An Integrative Approach to Harm Reduction Psychotherapy: A Case of Problem Drinking Secondary to Depression

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Although drug and alcohol abuse continues to be widespread in our society, traditional approaches to treatment have had limited success at engaging and retaining clients, and have shown poor outcomes overall. Harm reduction is a new approach to treating substance abuse that may be more acceptable and effective for this large clinical population. This article describes the harm reduction paradigm and the author's use of harm reduction within a psychotherapeutic approach that integrates cognitive and behavioral interventions with a psychodynamic understanding of substance use as personally meaningful. The approach is illustrated by a case of a client who presented with alcohol abuse secondary to depression.

• substance abuse • harm reduction • psychotherapy • psychotherapy integration • psychodynamic psychotherapy • moderation training • alcohol abuse

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The treatment of alcohol and drug users in the United States continues to have poor success an engaging and retaining clients in interventions that lead to the reduction of substance use and related problems. Clinical observations and empirical studies typically report that a majority of clients seen initially do not successfully complete treatment or maintain their gains after treatment. These poor outcomes hold true across modalities (e.g., inpatient vs. outpatient) and across different theoretical approaches. They are particularly poor when there is coexisting psychopathology (K. Carey & M. Carey, 1990) or severe psychosocial dysfunction. These poor outcomes do not include the large number of substance abusers who do not seek treatment.

Whereas these results are, in part, related to the complex and challenging nature of these problems, we might also consider how a set of basic assumptions, which traditionally informs the treatment of substance abuse, contributes to this limited effectiveness. Drug and alcohol treatment has been generally informed by an "abstinence-only" philosophy. According to that model, abstinence from all mood-changing chemicals is the only acceptable goal for substance abusers; it must

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be accepted by the client in order to gain access to treatment, and must be relatively quickly achieved and maintained to remain in treatment. Substance users seeking help for issues other than substance use are routinely denied psychotherapy and referred to substance abuse treatment, whereas substance users unwilling or unable to accept abstinence are denied treatment. Abstinence is the criterion of success for the client and treatment provider and the prerequisite to anything else being addressed.

Although abstinence may be the ideal in terms of risk reduction for many substance abusers, it may be argued that the majority of users are not willing or able to accept this as their goal at the beginning of a treatment process for a variety of legitimate reasons. Consequently, they are met with an expectation that keeps them from becoming effectively engaged at the start. This "zero-tolerance," "high-threshold" approach simply does not begin where many clients are, and may elicit client "resistance" by attempting to impose goals that are not matched to clients' needs. Substance abusers may need to resolve a number of different issues before they may be open to consider abstinence. These include: a desire to moderate rather than stop using; concrete reality issues or emotional problems that the substance is used to cope with; fears about coping without the substance; or motives during the use that must be identified and addressed in some other way. Treatments that require a commitment to abstinence before addressing issues such as these put the cart before the horse by asking clients to do something they cannot possibly do, thereby setting up failure and keeping people from seeking help.

HARM REDUCTION AND THE DIVERSITY OF SUBSTANCE USERS

Substance abusers are a broadly diverse group of people who differ on many important variables including severity of substance use, personal goals regarding use (e.g., moderation vs. abstinence), motivation and readiness to change, coexisting psychopathology and psychosocial status, and supports. It is obvious that any one-size-fits-all model is doomed to fail with the majority of clients. This diversity suggests the need for a more flexible, inclusive, and comprehensive model to increase overall effectiveness at reaching this broad spectrum of people.

Harm reduction is an alternative paradigm for approaching the treatment of this diverse population that has many advantages over the abstinence-only approach, which may make it more acceptable and relevant to a greater number of clients and increase overall treatment effectiveness. Harm reduction first emerged as a set of public health strategies for reducing the spread of HIV and other risks associated with active substance use (Heather, Wodak, Nadelman, & O'Hare, 1993); these include clean needle exchange, condom distribution, and methadone maintenance. Harm reduction is a pragmatic approach that accepts active substance use as a fact and assumes that substance users must be engaged where they are, not where the provider thinks they should be. It recognizes that substance use and its consequences vary along a continuum of harmful effects for the user and the community, and that behavior generally changes by small incremental steps. Therefore, any movement toward decreased harm is seen as a step in the right direction. For many users, abstinence is considered ideal in terms of reduction of harmful consequences, but alternative goals that "step down" the negative consequences of substance use are also embraced (Marlatt & Tapert, 1993).

A growing number of researchers and clinicians have broadened the application of the harm reduction approach to psychotherapy and counseling of active drug users (K. Carey & M. Carey, 1990; Marlatt & Tapert, 1993; Rotgers, in press; Rothschild, 1995). I have come to think of harm reduction psychotherapy as a general category of psychological interventions that seek to reduce the harm associated with active substance use without having abstinence as the initial goal. Harm reduction psychotherapy embraces a set of assumptions very different from those inherent in the abstinence-only approach, and has useful implications for the assessment and initial engagement of substance abusers, goal setting, attention to issues other than substance abuse, and the direct focus on modifying substance use itself.

