Introduction

G. ALAN MARLATT
LISA J. ROBERTS
University of Washington, Seattle

The treatment of addictive behaviors has much to contribute to the field of psychotherapy, including alcohol and substance use problems, pathological gambling, and compulsive high-risk sexual behaviors. In the past two decades, significant advances have been made in developing new therapeutic approaches that have been shown to be effective in clinical research trials with alcohol and drug problems (Buelow & Buelow, 1998; Miller & Brown, 1997). Two such approaches, which have particular relevance for psychotherapists working in this field, are relapse prevention and harm reduction.

The original relapse prevention model (Marlatt & Gordon, 1985) was designed to enhance the maintenance of abstinence (i.e., to prevent relapse) following treatment for alcohol and drug problems. Other applications of relapse prevention have expanded the model to apply to the prevention of relapse for a variety of other clinical problems (e.g., Laws, 1989; Wilson, 1992). A second application of relapse prevention, often called "relapse management," is to provide therapy assistance for clients who are experiencing relapse problems, either on an episodic or chronic basis. The goal is to help the client to both reduce the magnitude of the relapse episode (reduce the frequency, intensity, and duration of lapses) and to minimize the harmful consequences.

Harm reduction (Marlatt & Tapert, 1993; O'Hare, Newcombe, Matthews, Buning, & Drucker, 1992) has emerged in recent years as an alternative to traditional abstinence-based treatment for addiction problems. Spurred by the link between active drug use and HIV infection (especially among intravenous drug users), harm reduction programs were initially promoted as a means of reducing the risk or harm of active drug use. Needle exchange, designed to help reduce the spread of HIV among intravenous drug users, is the best-known example of the harm reduction approach (Des Jarlais, 1995).

• *Correspondence and requests for reprints should be sent to G. Alan Marlatt, University of Washington, Seattle, Box 351525, Seattle, WA 98195-1525.*

In Session: Psychotherapy in Practice, Vol. 4, No. 1, pp. 1–8 (1998)

CCC 1077-2413/98/010001-08

In addition to needle exchange, several other harm reduction methods have received attention in clinical and research studies, including moderate or controlled drinking for problem drinkers, nicotine replacement therapy for smokers, safe sex programs for individuals at high risk for HIV, and methadone maintenance for heroin addicts (Marlatt, in press). Harm reduction is based on a humanistic and pragmatic philosophy to help individuals who are unable or unwilling to embrace abstinence as the only acceptable treatment goal (Marlatt, 1996).

Harm reduction and relapse prevention share a number of common assumptions about how addictive behaviors develop and how they can be treated. The goals of the two approaches overlap when it comes to helping clients who are currently involved in an addictive behavior. Such clients include both those who have relapsed in their pursuit of abstinence as well as those who are ongoing active users.

In this issue, we introduce a new and exciting application of relapse prevention and harm reduction approaches to the treatment of clients with dual disorders: those who present with a combination of co-occurring addictive and mental health (i.e., psychiatric) problems. As is made clear from the case studies presented in this issue, therapists are in a unique position to provide an integrated approach to working with clients with both types of problems.

The ideological split between the traditional substance abuse camp and those identified with mainstream psychotherapy approaches is motivated, in large part, by competition among service providers and the resulting turf wars over client ownership and preferred treatment approach. The resulting "dueling diagnostics" between the two opposing camps often leaves the client in the lurch. Our clients are often confused over the mixed messages they receive from substance abuse counselors and traditional psychotherapists. The former group tells the client, "You are depressed because you drink too much—stop drinking and your depression will go away." In the latter group, many psychotherapists tell the client, "You are drinking because you're depressed—this is an attempt to self-medicate your symptoms; if we alleviate your depression, your drinking will no longer be a problem." In an integrated harm reduction approach, the drinking and the depression are interrelated.

