is that the part of the patient that wants to change may make all sorts of commitments and plans while the part of the patient that wants to keep using as usual stays out of the room and continues to do what he has been doing. Empathizing with both sides of the patient's ambivalence keeps the conflict inside the patient. Both are invited to be present and speak in therapy and both can be considered in the exploration of new goals.

The decisional balance sheet (Janis & Mann, 1977) is a strategy for systematically evaluating the pros and cons of making any decision to change. It has been shown to be a powerful tool for facilitating change (LaBrie et al., 2006) and is considered to be a key to increasing motivation for change by many within the behavior change field (Miller & Rollnick, 1991; Prochaska, Norcross, & DiClemente, 1995). Through a thorough examination of the pros and cons of the current problem behavior and the change one is considering, this technique supports the patient in a detailed assessment of her motivations on both sides of her ambivalence. The decisional balance has been adapted to addiction (Denning, 2000).

The transformational chairwork method is designed for patients struggling with addictive behavior and other decisional conflicts (Kellogg, 2008). Voice dialogue (Stone & Winkelman, 1988; Tatarsky, 2003) can help patients clarify and own their ambivalence about changing self-defeating behaviors. Both techniques are experiential strategies that help patients explore the parts of them that have conflicting feelings about changing. We have found these approaches to be particularly useful when working with patients who tend to have difficulty identifying their feelings or are dissociated from the aspects of themselves that are expressed through the problem behavior.

Harm Reduction Goal Setting

There is an inherent paradox in harm reduction work. On the one hand, harm reduction places a primary importance on accepting people where they are, on their terms and around their goals. Interventions are designed to meet people where they are, not where the clinician wants them to be. On the other hand, harm reduction also promotes positive change and growth toward optimal health. This moves the focus beyond the reduction of drug-related harm to the healing and resolution of suffering and other issues that are related to problem substance use. This “gradualism” approach (Kellogg, 2003) seeks to make use of the full array of effective harm reduction and abstinence-oriented treatments to help addicted individuals move along a continuum from problem use to nonproblematic use or abstinence.

Therapeutic goals emerge from the assessment of why the patient is coming and exploration of the patient’s ambivalence about change. The question of what the patient’s goals are promotes curiosity and self-reflection on her motives and needs. In effect, the question says that the therapy is about and for the patient, and it acknowledges the central importance of client’s active participation, choice of goals, agency, and motivation in the success of the therapy.

The ideal use plan strategy is designed to help patients in the following ways: (a) assess the problematic aspects of their substance use, (b) enhance motivation to make positive changes, (c) choose harm reduction goals, and (d) plan strategies for working toward their new goals. Patients are asked to describe, in writing or verbally, their ideal pattern of use, one that maximizes the benefits and minimizes the risks and negative consequences (Tatarsky, 2003). The plan should include what substances, routes of administration, amounts, frequency, and circumstances of use. It should also specify the strategies that would support the successful implementation of the plan. The patient can now attempt to implement to plan in her life and see how effective it is at achieving her goals. Viewed as an experiment, whatever happens is potentially useful information that can be used to revise the plan to more effectively achieve one’s goals.

Active Strategies for Positive Change

Once the patient has clarified the problematic aspects of substance use and set specific goals, it is possible to devise strategies to work toward these goals. We describe below a set of cognitive and behavioral strategies that patients can use in their efforts to change self-defeating patterns of substance use and implement changes in related personal and social circumstances. These strategies have strong research support in addictive behaviors (Hester, 1995; Longabaugh & Morgenstern, 1999).

