

“FIRST, DO NO HARM” :

A REVIEW OF *HARM REDUCTION PSYCHOTHERAPY* BY ANDREW TATARSKY



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Andrew Tatarsky, an innovative clinical psychologist practicing in Manhattan, has produced a timely and targeted professional document-of-practice. Timely, because the idea of harm reduction (making drug policy not based on punishment, but on the broadest possible assessment of the net-least harm to society) is just beginning to be accepted in policy and practice. Targeted, because it is a document of and for clinical practice, one that cuts across theoretical orientations. Each of the ten chapters is written by a different practitioner, each with a client case study (five dealing with alcohol, one with opiates, one with amphetamines and three with multiple substances) and each with an analysis by Dr. Tatarsky. The net effect is to bring the audience into the authors' process and experience as professionals: This is a book by clinicians and for clinicians (and students), only secondarily for the policy makers and the lay-activist audience, and only indirectly meant to communicate with the scientific community.

One complaint that can be made about the book concerns its application to policy. In practice, an “N of 10” is actually a good-sized data set for case-based clinical research. (As an old methods professor used to intone: “One subject to hypothesize; two to validate; three to publish.”) Yet Tatarsky attempts little policy-directed scientific generalizing from the quite rich database the book presents. Of course, one book can't be all things to all audiences and this volume doesn't try to be, but rather offers an expert and deeply felt clinical manual and roadmap for the dissemination of operational harm reduction practices to the psychotherapeutic community.

Twelve-Step Degrees of Separation

Harm reduction diverges sharply from the currently accepted treatment model for alcohol and drug problems: abstinence and twelve-step treatment. According to Tatarsky (2002a) however, the Big Book of AA is “the original harm reduction text” and abstinence can be the best harm reduction approach. In fact, the 12-step approach pioneered by Alcoholics Anonymous (AA) does not actually require abstinence – only the “desire” to stop. The original idea was that talking with other recovering alcoholics made it easier to not drink, that night. Tatarsky believes that today's AA, with its embarrassing “day counting” (as in, “Hi, I'm Joe, and I've been sober for [only] one day...”) and advice to “stick with the winners” (i.e., avoid those who still drink) reflects a contamination of the original spirit of AA by competitive, shaming trends in the larger culture.

What if the “abuser” is not sure he or she wants to stop? Paradoxically, to tap a 12-step

community for support in making this decision, the user must already have the “desire to stop.” Since most alcoholics and drug addicts are, by definition, not at a point where they can consistently choose to stop, AA’s abstinence requirement in essence skims the cream off the top of the pool seeking to be cured. Alcoholics Anonymous outcome data look better as a result, as does its reputation and funding options. With only five percent of those who come to AA staying with it, is AA successful? It’s hard to say – remember, AA is “anonymous” – but Tatarsky believes that for many, AA has not been a success. And these individuals should not be forgotten; they are just as deserving of a brighter future in which their destructive patterns of drug and/or alcohol abuse are reduced, if not eliminated.

Alcoholics Anonymous is a highly structured program with specific, enforced requirements for thinking and acting. These cult-like qualities can potentially be used for the good, but frequently do enormous damage to those who don’t remain. In the world of AA – and so, in most treatment programs – if you are not abstinent, then “You still must have to hit a lower bottom.”

Alcoholics Anonymous has changed from a community of peer assistance to something much more akin to the “disease concept” of medicine. Once the user has been “in disease” with any substance, then any future use of any intoxicating substance is evidence of “relapse.” The beauty of harm reduction is its “compassionate pragmatism.” Harm reduction psychotherapies take no *a priori* position about drug use; what matters is the way that use may be harmful to users, family, community – a net-least detriment, systems approach.

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Policy Implication: First Do No Harm

One of the more profound conclusions frequently raised by the book’s authors is simply that we must return to “good clinical practice” in the treatment of addicts. Why should people having difficulty with their (albeit unprescribed) medications be treated any differently than any other patients? Psychotherapy for drug abuse is no different than other forms of treatment, and a major accomplishment of *Harm Reduction Psychotherapy* is to humanize the face of the drug user, who has been the only patient told: “I’ll only treat you if you come to treatment cured.”