The development of an integrated approach to working with clients with both kinds of problems is the theme of this issue. Therapists who can assist clients to understand the functional relationship between their addictive behavior and other psychiatric or behavioral problems are beginning to emerge on the professional scene. Rather than referring clients who report active alcohol or drug use to specialized substance abuse treatment programs, these therapists are willing to meet their clients "where they are," and to work with them to reduce the harmful consequences of both types of problems. Therapists align themselves with the client's goals, rather than imposing goals upon the client (e.g., insisting upon total abstinence as a precondition of receiving therapy).

In this introduction, we first provide an overview of harm reduction and relapse prevention approaches as they have been applied in the treatment of addictive behaviors. The application of these methods in the treatment of clients with co-occurring addictive behavior and psychiatric disorders is then discussed.

HARM REDUCTION

As noted previously, harm reduction refers to policies and programs designed to reduce or minimize the harm associated with ongoing or active addictive behaviors.

Interest in this approach began in Europe, in response to the rapidly rising rate of HIV infection among injecting drug users, and growing evidence that the criminal justice approach to controlling drug use was exacerbating the problem, rather than reducing or eliminating it (Engelsman, 1989; Heather, Wodak, Nadelmann, & O'Hare, 1993; Marks, 1991; O'Hare et al., 1992). Harm reduction methods are based on the assumption that habits can be placed along a continuum of harmful consequences. The goal of harm reduction is to move the individual along this continuum, or take steps in the direction to reduce harmful consequences (Des Jarlais, 1995; Marlatt, Baer, & Larimer, 1995; Marlatt, Larimer, Baer, & Quigley, 1993; Marlatt, Somers, & Tapert, 1993).

In an article providing an overview of the harm reduction approach, four basic principles of this model are discussed (Marlatt, 1996). The first principle is that harm reduction provides a pragmatic and humanistic alternative to the moral/criminal and disease models of drug use and addiction. Unlike advocates of the moral model, many of whom view illicit drug use as morally repugnant and who advocate a zero-tolerance approach through punishment and prohibition (as in the current War on Drugs), harm reduction shifts the therapeutic focus away from drug use itself to the consequences of addictive behavior. These consequences are evaluated primarily in terms of whether they are harmful or helpful to the user and to the society at large, not on the basis of whether the drug use itself is considered morally wrong.

Also, in contrast with the disease model of addiction (which defines addiction as a biological/genetic pathological condition) with its insistence upon total abstinence as the only acceptable goal of treatment, harm reduction supports offer a wide range of policies and procedures designed to reduce the harmful consequences of addictive behaviors.

A second principle is that although harm reduction accepts abstinence as an ideal outcome, other treatment goals that reduce harm are accepted. Harmful effects of unsafe drug use can be placed along a continuum, similar to the range of temperatures on a thermometer. When things get too hot or dangerous, harm reduction promotes "turning down the heat" to a more temperate level.

The third principle holds that harm reduction has developed with considerable input and partnership with active drug users. Recall, for example, that needle exchange programs for intravenous drug users began in the Netherlands in response to addicts who belonged to a union of users (known in Holland as the "Junkiebond"), and who advocated drug policy changes that would permit the legal exchange of needles in order to reduce the risk of HIV infection. Thus, harm reduction has emerged primarily as a "bottom–up" approach based on addict advocacy, rather than a "top–down" policy advocated by drug policy bureaucrats. In the case studies presented in this issue, the shared development of treatment goals between therapist and client is illustrative of this partnership principle.

A fourth and final principle is that harm reduction promotes low-threshold access to services, including psychotherapy, as an alternative to traditional high-threshold programs. Rather than setting abstinence as a precondition for receiving treatment for addictive behavior problems, supporters of the harm reduction model are willing to reduce such barriers, thereby making it easier to "get on board" and get started. This attitude is user friendly, and helps reduce the stigma associated with getting help for these kinds of problems by providing an integrative, normalized approach to substance use that often co-occurs with other psychological problems (Marlatt, 1996).