- *Education* about harm reduction provides a framework for patients to understand the basis for integrative harm reduction psychotherapy models and differentiate it from abstinence-only approaches. Teaching the psychobiosocial, multiple meanings, and the stages of change models provides the framework for the focus of therapy.
- *An experimental attitude* sees the process of change evolving from a process of trial and error to find new solutions.
- *Urge surfing* (Marlatt & Kristeller, 1999) is a strategy for reflecting on urges and not acting from impulse. The patient is first taught to identify the urge as a set of sensations and associated thoughts. The next step is to cultivate an attitude of uncritical observation. This technique puts space around the urge, interrupts the habitual self-defeating habit pattern and makes alternative choices possible.
- *Identify the event-thought-urge-thought-choice-action sequences* related to problem substance use. Urge surfing enables identification of the thoughts and feelings in these chained sequences and makes it possible to intervene at each part of the sequence to consider a new choice.
- *Thinking through the urge* to its inevitable or likely conclusion if it is acted upon can help one to decide to act or not.
- Considering the *decisional balance and dialoguing* with both sides of one's ambivalence will help one make a choice from awareness rather than impulse.
- *Reflecting on one's reasons* for deciding to make a desired change can help one stay motivated for that change.
- *Identifying triggers* becomes possible as patients can now reflect on what was happening just before or while they became aware of the urge. This is the intersection between substance use and its meaning and function in relation to psychobiosocial issues.
- *Managing or resolving triggers* increasingly becomes the focus of treatment as these issues are identified. Cognitive-behavioral strategies, such as relaxation training and assertiveness training, are alternative, less harmful ways of managing triggers.
- *18 Alternatives*. The patient might come up with a list of 18 alternative responses to the typical triggers that cause a desire to use in self-defeating ways.
- *The Game Plan*. This is plan for implementing desired changes in situations in which the old behavior has occurred in the past. The plan is designed to anticipate challenges to one's plans and prepare strategies to meet them.

Case Illustration

L was a 38-year-old single, professional woman referred to me by her primary care physician.¹ Her daily drinking and marijuana smoking was potentially life

¹The case of L was treated by Andrew Tatarsky.

threatening because a hangover could and occasionally did precipitate a diabetic coma that could kill her. Although she took insulin daily to control the diabetes, her substance use and hangovers in conjunction with a frequent failure to take her medication and stay on her strict diet, often rendered the treatment ineffective. Over the course of her life she had fallen numerous times as a result of these comas and broke bones in her arms and legs on several occasions and smashed her car into a tree, badly bruising herself in the accident. After many years of suggesting that she attend A.A. and abstain from all substances with no success, her physician recommended harm reduction psychotherapy because she insisted that she was only interested in pursuing moderation and safer use. L was a professionally successful, intelligent, good-looking woman who dressed in a somewhat masculine style. She appeared to be open and engaged, smiling frequently, and apparently motivated for help. Her smile, however, seemed forced, and there was a wooden quality to her that left me feeling anxious in her presence, imagining that there was a much more troubled part of her than she revealed.

L seemed relatively unconcerned about the severity of her substance use as she said that she wanted to see if she could cut back to a safe level of use. I agreed to an initial plan to see if I could help her identify safe limits and support her in strategizing to stay within those limits. This led her to express relief and gratitude. We agreed to meet twice weekly. Despite her dangerous behavior and odd affect, there was also something about her that left me feeling hopeful. I also had a sense that I had to respect her boundaries and follow her lead.

I suggested that we try to identify what was a dangerous level of use (when she woke up hung-over and lightheaded) and what would be safe limits. This sparked her curiosity. I suggested that she monitor her use between sessions by counting and charting her drinks and pot smoking, noting the circumstances and feelings surrounding her use and how she felt while using and the next day. She liked the charting, saying it gave her a sense of control. I also suggested she practice urge surfing to identify the desire to use and related sensations, thoughts, and feelings. A microanalysis of her use revealed that she smoked pot and over-drank nearly every evening to have fun with friends, to feel sexual without feeling violated by a man, to manage stress and fatigue after work, and to fall asleep. Excessive substance use enabled her only experiences of pleasure and relaxation. Through trial and error we identified two standard drinks over a 2-hour period as a level of drinking that did not result in a hangover. Despite her conscious desire to keep to this limit, she nearly always over-drank.

I wondered aloud why she would put herself at such great risk. Exploring this question over the next several weeks revealed a history of multiple traumas early in her life that she had kept from awareness with the support of her substance use. As she described her traumatic experiences to me, she quickly fell into an intense, frightening depression that was accompanied by grief, rage, self-hate, and unremitting images of stabbing and shooting herself in the head. Together, we gradually pieced together the following history.

L's first diabetic coma occurred in the school playground in 10th grade in front of the entire school community. She awoke from it to find everyone staring at her "in horror, like I was a monster ... not feeling alive, like a ghost." After this experience she felt deeply humiliated and was rejected by her peers at school. No one helped her deal with how she felt about the coma and resulting peer reactions. She felt that school officials and doctors dealt with her like a "disgusting bug pinned to the wall." She admitted to having drunk beer and smoked pot a few days before the incident.