INTEGRATIVE HARM REDUCTION PSYCHOTHERAPY

I will summarize an approach to harm reduction psychotherapy that I have developed in my own practice with a broad range of substance-using clients over the last 13 years. This model recognizes that psychodynamic meaning, social learning and conditioning, and social-interpersonal and biological factors may all play a role in the genesis of substance use problems, and that the specific contribution of each must be understood to develop treatments that are uniquely tailored to the needs of each client.

In the following section I describe the treatment approach and its clinical rationale. I will then present a case illustration that will show how the harm reduction orientation was useful in treating a rather complicated dual-disordered client. The treatment resulted in a significant reduction in the client's drinking to a stable, low–moderate level while also addressing a set of related emotional, interpersonal, and lifestyle issues that were identified in the course of working on the drinking problems that led him to seek treatment. Finally, I will discuss the implications of this case for general applications of this approach and for the treatment of this type of client.

The Integrative Model

This approach begins with the assumption that substance use problems may result from a variety of different psychological, social, and biological factors unique to each person. People use substances because they address some psychological, social, or biological needs. We may define substance use as problematic or excessive when it compromises or interferes with other important needs and values. For any substance use treatment to have a chance of being successful, it must begin with an effort to discover the specific reasons or motives that have made the substance so compelling. As these factors are identified, strategies and modalities can be combined to target them specifically.

Contemporary psychodynamic writers on substance problems have generally emphasized the "adaptive" value that substances may fulfill as one possible reason that substance use becomes compelling (Khantzian, Halliday, & McAuliffe, 1990; Wurmser, 1978). According to this perspective, substances may come to serve important psychological functions that help the user cope more effectively. They may be relied on to "self-medicate" or defend against overwhelming affect states, regulate fragile self-esteem, support interpersonal effectiveness, comfort or soothe one-

self, or tranquilize the harsh inner critic ("superego") to allow temporary experiences of pleasure unavailable when sober, among other possible functions.

Over time, chronic substance use generally takes on multiple functions for the individual as it becomes increasingly integrated into one's psychological functioning and lifestyle. Chronic use is also often associated with psychological, conditioning, lifestyle, and biological changes that compound the original motives for using and increase the pressure to use.

Goals of Treatment

The goal of this work is to engage clients in a relationship that will support them in clarifying the problematic aspects of their substance use and work toward addressing those problems with goals and strategies that are consistent with who they are as individuals. The ideal outcome of this approach is to support the user in reducing the harmfulness of substance use to the point where it has minimal negative impact on other areas of his or her life. Whether the outcome is moderation or abstinence depends on what is practically realistic for the client, and emerges from the treatment process. Ultimately, this is accomplished by identifying the various bio-psycho-social factors that initiated and contributed to ongoing substance use, and discovering alternative, more effective, drug-free solutions. However, the harm reduction principle places the value of engaging clients in treatment around their own initial goals as the starting point, with the ultimate goal of treatment emerging from the process of the therapy.

Engagement/Assessment Phase

The cornerstone of all effective treatment is the therapeutic alliance between client and clinician around shared goals. Thus, the focus of therapy must be on the client's definition of the problem and goals. By starting with an attempt to understand the client's reason for coming, an alliance can form around a mutual exploration of the client's concerns and how, if at all, the substance use impacts on them. Without preconceptions about the substance use, we are freed to join the client in the exploration, keeping open the question of how the substance impacts other areas of the client's life. This puts us on the same side as the client, avoids power struggles about what the client "should" do, and conveys a respect and empathy for the client that is conducive to the client feeling safe and supported in our presence.

The nature of the problem is explored through a detailed consideration of the client's reason for coming, the current substance use pattern, history of use, and the impact of the substance on other important areas of life. It is acknowledged that the substance has some positive value to the user and that this must be weighed against the negative consequences of use. Identifying the positive function of the substance opens up the issue of whether other, more effective and less harmful ways of meeting these needs may be discovered.

Clients are taught a self-observation strategy for developing a clear picture of how substances fit into their lives in relation to situational triggers, thoughts and feelings, and positive or negative consequences of use. The strategy consists of paying close attention to physical sensations, thoughts, and sense perceptions in the present moment and describing them in detailed, nonjudgmental language as fully as possible. Then, clients are asked to use the technique whenever they become aware of thoughts or behaviors that are related to using drugs or alcohol in order

to identify the thoughts and feelings that immediately preceded and followed the substance-related behavior. This may be assisted by having clients keep written records of these observations that can be brought into sessions to be reviewed with the therapist.

Goal Setting

As the problematic aspects of substance use and other issues of concern to the client clarify, it becomes possible to establish goals and agree on a treatment plan to work toward them. I take the lead from what is most pressing to the client, whether this is working toward moderation or abstinence, clarifying the motivational obstacles to addressing the substance use directly, or addressing some other nonsubstance-related issues. Rather than beginning with my assumptions about how realistic these goals are, I state my experience with other similar clients where appropriate, and suggest a pragmatic approach to determining if the client's goals are achievable; we can discover together what is practically possible by working together toward the client's chosen goals. Goals and strategies can be revised as difficulties are encountered along the way.