RELAPSE PREVENTION

Relapse prevention is a cognitive–behavioral self-management training program designed to enhance the maintenance of therapeutic gains (Marlatt & Gordon, 1985). With skills training as the cornerstone, relapse prevention teachers clients: (a) to understand relapse as a process; (b) to identify high-risk situations; (c) to learn how to cope with cravings and urges to engage in the addictive behavior; (d) to reduce the harm of relapse by minimizing the negative consequences and learning from the experience; and (e) to achieve a balanced lifestyle, centered on the fulcrum of moderation. Relapse prevention techniques have been developed for individuals with co-occurring substance abuse and other serious psychiatric disorders such as schizophrenia (Daley, 1994; Roberts, Shaner, Eckman, Tucker, & Vaccaro, 1992) and borderline personality disorder (Linehan & Dimeff, 1995).

HARM REDUCTION AND RELAPSE PREVENTION

How does harm reduction compare with the relapse prevention model? In the treatment of addictive behaviors with abstinence as the goal, relapse prevention can be applied as a maintenance-stage strategy to prevent relapse (such as helping clients learn coping skills to deal with high-risk situations for relapse). If relapse occurs, however, relapse prevention methods can be used to interrupt the relapse process, such as taking steps to prevent the escalation of an initial lapse into a full-blown relapse. In working with ongoing relapse problems, this relapse management approach overlaps considerably with harm reduction strategies. Both approaches offer help for the active drug user, regardless of the goal (abstinence vs. reduced harmful consequences). For clients who pursue an abstinence goal and who are experiencing relapse, relapse prevention is designed to help them reduce their frequency/intensity of relapse episodes, to keep them engaged in the treatment process, and to motivate their renewed efforts toward behavior change. As an approach to relapse management, relapse prevention thus represents a tertiary prevention approach to harm reduction, designed to reduce the magnitude of relapse (Marlatt & Tapert, 1993).

ONGOING CHALLENGES WITH COMORBIDITY

That clients present with more than one presenting problem is not new to clinicians. Recent empirical studies have illuminated the high rates of comorbidity among community samples (Regier et al., 1990), and there has been a growing number of reports of comorbidity among clinical samples (Cuffel, 1996; Khalsa, Shaner, Ang lin, & Wang, 1991; Ross, Glaser, & Germanson, 1988). Clinicians must often provide treatment for individuals who may not meet diagnostic criteria, but instead present with a multitude of symptoms and problems that interactively impair their functioning.

Carey (1991) outlined four challenges that have impeded clinical research and progress with dually diagnosed (substance abuse and co-occurring psychiatric disordered) individuals: (a) access to the existing literature; (b) access to dually diagnosed population; (c) heterogeneity of the population; and (d) establishment of ac-

curate diagnoses. Her article is useful to illustrate the developmental milestones that have occurred in the context of the treatment of dual disorders, and also to draw attention to topics that are important and have yet to receive adequate attention from clinicians and researchers.

With regard to access to the literature, Carey (1991) pointed out the lack of consistent descriptive labels. Carey recommended the use of the term "dual diagnosis" as opposed to "mentally ill chemical abuser" (MICA) or "psychiatrically impaired substance abuser" (PISA). The second obstacle had to do with the lack of integrated services for individuals with co-occurring substance abuse disorders and psychiatric disorders. Most service systems are not equipped to deliver integrated services for multiple disorders. The third challenge had to do with the heterogeneity of the population. Carey created a matrix of subgroups within the dual-diagnosis population that consisted of major psychiatric disorders (schizophrenia, bipolar disorder, major depression, anxiety disorders, and personality disorders) and drugs of abuse (CNS depressants, CNS stimulants, marijuana/hallucinogens, opiates/analgesics, and inhalants/PCP). The fourth challenge was the problem around reliable and valid diagnosis. This problem is exacerbated by inadequate training in multiple areas, lack of adequate diagnostic instruments, and the interactive nature of drugs and symptoms.