Her parents assumed this had caused the coma and punished her by grounding her at home for a month. Feeling “banished from the human race,” she recalled days of screaming alone in her room to express the pain of aloneness, shame, and self-hate. She began banging her head on the wall to punish her body for betraying her.

I remarked that I was struck by how punitive her parents had been. She then described her experience of growing up with a controlling, punitive mother who spanked her and had her sit in the corner for “doing anything mother disapproved of.” Mother’s daily spankings would escalate if L cried or resisted and took on a sexual quality as mother pulled her underpants down and put L over her knee. L remembered feeling “like a wooden doll completely controlled like a puppet,” her first experience of dissociating as a way to cope with terrifying and humiliating experiences. L’s father was a salesman who frequently travelled and was distant and uninvolved with her. Dissociating her feelings with mother became the template for coping with the later trauma by blunting her feelings, “zoning out,” with the aid of substances. Although there was no apparent psychiatric history L was aware of in her family, she believed that her mother was “overwhelmed and depressed” about often being alone with her L because of her father’s business trips. L felt as if she was the primary person in her mother’s life and that was why she was the target of her mother’s intense demands for submission and sexualized violent punishment. Her father seemed to be emotionally cutoff when he was around. He did not intervene in the drama that played out between L and her mother, saying the childcare was the mother’s domain. L concluded from these relationships that other people could not be relied upon for emotional support and developed a conviction that she was destined to live life without close or intimate relationships and instead having only herself to rely on.

L “floated” through high school and college, increasing daily drinking and pot smoking, having frequent diabetic comas, sometimes coming to consciousness in the woods, dirty, with torn clothes and lost. She was isolated with no friends, speaking little in class, expecting humiliation, and developing the sense of being a walking dead person, “like Frankenstein.” Having little interest in anything professionally, she drifted into her profession “because it was easy.” Her desire for intimacy was dissociated as she saw herself as someone who could never have a close relationship with anyone. She felt banished from civilization as she had felt banished to her room as a child. She relied on substances rather than people to comfort herself, to not feel painful feelings, and to allow herself to feel feelings that her mother forbid her to feel, like sexuality, sadness, and rage.

The therapeutic focus shifted to healing the unresolved traumas and keeping her safe. My respect for her boundaries and pace enabled her to express pain that she had never before been able to put into words. I was like the comforting mother she had not had, witnessing the flow of previously unexpressed terror, shame, rage, grief, and self-hate that she now expressed as she described her traumatic experiences of humiliation, punishment, and betrayal by “everyone” in her life. When her depression became so intense that she began having difficulty getting to work in the morning and became fearful about taking her life, I also recommended a medication evaluation. She began an antidepressant, Prozac, initially taking 20 mg daily and raising the dose to 40 mg daily over the next three months. Over this period she began to feel somewhat less overwhelmed by her feelings and less afraid of suicidal impulses. This relief enabled the psychotherapeutic work to proceed.

I cared deeply for the terrified, hurt little girl who was crying and screaming words in our sessions that she had never been able to speak before. The substance use

continued, the depression raged, and she began to appear more depressed and withdrawn in sessions. I remarked on this change and, to my shock, she said, "I don't think you care at all just like all those other doctors!" Resisting the temptation to defend myself and feeling confused, I told her that I deeply cared about her and wondered why she didn't know it. She said, "You say goodbye before the weekend, go off to your family, and I go off to my home alone feeling like killing myself and putting myself at risk with substances."

I had unwittingly fallen into a therapeutic stance that reenacted the unhelpful relationships with authority figures earlier in her life. This contrast between how I felt with her and how she experienced me made me wonder if the doctors involved with her around the first diabetic coma had been in a similar position. She had learned in her relationship with her mother not to question authority or express her needs, and, thus, she may not have told her doctors what she needed and that she was not feeling helped. In our work, we had set up a similar relationship that contributed to the rupture between us. However, now she was able to express her dissatisfaction to me and give us the opportunity to repair our relationship. The strength of our earlier alliance and my active interest in knowing how she felt set the stage for her to tell me her negative feelings about me and our work.

I asked how she would know I cared and how I could be more helpful. She said she needed me to be more actively involved in helping her plan for safety, manage her frightening feelings, and plan alternative ways of caring for herself. I became more active in strategizing to help her manage her feelings and keep herself safe. I also was more vocal in telling her how I felt about her, expressing concern and pride in the work she was doing.