For many clients' whose substance use continues to serve some positive function, the question of whether they can moderate their use must be answered before they will consider stopping. This is more likely answered by a supported, direct attempt that includes learning ways to achieve moderation. If clients are unable to achieve moderation in this context, they are more likely to have a clear recognition of why it has not been possible for them based on their own observations, and are more likely to consider stopping altogether.

Working toward Change

From this process an "ideal substance use plan" is developed, which is designed to maximize the positive value of using substances for the client while minimizing the negative impact of using *to the point the client is ready to go at present.* Ideal route of administration, amount, and frequency of substance use are arrived at empirically by examining the client's experience with using. As the client attempts to put the plan into effect, how well it achieves the desired goals can be assessed in an ongoing way, and the plan can be fine-tuned to achieve more effectively the goals as therapy proceeds.

Difficulties encountered in successfully implementing the plan are microanalyzed to identify the situational and psychological issues that are driving excessive use. These difficulties may be related to conditioned environmental or emotional "triggers," social pressures, emotional states that substances are used to cope with, or motives about which the client may be unaware (e.g., the passive, self-destructive expression of anger through substance use that hurts oneself). The identification of these motives leads to the exploration of alternative ways of coping. These may include the full range of coping skills such as relaxation training, anger management, assertiveness training, and identifying and verbalizing feelings in constructive ways. The therapist teaches these coping skills and invites the client to practice them in therapy sessions and in the client's life. This permission-giving stance may challenge clients' early messages that caring for oneself is unacceptable and help empower them to use their innate capacities to care for themselves effectively. When they become aware of the variety of motives for using substances, the

compulsive "need" to use them may abate as it becomes possible to make alternative choices. At this point, a discussion of other ways to manage, express, or resolve these broader emotional or characterological issues becomes possible. The envisioning of alternative possibilities is a prerequisite for many people to feel motivated to consider giving up their familiar, habitual ways of coping. Over the course of therapy, the focus of the work broadens from substance use to a whole set of larger issues related to getting to know oneself better, learning to listen to and accept oneself more deeply, and discovering more effective ways of caring for oneself.

Because this approach does not begin with preconceived goals, it is applicable to a broad variety of people with substance use issues. With some clients this work is relatively simple and straightforward and may consist of a small number of contacts of evaluation and recommendations resulting in dramatic, long-term, positive changes in use. With many others, however, the work is very complicated, uncertain, and difficult for both client and clinician. This is often what is required for the resolution of substance problems that exist in more complex psychological and sociological contexts. This reality, which is avoided by the abstinence-only approaches, is embraced by harm reduction psychotherapy.

CASE ILLUSTRATION

Presenting Problem/Client Description

Tom is a 43-year-old single, White, Italian American gay man who consulted with me because he was concerned about "drinking too much and at the wrong times" and wanted "to get it under control." He called me specifically because he had heard of my reputation as an alcohol treatment specialist who will work with problem drinkers who do not want to stop drinking. We agreed to meet for a consultation.

Tom appeared at my office looking somewhat scared at our first meeting. The faint odor of alcohol accompanied him as he entered my office and I found myself feeling somewhat anxious and wondering if this would interfere with our work. As it turned out, this first meeting ended with us both feeling optimistic about the possibility of doing some valuable work together: A feeling that has been born out by the 3 years of weekly psychotherapy that has continued to the present.

He was a somewhat heavy man, looking his age, wearing a neatly trimmed mustache and a hoop earring in his right ear. Along with his neat, casual style of dress, he projected the image of a hip, "downtown," arty man trying to look younger than he was. An initial wariness and somewhat guarded manner melted quickly in response to my interested, empathic, accepting stance. He seemed hungry for contact and expressed intense gratitude for my willingness to help him on his terms; that is, while he continued to drink. As Tom described why he had come, I quickly got the impression that he was a very bright, honest, emotionally vulnerable man. And I immediately liked him.

Over the next few meetings, he revealed himself as sensitively tuned in to the nuances of my reactions to him, belying both a keen attention to detail and a particular sensitivity to the emotional responses of others. He expressed a strong need for emotional support and reassurance, frequently asking if I thought he was "doing it right," showing me things that he had done to address his problems and asking for my approval. These aspects of himself revealed a very fragile sense of self and an intense reliance on the approval of others for his self-esteem. I wondered if this vul-

nerability might be directly related to his drinking, a suspicion that was to be supported in several important ways.