That harm reduction practice has grown so rapidly is all the more impressive when one considers that essentially all government funding and program licensing require user abstinence. There is now a multi-billion dollar drug and alcohol treatment industry, paid for by the government, that sets up failure with its high hurdle of absolute abstinence. When they can’t – or don’t choose to – comply, many end up feeling even worse – like failures – resulting in further escalation in their substance abuse. Such lapses are then viewed as moral failures, with the implicit message from the authorities to go even lower, to hit bottom, in order to be allowed treatment. Even when this policy ends in long-term abstinence as claimed, it makes treatment more volatile, eliciting more harmful, costly behavior on the road to success than the more moderate harm reduction approach.

Strengths and Weaknesses

This is a book whose weaknesses are truly

also its strengths. Chapter One overview of harm reduction reviews the literature, but the reference list at the end of the chapter doesn't in-

clude many of the studies cited. There is little effort to draw generalizations across the ten cases or to integrate the book's findings with the literature review in Chapter One. The book comes with theoretical foundations, but does not attempt to extend that theoretical scaffolding. *Harm Reduction Psychotherapy* never purports to be a college text, yet in foregoing the potential to contribute to the policy research literature, it limits its utility in all but clinical training courses.

As William James famously said, "The cure for dipsomania is religiomania," that is, alcoholism can be cured by peak spiritual experience. Yet while the authors frequently discuss "dual diagnosis" (substance abuse in addition to another psychological or physical ailment) and the implications of multiple substance use, the book doesn't discuss the extensive literature on the use of psychedelics to treat substance abuse, for example, Dr. Evgeny Krupitsky's 2002 research with Ketamine at the Leningrad Regional Center for Alcoholism and Drug Addiction Therapy. Similarly, while the "self-medica-

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tion" concept is discussed at length, the book does not take up the possibility of "benefit enhancement" coming from psychedelic psychotherapy, as shown in the research on the use of peyote in the Native American Church to assist alcoholics, most recently by an author of this review, Dr. John Halpern (2001, 1996).

Yet in part by focusing on practice rather than research, *Harm Reduction Psychotherapy* emerges as a groundbreaking, heartfelt and ultimately successful book. It takes as its formidable task the promulgation of a new treatment paradigm for therapy *with substance users* – not necessarily *for substance abuse*. This is a field manual for psychotherapists and trainees which, if followed, has the potential to make "good clinical practice" the normative experience for substance abusers and users.

Tatarsky's Path

Harm reduction is a new and controversial movement and most government agencies and HMOs still view it with hostility or suspicion. It is not surprising then that earlier in his career as a practitioner, Tatarsky experienced great anxiety and uncertainty about how to navigate this issue.

His outpatient practice was fully caught up in the requirement for abstinence. Tatarsky "felt like an imposter," unable to discuss the things he was noticing and feeling with his clinic supervisor. He was alienated, uncertain – conceptually, "in the closet" – and in conflict. After starting a private practice, Tatarsky felt more freedom to ex-

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periment with the unconventional treatments he was increasingly drawn to for his drug and alcohol using patients. It was only later, during a conversation with a mentor, Alan Marlatt (who co-wrote the fledgling field’s more data-oriented book) that Tatarsky was informed, “You are doing harm reduction,” and found a community to support him. Reassured and empowered, Tatarsky came into his own as a practitioner, with this important book one result. We can only hope that the policy-making community will follow Tatarsky’s path and arrive at the same outcome. ■

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Life After Ibogaine Treatment

If you have been treated with Ibogaine, we need your help! The research team from the Free University of Amsterdam, The Netherlands, is looking for who have been treated with ibogaine in relation to narcotic addiction. A successful outcome of the treatment is not a requirement for participation. The goal of our research is to determine the long-term stable effects of Ibogaine treatment. Participation in our study is quite simple. We would need each participant to fill out a questionnaire in order to provide us with details of their drug history and Ibogaine treatment. All the information obtained is confidential. Participants who are willing to take part anonymously are welcome as well. It is hoped this research project will provide validation for the original work of Prof. dr. Jan Bastiaans, who was the first medical doctor to treat heroin and other opioid users with ibogaine. Your support is appreciated. If you would like to participate, please contact Udi Bastiaans at +31-20-6423820 or e-mail e.bastiaans@stu.med.vu.nl.