Her willingness to express her dissatisfaction and my willingness to listen and change my stance restored a sense of a collaborative alliance between us concerning an approach that felt more helpful to L. More important, it created a new relational experience in which her feelings were taken seriously, and she was responded to in a way that had not occurred earlier in her life. This experience in therapy contributed to improving her self esteem, trust in her relationships, and hope for the future. L now became more motivated to dramatically reduce her substance use, which she now felt was a threat to her growing sense of possibility.

Managing difficult feelings in a safe way rather than by using substances became the primary focus of therapy. L became motivated to use urge surfing to identify the moments when she felt the desire to abuse substances. She began to track the sequences of events, thoughts, and feelings surrounding these moments and started to identify the circumstantial and emotional triggers. She began to think of the impulse to use a substance excessively as a sign that something else was going on that needed her attention, a need or painful feeling. As L was able to make these associations in the moment, she began to consider various strategies for managing her needs and feelings in safer, healthier ways and for caring for herself more effectively.

Painting became a major outlet for her affect storms and through it enabled her to reclaim dissociated parts of herself and find her lost, lovable child self. The painting initially involved throwing paint as active energetic expression of feelings. Gradually the paintings began to take the shape of a person. One day she came in with a painting of a beautiful little girl saying, "I found the beautiful self I thought was dead." With some fear, she joined a gym and began to take pleasure in exercise as she now felt that her body was worthy of positive attention. In contrast to the body that had betrayed her, now her body became a source of pleasure, strength, and fun.

She joined a local yoga studio and began to practice yoga and meditation; she found that they helped with relaxation and managing painful feelings. I had suggested that these practices would support her efforts at self-monitoring and managing her painful feelings and she was a quick study. Her growing sense of being valued and growing optimism about relationships and being able to join the world motivated her to begin exploring and learning techniques that could help her care for herself more effectively and emboldened her to enter situations in which she had previously felt unwelcome. She developed an evening ritual that combined meditation and yoga with relaxing music and herb tea rather than intoxicants. She began taking more trips into the countryside on weekends for relaxation and fun.

Her growing positive feelings about herself and her possibilities in the world and the pleasure and satisfaction she was taking in these activities enhanced her motivation to moderate her drinking and pot smoking. She committed herself to attempt to modify her drinking to a two-drink limit in one evening with some sober days each week and marijuana only occasionally in social situations. She worked with the ideal use plan exercise to think through in detail what changes she would have to make in her life and in her evening routine to successfully reach her target substance use goals. Some strategies that she found useful were doing her relaxing ritual as soon as she got home from work before drinking, pacing her drinking by watching the clock, and seeing how long she could stretch out a glass of wine by taking small sips and alternating water between her drinks. This led to a process of gradually reducing her substance use in small incremental steps in the direction of her goals. In the third year of therapy, she achieved her targets.

L now became aware of her desire for a passionate romantic relationship and satisfying work and began to actively pursue both. She felt as if she was now entitled to be in good relationships and could be open with others about herself. She joined some Internet dating services and began going on dates. These experiences were seen as opportunities for her to discover what she wanted in a partner and to continue to work on the residual feelings of anxiety and mistrust that came up when considering the possibility of an intimate relationship. She eventually met a man with very similar interests and who was at a point in his life in which he was also making major positive changes. As of this writing, they have now been living together in a satisfying committed relationship, something she had never imagined would be possible for herself only a few years before. She also decided to leave her job after being offered early retirement with a good severance package. Spending time away from work helped clarify that she would find it more satisfying to be working in the area of spirituality and health, and she found a job in a company with this focus and where she could use her executive skills.

After 5 years of two- or three-times-weekly sessions, she ended her therapy feeling that she had completed her work. She achieved her initial goals regarding her substance use and found satisfying solutions to the complex personal and lifestyle problems that had been expressed through her problematic substance use.

Clinical Issues and Summary

Despite her awareness of the life-threatening nature of her substance use, L was motivated to begin therapy only when she found a harm reduction approach that would accept her active substance use and form an alliance around her goals of moderating substance use. It soon became clear that her substance abuse had multiple meanings related to a history of multiple traumas and their sequelae. The

therapeutic focus and therapist's approach changed over time as the patient's needs changed. Substances kept a suicidal depression at bay while also helping her medicate feelings of loneliness and anxiety and find moments of pleasure and relaxation unavailable to her. Active substance use had to be accepted in therapy as the meanings and functions of it were assessed. The depression, traumas, and associated problems with self-esteem and trust in relationships had to be processed and resolved to some extent in order for her to become sufficiently motivated to reduce her substance use. This was facilitated, in part, by a difficulty that emerged in the therapeutic relationship. A rupture in the patient-therapist alliance occurred that was a reenactment of her early traumatizing relationships. When L expressed that she felt that the therapist did not care about her, the therapist responded to L in a way that created a new relational experience for her that contributed to her increased hopefulness about the future. This motivated her to reduce her substance use and create a more satisfying life.