Although he said that he did see his drinking as a problem, an important factor motivating him to come was pressure from his job. His supervisors at the art museum where he held a very responsible position as a curator had made his being in treatment a condition for him to remain in his job. Tom was in a crisis in his workplace. He was very upset about how this coworkers and supervisors had initially responded to his excessive drinking and felt that he was being misjudged and misunderstood by them. This was the second time he was seeking treatment for his drinking, the first being 9 months previously when he said he had been "coerced" by his job into attending an intensive alcoholism treatment program, thinking at the time that he had no options. Tom described how a group of his colleagues at work had orchestrated an "intervention" to get him into treatment for his drinking. As he spoke, he was filled with obvious feelings of anger and sadness. Without warning, they confronted him at the start of the workday and told him that they had made arrangements for him to be evaluated by a well-known alcohol treatment program that morning and that a car was waiting outside to take him. It was made clear to Tom that he had no choice but to go unless he wanted to risk losing his job of 23 years. Tom said that he felt "shell-shocked." He said that he had never been approached by anyone about his drinking or job performance before this and felt utterly humiliated and betrayed. He wondered why no one had spoken to him if they had concerns and said that he would have willingly gone for an evaluation if he had been consulted and included in the process. However, he felt that he had no choice but to go along with their "suggestion," and went for the evaluation.

At the evaluation, he was told he was alcoholic. The interviewer said that he believed that Tom was minimizing the nature of his problem and that he believed that Tom needed to stop drinking altogether. He recommended that Tom enter the program's 4 night per week intensive outpatient program. Tom thought that he had no alternative and entered the program under pressure.

During the course of that treatment Tom was completely abstinent. He said that he had questions about whether he could drink safely in the future, but was not able to explore them because they were "taboo" in the program. He quickly learned this by the staff's automatic, seemingly presumptuous response to his questions with proclamations of his minimizing and denial and "inability to accept his disease." He said that his treatment experience left him feeling "traumatized" and wary of entering therapy again. Later or in our work together, he described feeling that this first treatment had contributed to his feeling worse about himself than when he began.

Shortly after completing the 6-month treatment program he began to drink again. His drinking quickly came to the attention of his supervisors at work after he made some calls to coworkers while intoxicated and appeared at a work function obviously drunk. This led his supervisors to again require Tom to seek treatment or risk losing his job.

He now felt nervous on the job, afraid that expressing his feelings might further jeopardize his relationships there. These feelings were distracting him and interfering with his concentration at work and on a book that he was writing. He said that as a result of this rupture in his relationship with his workplace of 23 years, he felt "more lonely than ever." He saw his most recent drinking as his way of handling his feelings of anger and loneliness. He said that his "job's attempt to help had not helped at all," and had left him with feelings that compounded the more long-standing problems that contributed to this drinking.

Case Formulation

Initially, I was unclear about the nature of Tom's drinking problem or whether he could successfully moderate his drinking. But my initial impression was that he was a problem drinker whose excessive drinking was secondary to depression. From his history, his depression seemed to result from the loss of important sources of support for his fragile sense of self. These self-esteem problems, in turn, were related to a high degree of self-esteem vulnerability, which Tom had managed through his dependence on external sources of positive feedback from others. These relationships were preserved by his overly friendly, nonconfrontational interpersonal style of relating to others at the cost of his feeling free to express anger or sexual desire in a direct, assertive way.

The harm reduction approach was used to set up a therapeutic context for evaluating Tom's problems and establishing a therapeutic alliance with him while he continued to drink. The integrative aspect of this approach enabled me to explore the various meanings and functions of Tom's drinking while actively supporting the use of specific coping strategies for addressing his needs in more direct, effective, alcohol-free ways.

Course of Treatment

Assessment/engagement phase. I agreed to work with Tom to explore whether he could successfully moderate his drinking. We agreed to meet once weekly for 45-min sessions. I told him that I did not believe that it was possible to know whether he could successfully make this change in his drinking, and I suggested that we adopt an experimental attitude toward this question. Tom said that he liked this framework as a starting point for our work together. He said that he was aware that it might not be possible for him to learn to control his drinking, but that he needed to give it a serious try before he could ever accept that he would need to abstain altogether.

Our initial alliance was quickly formed around the shared goal of seeing whether Tom would be able to moderate his drinking. My initial stance conveyed an understanding and respect for what was important to Tom, and contributed to an atmosphere of safety in the therapy. Tom quickly developed very positive feelings about working with me and said the he felt optimistic about being able to get what he needed. My interest in supporting him in discovering whether he could achieve his desired drinking goal also had some value in relation to some of the particular aspects of Tom's character problems: Vulnerabilities that are often present in clients with substance abuse problems. Tom's willingness to go along with his prior treatment despite feeling that it did not address his needs was characteristic of his relational tendencies generally. His self-esteem was so dependent on the approval of others that he generally went along with the wishes of others even when they might be in stark contrast to his own. This was shown by his passive acceptance of what he felt to be mistreatment at work, as well as a pattern of personal relationships in which he was physically or verbally abused and taken advantage of in one way or another. Rather than change the pattern of relating, he became increasingly isolated in his life. Like many problem drinkers, his drinking expressed his anger passively rather than in words or appropriate assertive action. This, in turn, contributed to his already poor self-esteem, leading to a deepening depression over the previous 10 years and increased drinking to numb himself against these painful feel-

ings. My willingness to support Tom in investigating what he needed to clarify for himself helped him to identify what was important to him and find the resources within himself to commit himself to the work.