Since the publication of Carey's (1991) article, some of her challenges have received attention and additional challenges have arisen. It is now increasingly accepted that dual-diagnosis clients require simultaneous and integrated psychiatric and substance abuse treatment (Bond, McDonel, L. D. Miller, & Pensec, 1991; Drake, Yovetich, Bebout, Harris, & McHugo, 1997; Hellerstein & Meehan, 1987; Kofoed, Kania, Walsh, & Atkinson, 1986). The articles in this issue of *In Session* are illustrative of the integrated approach. In addition, an increasing number of clinicians and researchers have developed methods of tolerating diagnostic uncertainty (Shaner et al., in press).

Areas that have not been sufficiently addressed include the use of adequate labels and the heterogeneity within those samples. Although the term "dual diagnosis" is an improvement upon PISA and MICA, it is not sufficient. For example, it does not differentiate individuals with schizophrenia and cocaine dependence from individuals with co-occurring spinal cord injury and substance use disorders. One possible improvement is to use the term "co-occurring disorders" and specify the disorder and abused substance. However, this is still not a complete solution because nature does not necessarily carve out disorders neatly at the joints. So, it is possible to have a sample of individuals with schizophrenia and cocaine dependence with additional subsamples that also meet criteria for other drugs of abuse, other serious medical problems such as HIV, and personality disorders. This heterogeneity poses a problem for both practitioners and researchers.

Another problem with diagnostic heterogeneity of samples is its effect on the generalizability of empirical studies. For example, in a recent study, R. A. Brown, Evans, I. W. Miller, Burgess, and Mueller (1997) described the results of a cognitive–behavioral treatment for depression and alcoholism. Upon closer examination, the 35 participants who met the criteria for the study fulfilled *DSM–III–R* criteria for alcohol dependence and had a Beck Depression Inventory score of 10 or greater. Thus, the authors referred to the participants as "alcoholics with elevated depressive symptoms" (p. 716). However, even though the sample size for that study was 35, a total of 113 individuals were considered for study participation; as such, only

31% of the potential participants met study criteria. Of those, 17 of the 113 (15%) were excluded for psychiatric symptoms. Researchers who seek homogenous groups in order to have adequate statistical power to detect effects, are also faced with problems about how faithfully the findings relate to clinical reality. In other words, it is often the case that researchers select pure samples of participants to study because, statistically, it is easier to find differences, but clinicians do not have the luxury of working only with pure samples. Thus, the approaches that often demonstrate efficacy or effectiveness in clinical trials are not as easily used in real-life settings. Clinicians typically provide interventions for individuals who have a multitude of problems and/or diagnosable disorders. Clinicians do not have the luxury of withholding treatment because their clients are more complex than participants treated in research studies. As the cases in this issue illustrate, most present with many more than two issues/disorders.

Finally, although defining successful treatment outcome was not described by Carey (1991) as a problem, it remains an important clinical and research issue. Rather than measuring outcome by substance use per se, an emphasis should be placed on the ability of individuals to function in society. O'Brien and McLellan (1996) have suggested that one approach is to measure successful outcome in terms of reduction of alcohol and drug use, personal health and social functions, and reduction in threats to public health and safety. Their suggestion is to use the Addiction Severity Index (ASI), a structured interview that determines the need for treatment across seven domains (medical status, employment status, legal problems, family/social relations, drug use, alcohol use, and psychiatric status). By using such a measure, success may be assessed in degrees of severity across all the aforementioned areas relevant to successful treatment. This approach to assessment over multiple problem areas, rather than a single focus on substance use outcomes (abstinence vs. relapse) is consistent with a harm reduction approach.

WHY IS HARM REDUCTION A USEFUL WAY OF CONCEPTUALIZING COMORBIDITY?

Harm reduction is a useful way of conceptualizing comorbidity for a number of reasons (Carey, 1996). As noted earlier, harm reduction approaches allow flexible treatment planning, to help meet individuals where they are in terms of readiness to work on problems. It is a collaborative process, where the client dictates what is important and the therapist is able to provide information and feedback on how to implement change. What is most unique about this approach is that it utilizes a gradual, process-oriented approach whereby success is not defined as a final outcome, but movement in the direction of less risk. It also focuses on overall psychosocial functioning, as opposed to arbitrary expectations (abstinence only) that might increase treatment refusals and dropouts.