This case is an example of the complexity of psychological and interpersonal difficulties that, we believe, are usually intertwined with serious substance abuse. The case of L illustrates how a harm reduction approach can effectively attract and engage active substance using patients in therapy, support the establishment of a strong therapeutic alliance and, through small incremental positive changes, proceed toward successful outcomes with substance use and a wide range of cooccurring personal issues. It also shows how active strategies and exploration of meaning can be integrated and are supported by a facilitating therapeutic relationship.

Viewing substance use problems within a psychobiosocial perspective suggests the need for a therapeutic approach that flexibly integrates relational psychoanalytic and cognitive-behavioral interventions. Integrative Harm Reduction Psychotherapy is one such approach. Although the effectiveness of integrative harm reduction psychotherapy has not been subjected to randomized controlled trials, its seven therapeutic tasks are guided and informed by decades of clinical research. We believe that this approach, with its attention to therapeutic relationship, has particular value in attracting and retaining substance misusing patients in therapy and facilitates the complex work associated with helping patients resolve problematic substance use in the context of cooccurring disorders.

Selected References and Recommended Readings

- Dearing, R.L., Barrick, C., Dermen, K.H., & Walitzer, K.S. (2005). Indicators of client engagement: Influences on alcohol treatment satisfaction and outcomes. *Psychology of Addictive Behaviors*, 19, 71–78.
- Hester, R.K. (1995). Behavioral self-control training. In R.K. Hester & W.R. Miller (Eds.), *Handbook of alcoholism treatment approaches: Effective alternatives* (pp. 148–159). Needham Heights: Allyn & Bacon.
- Janis, I.L., & Mann, L. (1977). *Decision making: A psychological analysis of conflict, choice, and commitment*. London: Cassel & Collier Macmillan.
- Kellogg, S.H. (2004). Dialogical encounters: Contemporary perspectives on “chairwork” in psychotherapy. *Psychotherapy: Research, Theory, Practice, Training*, 41, 310–320. Available at: <http://transformationalchairwork.com/articles/>
- Kellogg, S.H., & Kreek, M.J. (2005). Gradualism, identity, reinforcements, and change. *International Journal of Drug Policy*, 16, 369–375. Available at: <http://gradualismadadiction.org/articles/>

- Khantzian, E.J., Halliday, K.S., & McAuliffe, W.E. (1990). *Addiction and the vulnerable self: Modified dynamic group therapy for drug abusers*. New York: Guilford Press.
- Krystal, H. (1977). Self- and object-representation in alcoholism and other drug-dependence: Implications for therapy. *NIDA Research Monograph*, 12, 88–100.
- LaBrie, J.W., Pedersen, E.R., Earleywine, M., & Olsen, H. (2006). Reducing heavy drinking in college males with the decisional balance: Analyzing an element of Motivational Interviewing. *Addictive Behaviors*, 31(2), 254–263.
- Longabaugh, R., & Morgenstern, J. (1999). Cognitive-behavioral coping-skills therapy for alcohol dependence: current status and future directions. *Alcohol Research & Health*, 23(2), 78–85.
- Marlatt, G.A. (1998). *Harm reduction: Pragmatic strategies for managing high risk behavior*. New York: Guilford Press.
- Miller, W.R., & Rollnick, S. (2002). *Motivational interviewing, 2nd ed., Preparing people to change*. New York: The Guilford Press.
- Prochaska, J.O., Norcross, J.C., & DiClemente, C.C. (1994). *Changing for good*. New York: Morrow.
- Rothschild, D. (2007). Bringing the pieces together: Relational psychoanalysis and harm reduction therapy in treatment with substance abusers. *Psychoanalytic Perspectives*, 5(1), 69–94.
- Safran, J., & Muran, C.J. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York: Guilford.
- Stone, H., & Winkelman, S. (1988). *Embracing ourselves*. New York: New World Library.
- Tatarsky, A. (2002). *Harm reduction psychotherapy: A new treatment for drug and alcohol problems*. Northvale, NJ: Jason Aronson, Inc.
- Tatarsky, A. (2003). Harm reduction psychotherapy: Extending the reach of traditional substance use treatment. *Journal of Substance Abuse Treatment*, 25, 249–256.
- Young, J.E., Klosko, J.S., & Weishaar, M.E. (2003). *Schema therapy. A practitioner's guide*. The New York: Guilford Press.