The first phase of the treatment focused on clarifying the nature of his drinking. This assessment was designed to identify the problematic aspects of his drinking, to discover how his drinking was meaningfully related to his emotional and external life issues, and to get a baseline level of drinking to develop clear behavioral drinking goals to work toward. To this end, I suggested several behavior therapy strategies. I taught Tom the self-observation techniques described previously to identify the relationships between external events, thoughts, and feelings and thoughts or feelings related to alcohol. I describe this to clients alternately as "self-monitoring," "awareness training," or "mindfulness," and think of it as related to the psychoanalytic concept of the "observing ego." I also suggested that between sessions, Tom try to practice observing the accompanying thoughts, feelings, and circumstances whenever he noticed the desire for a drink, and keep a mental or written record that we could review together in sessions. I suggested that the initial purpose was to get a clear picture of his current drinking and that he not change anything until he could identify specific goals for himself.

This examination included both written and mental notes over the first several weeks. It revealed that the current pattern of Tom's drinking was between 2 to 6 drinks daily, and occasionally as many as 12. His drinking mainly occurred in bars where he went to make social contact with "bar friends" or to meet sexual partners. He said he had been generally drinking in this way for the last 10 years, but thought it had slowly increased over this period to where it was at the time of our initial meeting. He said that he did not experience "blackouts," alcohol withdrawal, or medical problems as a result of his drinking. The negative consequences that he did identify were exercising poor judgment and engaging in inappropriate and risky behavior, including unsafe sex, while drinking. Specifically, he reported having frequently been out late drinking before a workday, arriving at work with alcohol on his breath, still somewhat intoxicated or hung over, and unable to work at full capacity. He had made several calls to coworkers while drunk, expressing dissatisfaction about work in ways that others felt uncomfortable about. He would also often take strangers home from bars and had been robbed and beaten up several times.

Tom thought that his drinking was excessive, inappropriate, and self-destructive but he did not want to see himself as an alcoholic who could never learn to control his drinking. He said that he had never really tried to control his drinking, and he thought that there were a number of emotional issues "causing" him to drink excessively. He said that he wanted to try to learn better control.

We reviewed Tom's drinking history in depth to understand together how drinking fit into the larger context of his life. It became clear that the escalation in Tom's drinking was a response to two major issues in his life which, in turn, were related to deeper emotional and characterological problems that were identified and became the focus of our ongoing and current work together.

These both related to the loss of important social supports that provided Tom with a sense of belonging, self-esteem, and possibilities for intimate and sexual relationships. In his twenties and thirties, Tom had been a well-respected, popular artist in the "downtown" scene. He was also very actively involved in the gay community during the 1960s and 1970s when there were many opportunities for social and sexual contact. These two intertwined communities gave Tom a sense of belonging, pride in his artistic and social accomplishments, and opportunities for in-

timate relationships of which he had two important, long-term lovers and many briefer, casual, sexual encounters. As he grew older, looking older and heavier, and as the AIDS crisis hit in the early 1980s, he gradually withdrew from these worlds; he was no longer as desirable, and the opportunities for intimacy disappeared with the changing times. He began to satisfy his need for social contact with the pseudo-contact available in bars, but stopped having casual sex because of his fear of AIDS. He also drank increasingly as a way to blot out his feelings of sexual frustration and loneliness. However, during the 1980s, his career at the art museum took off and he gained another support system to replace those he had lost. He moved into progressively more responsible positions and developed a highly respected status with coworkers and artists with whom he worked. During this period, his social life became increasingly constricted, but he derived great satisfaction from his relationships with people connected with his job. In the several years prior to entering treatment, there was a major change in the administration's support of his interests and the staff in general. Support staff were let go, the physical plant was allowed to deteriorate, raises became smaller, and his input seemed less valued. The staff group became more competitive as a result, and the earlier sense of community was fractured. These changes left Tom feeling powerless and "unloved." Tom's drinking became more frequent and intense. It was in this context that the "intervention" was done to get Tom into treatment.

Whereas Tom was aware that he had been unhappy at work and had lost a sense of importance that he had felt both in work and in the art and gay communities that he had been a part of, and he was aware that his drinking had become excessive and problematic, he had not made the connection between the two.

Goal setting. Early on, I observed to Tom that his recent drunken, inappropriate phone calls to colleagues at work seemed to be the only times he was letting them know how angry he was about the intervention in which they had participated. He agreed with my observation, saying that he felt very unsafe expressing anger in general, and particularly now at work after his job had been threatened. I then said that I wondered whether he was using alcohol to free himself up to express the feelings that he was unable to express when sober, as well as defying their efforts to control him by flaunting his drinking at them. These interpretations were received by him as an affirmation of how he felt, and seemed to help him become clearer about how he had been feeling. He became more aware of the underlying messages carried by his drinking. But this raised another question in my mind that I shared with him: Why would he express his anger and defiance in ways that would put him at risk for losing his job? Tom, like many similar clients, was self-reflective and curious enough about himself to become very interested in this question. The exploration that followed as we reflected together in the safety of the therapeutic space led to a series of associations to previous relationships with parents and significant others in which he was prone to blame himself for conflicts rather than freely express criticism of them. His fear of losing their affection and acceptance and guilt about hurting those whom he loved seemed to explain the conflict that led him to feel inhibited about expressing anger and other assertive feelings. The self-destructive aspect of his drinking seemed to be a way of punishing himself to assuage the guilt that was provoked by his expression of anger at his colleagues, the most important people currently in his life.