Because harm reduction is based on the concept of using a gradual approach to achieve individuals' goals, it is a more flexible approach. Working with individuals with comorbid disorders is often frustrating because there are, frequently, missed appointments, uncompleted homework assignments, and so on. As the cases in this issue illustrate, using a harm reduction approach allows for working with individuals and tolerating nonadherence. This approach is also useful for anticipating and coping with crises, which is a common experience that is also described in the articles in this issue.

OVERVIEW OF THIS ISSUE

The four case studies presented in this issue all deal with the treatment of dual disorders from a harm reduction perspective. In the first article Andrew Tatarsky describes his integrative approach to harm reduction psychotherapy with a male client whose excessive drinking was secondary to his problem with depression. Debra Rothschild, in the second article, describes her treatment of a female client with comorbid alcohol dependence and depression, along with associated relationship problems. In the third article, Patt Denning describes a case of a male client who is HIV positive and presents with a history of polydrug abuse. The final article, described by McCann and Roy-Byrne, presents a case of a woman with a combination of problems including attention deficit disorder, posttraumatic stress disorder, and cocaine use. Several theoretical orientations are represented among the four clinicians, ranging from cognitive–behavioral therapy to object relations theory and psychodynamic treatment. The issue concludes with a summary and evaluation of this approach to therapy in a clinically sensitive, incisive commentary by Judith Gordon.

SELECT REFERENCES/RECOMMENDED READINGS

Bond, G. R., McDonel, E. C., Miller, L. D., & Pensec, M. (1991). Assertive community treatment and reference groups: An evaluation of their effectiveness for young adults with serious mental illness and substance abuse problems. *Psychosocial Rehabilitation Journal, 15,* 31–43.

Brown, R. A., Evans, M., Miller, I. W., Burgess, E. S., & Mueller, T. I. (1997). Cognitive–behavioral treatment for depression in alcoholism. *Journal of Consulting and Clinical Psychology, 65,* 715–726.

Buelow, G. D., & Buelow, S. A. (1998). *Psychotherapy in chemical dependence treatment: A practical and integrative approach.* Pacific Grove, CA: Brooks/Cole.

Carey, K. B. (1991). Research with dual diagnosis patients: Challenges and recommendations. *The Behavior Therapist, 14,* 5–8.

Carey, K. B. (1996). Substance use reduction in the context of outpatient psychiatric treatment; A collaborative, motivational, harm reduction approach. *Community Mental Health Journal, 32,* 291–306.

Cuffel, B. (1996). Comorbid substance use disorder: Prevalence, patterns of use, and course. *New Directions for Mental Health Services, 70,* 93–105.

Daley, D. (1994). *Preventing relapse: Dual diagnosis workbook series.* Center City, MN: Hazelden.

Des Jarlais, D. C. (1995). Harm reduction: A framework for incorporating science into drug policy. *American Journal of Public Health, 85,* 10–12.

Drake, R. E., Yovetich, N. A., Bebout, R. R., Harris, M., & McHugo, G. J. (1997). Integrated treatment for dually diagnosed homeless adults. *Journal of Nervous and Mental Disorders, 185,* 298–305.

Engelsman, E. L. (1989). Dutch policy on the management of drug-related problems. *British Journal of Addiction, 84,* 211–218.

Heather, N., Wodak, A., Nadelmann, E., & O'Hare, P. (Eds.). (1993). *Psychoactive drugs and harm reduction: From faith to science.* London: Whurr.

Hellerstein, D., & Meehan, B. (1987). Outpatient group therapy for schizophrenic substance abusers. *American Journal of Psychiatry, 144,* 1337–1339.

Khalsa, H. K., Shaner, A., Anglin, M. D., & Wang, J. C. (1991). Prevalence of substance abuse in a psychiatric evaluation unit. *Drug and Alcohol Dependence, 28*(3), 215–223.