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Harm Reduction Reading List

Popular Books

Anderson, K. (2010). *How to Change Your Drinking: A Harm Reduction Guide to Alcohol*. Second Edition. New York, The HAMS Harm Reduction Network.

Rotgers, F., Kern, M. and Hoeltzel, R. (2002). *Responsible Drinking: A Moderation Management Approach for Problem Drinkers*. Oakland, CA., New Harbinger Publications.

Denning, P., Little, J. and Glickmen, A. (2003). *Over the Influence: The Harm Reduction Guide for Managing Drugs and Alcohol*. New York, The Guilford Press.

Professional Publications

Tatarsky, A. *Harm Reduction Psychotherapy* (2002). *Harm Reduction Psychotherapy: A New Treatment for Drug and Alcohol Problems*. Lanham, Maryland, Jason Aronson Inc.

Kellogg, S. H., & Tatarsky, A. (2012). Re-envisioning Addiction Treatment: A Six-point Plan, *Alcoholism Treatment Quarterly*, 30:1, 109-128.

Tatarsky, A., & Kellogg, S. (2012). *Harm Reduction Psychotherapy*. In: Marlatt, G.A., Larimer, M.E., & Witkiewitz, K. (Editors). *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors*, Second Edition. New York, NY, The Guilford Press.

Kellogg, S.H. & Tatarsky, A. (2010). The Addiction Treatment Roundtable: A Clinical Wisdom Study. *Journal of Social Work Practice in the Addictions*, 10:3, 339-341.

Tatarsky, A. & Kellogg, S.H. *Integrative Harm Reduction Psychotherapy: A Case of Substance Use, Multiple Trauma, and Suicidality*. *Journal of Clinical Psychology: In Session*, Vol. 66 (10), pp.123-135.

Tatarsky, A. & Marlatt, G.A. (2010). State of the Art in Harm Reduction Psychotherapy: An Emerging Treatment for Substance Misuse. *Journal of Clinical Psychology: In Session*, Vol. 66 (10), pp.117-122.

Tatarsky, A. *Harm Reduction Psychotherapy (A User's Guide to Developing Your Healthiest Relationship to Pot)*. (2010). In: Holland, J. (Editor). *The Pot Book: A Complete Guide to Cannabis*, Rochester, VT, Inner Traditions.



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Tatarsky, A. & Kellogg, S.H. (2010). Integrative Harm Reduction Psychotherapy: A Case of Substance Use, Multiple Trauma, and Suicidality. *Journal of Clinical Psychology: In Session*, Vol. 66 (10), pp.123-135.

Tatarsky, A. Guest co-editor. (2010). Harm Reduction in Psychotherapy, *Journal of Clinical Psychology: In Session*, Vol. 66 (10).

Kellogg, S. H., & Tatarsky, A. (2009). Harm Reduction Psychotherapy. *Encyclopedia of Substance Abuse Prevention, Treatment, and Recovery*. Thousand Oaks, CA, Sage Publications.

Tatarsky, A. (Summer, 2008). Addiction, Meaning and Understanding. *Psych-e-News*, Magazine from the New York State Psychological Association, Division of Psychoanalysis, Issue #2.

Tatarsky, A. Harm Reduction Psychotherapy: Extending the Reach of Traditional Substance Use Treatment. (2003). *Journal of Substance Abuse Treatment*. Vol. 25, pp. 249-256.

Tatarsky, A. (1998). An Integrative Approach to Harm Reduction Psychotherapy: A Case of Problem Drinking Secondary to Depression. *In Session: Psychotherapy in Practice*. Vol. 4/ 2, pp. 16-29.

Marlatt, G.A.(Ed.), (1998). *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors*. New York, The Guilford Press.

Denning, P. (2000). *Practicing Harm Reduction Psychotherapy : An Alternative Approach to Addictions*. New York, The Guilford Press.