In addition to serving the self-soothing function of numbing the pain associated with the losses he had experienced over the prior 10 years, Tom's drinking might

also have a veiled expression of anger at the worlds that had abandoned him and at himself for having let it happen. This interpretation had a dramatic impact on Tom and led to a broadening of the focus of the therapy from simply on the drinking behavior and the immediate crisis at work to include his conflicts about expressing anger and other self interests, including sexual and romantic needs, and the character vulnerabilities and relational/interpersonal issues in which these conflicts were rooted.

I suggested that Tom describe his "ideal" pattern of drinking. This pattern would enable him to enjoy what he defined as the benefits of drinking without the negative consequences. This required that Tom do a cost–benefit analysis of his drinking based on what he found to be the self-affirming benefits of alcohol compared to the ways in which alcohol conflicted with things that were important to him. Tom decided that he wanted to limit his drinking to a level at which he felt somewhat relaxed but that his judgment was not impaired and his behavior remained under control. His drinking plan also included not drinking any evening before morning meetings at work, which occurred 3 mornings each week. And he decided that he would try not to drink when he was upset, as these were the times when he was more vulnerable to "overdo it," and these were the feelings that he wanted to develop other skills for managing. We agreed to establish drinking limits for the times he would drink and evaluate them over time to see whether they accomplished his stated goals. Based on his experience and some reading that I suggested, he decided on a limit of two drinks per drinking episode unless it was a episode longer than 3 hours when he could drink four drinks. He also decided to stick with wine rather than vodka, because he could better regulate his intake with wine.

Working toward moderation. By the end of the 2nd month of therapy, Tom had dramatically cut down his drinking to his target "ideal" drinking plan. By examining the external circumstances historically associated with heavy drinking in the past, and identifying the internal feeling states and external triggers currently associated with drink thoughts and urges, Tom developed an active plan to support himself in achieving his drinking goals. This plan included lifestyle changes that would support moderate drinking and alternative ways of addressing the painful issues that he had been using alcohol to cope with.

Tom lacked opportunities for socializing that were not connected with alcohol, and this vacuum needed to be filled with alternative ways of meeting people. As Tom considered this problem, he recognized that his lack of social contact was, in part, an avoidance motivated by a fear of being hurt and disappointed as he had been in the past. Tom recognized the value of social support for making the changes he was making, as well as giving him a context for tackling these fears. I suggested a group with a harm reduction orientation run by a colleague of mine. The group supported attempts at moderation in the spirit of helping members find out whether this was a viable option for themselves. Tom joined the group immediately. He was able to use the group effectively as a source of information and recommendations about coping strategies used by other group members and as an interpersonal laboratory for working on the social fears that kept him from socializing in his life.

As he monitored the drink-related thoughts that arose spontaneously and examined how he was feeling now that he was drinking much less, he more and more clearly saw how his drinking had been wrapped up with this angry, depressed withdrawal at work and in relation to his career in the art world. He saw how he had experienced the loss of support first in the art world and gay community and later

at work as a withdrawal of necessary support for his sense of self. He had reacted in a passive–aggressive way, expressed in excessive drinking at inappropriate times, which only compounded his deflated self-esteem.

I pointed out that this seemed related to a childlike sense of himself as dependent on the encouragement of others and fearful of risking further loss or retaliation if he expressed himself in a powerful, autonomous way. The strength of our therapeutic alliance, which had been built over the course of our work together, enabled me to feel that I could risk making such a direct confrontation to Tom, and he accepted it in the helpful spirit in which I meant it. Tom thought about my comments and became interested in exploring the fearful fantasies that had kept him trapped in this powerless state: the museum might fire him for making waves; if he decided that he couldn't get the support that he needed where he worked, he could never find a better job; if he tried to reinvigorate his career in the art world through writing, teaching, public speaking, and so on, he would never be accepted by his peers. He was able to see that all of these concerns were unrealistic, and more likely were based on echos of past relationships, mainly those with his father and mother.

Tom's father had been a hard-working, distant, uninvolved man who died when Tom was in his early twenties. Tom felt as if they never really knew one another. Tom said he always wished they had been closer, and wondered whether he could have done more to make that happen. He could see how he had actively avoided conflict with his father in the hope that they might be closer. On the other hand, Tom experienced his mother as too involved. She was always criticizing him and very reactive to his successes and failures. With her, he always tried to perform perfectly to avoid her disapproval, yet secretly resented the pressure and wished to be free of her. These relational binds set the stage for Tom's fragile self-esteem and later patterns of relating to others. Tom began to recognize how his drinking fit into these issues in several ways.