Kofoed, L., Kania, J., Walsh, T., & Atkinson, R. M. (1986). Outpatient treatment of patients with substance abuse and other co-existing psychiatric disorders. *American Journal of Psychiatry, 143,* 867–872.

Laws, D. R. (Ed.). (1989). *Relapse prevention with sex offenders.* New York: Guilford Press.

Linehan, M. M., & Dimeff, L. A. (1995). *Dialectical behavior therapy manual of treatment interventions for drug abusers with borderline personality disorder.* Unpublished manuscript, University of Washington at Seattle.

Marks, J. (1991). The practice of controlled availability of illicit drugs. In N. Heather, W. R. Miller & J. Greeley (Eds.), *Self-control and the addictive behaviors* (pp. 304–316). Botany Bay, Australia: Maxwell Macmillan.

Marlatt, G. A. (1996). Harm reduction: Come as you are. *Addictive Behaviors, 21,* 779–788.

Marlatt, G. A. (Ed.). (in press). *Harm Reduction.* New York: Guilford Press.

Marlatt, G. A., Baer, J. S., & Larimer, M. E. (1995). Preventing alcohol abuse in college students: A harm-reduction approach. In G. M. Boyd, J. Howard, & R. A. Zucker (Eds.), *Alcohol problems among adolescents: Current directions in prevention research* (pp. 147–172). Northvale, NJ: Erlbaum.

Marlatt, G. A., & Gordon, J. R. (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors.* New York: Guilford Press.

Marlatt, G. A., Larimer, M. E., Baer, J. S., & Quigley, L. A. (1993). Harm reduction for alcohol problems: Moving beyond the controlled drinking controversy. *Behavior Therapy, 24,* 461–504.

Marlatt, G. A., Somers, J. M., & Tapert, S. F. (1993). Harm reduction: Applications to alcohol abuse problems. In L. S. Onken, J. D. Blaine, & J. J. Boren (Eds.), *Behavioral treatments for drug abuse and dependence.* Bethesda, MD: National Institute on Drug Abuse.

Marlatt, G. A., & Tapert, S. F. (1993). Harm reduction: Reducing the risks of addictive behaviors. In J. S. Baer, G. A. Marlatt, & R. McMahon (Eds.), *Addictive behaviors across the lifespan* (pp. 243–273). Thousand Oaks, CA: Sage.

Miller, W. R., & Brown, S. A. (1997). Why psychologists should treat alcohol and drug problems. *American Psychologist, 52,* 1269–1279.

O'Brien, C. P., & McLellan, A. T. (1996). Myths about the treatment of addiction. *Lancet, 347,* 237–240.

O'Hare, P. A., Newcombe, R. Matthews, A., Buning, E. C., & Drucker, E. (Eds.). (1992). *The reduction of drug-related harm.* New York: Routledge, Chapman, & Hall.

Regier, D. A., Farmer, M. E., Rae, D. S., Locke, B. Z., Keith, S. J., Judd, L. L., & Goodwin, F. K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiological Catchment Area (ECA) study. *Journal of the American Medical Association, 264,* 2511–2518.

Roberts, L. J., Shaner, A., Eckman, T. A., Tucker, D. E., & Vaccaro, J. V. (1992). Effectively treating stimulant-abusing schizophrenics: Mission impossible? *New Directions for Mental Health Services, 53,* 55–65.

Ross, H. E., Glaser, F. B., & Germanson, T. (1988). The prevalence of psychiatric disorders in patients with alcohol and other drug problems. *Archives of General Psychiatry,* 45, 1023–1031.

Shaner, A., Roberts, L. J., Eckman, T. A., Racenstein, J. M., Tucker, D. E., Tsuang, J. W., & Mintz, J. (in press). Sources of diagnostic uncertainty among chronically psychotic cocaine abusers. *Psychiatric Services.*

Wilson, P. H. (1992). *Principles and practices of relapse prevention.* New York: Guilford Press.