These insights seemed to reinvigorate Tom. He felt validated in his anger and sadness about his past losses and current difficulties at work, yet felt optimistic about expressing himself in an active, assertive way in his life. He made plans to present at a major international conference in his area of expertise, became reenergized in his work on his book, and began to address problems at work. Tom went to his supervisors and spoke with them about his understanding of his drinking problems, as he now identified it. He explained to them about his moderation goal and plan for maintaining the changes by addressing the others issues in his life that were related to them. Over the next few months Tom was able to get their active support for his plan and began to bring ideas for new projects to them in a way that elicited their encouragement and helped rebuild a sense of teamwork, which he was now able to see how he had contributed to losing in the past.

In the 5th month of treatment Tom decided to attempt 30 days of abstinence from alcohol. This came from him with no direct recommendation from me. He wanted to prove that he could do it, in part, as a way to symbolically show the prior treatment program that they had been wrong about him, and because he really seemed to become interested in what he might learn about himself off alcohol when he was not doing it as a response to pressure from others or fear.

The 30 days went by in a rather uncomplicated way, although some very important work went on around the problem of how he might fill his time and what he might drink as alternatives to alcohol. He discovered several alcohol-free bars that he began to spend time in and became more active in the art world of gallery

openings and other art-related events. After this period he gradually reinstituted his drinking plan.

He told me about one minor "slip" that occurred a month later, now 7 months into the treatment. He had violated his two-drink limit by having four drinks in a 2-hour period. As he described the situation, he was not upset, as nothing inappropriate or risky had happened. He had internalized the value of examining his drinking to understand what fueled it and was eager to talk about it with me. He had been out at a bar to see the bartender who worked there. He was very attracted to him although he knew nothing would happen between them; the man was in a monogamous relationship. In talking about the slip, it became clear that his drinking helped him entertain a fantasy about something between them and, at the same time, was a response to sadness that was evoked by his awareness that nothing could happen. The slip had been a useful doorway to important issues not yet fully addressed in the therapy. This event brought the issue of Tom's intense wishes for sexual and romantic relationships into the therapy, and the conflicting feelings that had kept him frustrated and lonely.

This issue was also revealed in two instances when Tom had come to sessions while somewhat intoxicated, once early on in the therapy and a second time close to the slip just described. In both instances, soon into the sessions Tom mentioned that he had had two glasses of wine before coming. In the first instance, Tom said that he had wanted me to see him in that state. He was more spontaneous and lively than usual. I stated the obvious, that alcohol seemed to loosen him up, and said that I also wondered whether there were particular aspects of himself that he found easier to discuss after having had something to drink. He giggled and said, "Absolutely! It has to do with sex. I don't think I could have said that if I hadn't been drinking." Our discussion revealed that his drinking had enabled him to bring up a subject that he had otherwise been too inhibited to discuss with me. It also led me to wonder whether he was aware of any conflict or anxiety about his sexual wishes. He denied feeling conflicted and the subject was dropped for a while.

It reemerged during our discussion of the second time he came to session after drinking. Now, several months later, he was able to recognize that he had a whole set of uncomfortable concerns about talking about sex with me. Would I become uncomfortable and withdraw or criticize him? Would we be able to talk about sex and maintain our professional relationship, that is, not act out together sexually? He also began to recognize that he did feel some shame about his sexuality related to self-critical attitudes that he had not acknowledged as his own, instead projecting them into others. This process had been reflected in his worries about my criticizing him. This exploration of his feelings about discussing his sexuality with me led to our looking at how these issues contributed to his avoidance of close personal relationships in his life that had the possibility of becoming romantic.

In the following months, Tom's drinking stabilized in the ideal pattern that he had envisioned for himself. His relationships at work continued to improve and his career seemed to open up again with opportunities for consulting and professional acceptance that he had longed for. He began to seek out social opportunities in his professional world as well as through gay organizations that held activities of interest to him. During this period, he began to widen his circle of friends and to date.

At this point in the therapy, 10 months into the work, Tom's drinking was no longer an active issue, although he was aware that he needed to be ever mindful of his vulnerability to fall back into his earlier patterns of drinking. We discussed a re-

lapse prevention plan that included an identification of the emotional and lifestyle triggers that had been associated with heavy drinking in the past, and specific cognitive and behavioral strategies for managing them in alcohol-free ways. For example, Tom had identified sexual frustration and loneliness as two main precipitants of heavy drinking. However, the more important trigger seemed to be when he began to tell himself that it was hopeless for him to think that he could ever have a healthy, satisfying relationship and that the best he could hope for was whatever contact was available, regardless of how demeaning it was to his sense of self. Excessive alcohol use could then be justified as a necessary way of assuaging the feelings of shame and self-degradation accompanying these pursuits. Anticipating these feelings and depressing thoughts as heavy drinking triggers enabled Tom to come up with an alternative way of thinking about his loneliness and frustration when it arose; that is, as important feelings for him to learn to tolerate while he developed the social skills and socializing opportunities necessary for him to meet an appropriate partner. He would also actively affirm to himself the actual steps that he had taken, and progress that he had made, toward successfully meeting these needs in his life. The plan also contained specific goals for continuing to modify his lifestyle in ways that would further support moderate drinking and a plan for continued therapeutic work on the self-esteem and relationship issues that kept him vulnerable to relapsing to his earlier problem drinking.

Outcome and Prognosis

As the focus on alcohol receded into the background at this point, I will end the detailed description of Tom's treatment here. The treatment is still alive and productive at the time of this writing, 3 years since Tom and I first met. Over this period he has generally maintained his moderate drinking with a few minor slips similar to those discussed previously. These occurred around emotionally charged interpersonal situations and were used as opportunities for further learning that deepened Tom's work in therapy. The central focus of therapy has been on strengthening Tom's ability to maintain his self-esteem in more autonomous ways by thinking about his insecurities and by taking constructive actions in the world that give him direct feedback about his value as a person. A related focus has been on working through the threatening fears and fantasies that have kept Tom from freely expressing his emotional needs in relationships. This has helped Tom to feel more confident about, and successful at, pursuing satisfying relationships in his life. During this period his depression has not returned.

Tom has demonstrated an ability to cope without alcohol with many challenging situations that had been triggers for excessive drinking in the past. These strategies have become familiar tools in his repertoire of coping skills. This, in conjunction with his awareness of his emotional vulnerabilities and continuing commitment to his emotional growth, suggest a very good prognosis for the future.

CLINICAL ISSUES AND SUMMARY

Tom's case is representative of the experience of many problem drinkers in several important ways. Many are coerced into unnecessary, expensive, inappropriate, and intensive abstinence-oriented treatments as he was. Tom's experience of being unnecessarily "intervened" at work and coerced into treatment initially are, unfortu-

nately, very common. They reflect several dangerous tendencies that are reflected both in society's attitudes toward problem drinkers and other drug users, and in the typical treatment approaches that are available for these clients.

First, there is often an assumption that attempts to approach someone with an apparent drinking or drug problem will be met with resistance, minimization, and lying. This often results in a jump to the kind of drastic intervention that Tom experienced, which may actually increase a potential client's unwillingness to work on the substance problem. Second, his experience reflects a tendency to lump all excessive substance use in the category of addiction, with the generally accompanying assumption that abstinence is the only acceptable goal. Tom's first treatment experience did not allow for an open discussion of moderation of his drinking as an alternative goal to be considered. As a result, he had no way to explore in depth whether this might be possible for him and learn the necessary skills to seriously attempt this change in drinking behavior. The overwhelming majority of all forms of substance use treatment and training programs in this country require that participants begin with a willingness to work toward complete abstinence as the only acceptable goal. These limitations in thinking and treatment options prevent many people, like Tom, who wish to explore the moderation option from getting the support that they need to see whether this is possible for them. This lack of appropriate treatment may set people up to intensify their substance use because the actual problems are not addressed and become compounded by feelings of resentment, frustration, and anxiety caused by the negative messages given to them. That experience, as in Tom's case, can exacerbate the issues related to the problem drinking, contribute to intensified drinking, and set up both client and clinician to fail. This problem may explain much of the failure reported by the substance use treatment field.

By beginning with an attempt to join with the client around his or her view of the problem and desired goals, the harm reduction approach has a better chance of creating a therapeutic atmosphere of safety in which the client can begin to address the drinking meaningfully, *where the client is ready to begin.*

With Tom, this approach did lead to a strong alliance early on in the treatment, which supported him in achieving his goal of moderating his drinking while successfully addressing the angry depression, self-esteem problems, conflicts about constructively expressing anger and other relational needs, and the lifestyle deficits that needed to be modified to support continued moderate drinking.

Tom is representative of many problem drinkers whose drinking is secondary to powerful emotional issues driving the heavy use of alcohol. Many, like Tom, have the motivation and psychological-mindedness necessary for making good use of psychotherapy while successfully moderating their drinking. Many others recognize through their attempt at moderating their drinking that this is a practical impossibility and become more willing to accept abstinence as the most reasonable goal for themselves. The context created by this approach allows this awareness to arise from an examination by the client of his own direct experience rather than from the judgment of someone else.

CONCLUSION

The approach described and illustrated here is an example of harm reduction psychotherapy for active substance users that is based on an integration of psychody-

namic and social learning theories in its understanding of substance use problems and in the combining of cognitive and behavioral self-management strategies with psychodynamic interventions in the treatment process. The case illustration demonstrated its effectiveness in helping a client, whose excessive drinking was secondary to depression, achieve stable moderation of drinking while addressing a range of other emotional and lifestyle issues related to the drinking problem. This approach is also effective with clients whose ultimate goal is abstinence, as both the initial choice of goals and the outcome of the therapy emerge from a therapeutic process that clarifies what is ideal for each individual, rather than being prescribed in advance by the clinician.

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