

Beyond Harm Reduction: A New Model of Substance Abuse Treatment Further Integrating Psychological Techniques

Roy Futterman, Maria Lorente, and Susan W. Silverman

North Bronx Healthcare Network

A new model of substance abuse treatment is proposed that emphasizes working on the process of behaviors in session and is based on integrating recent developments in psychological theory and technique (behavioral, cognitive-behavioral, and psychodynamic) into a harm reduction framework, with examples from a clinic that uses this treatment. Implications for program development, patient engagement, retention, sobriety, and overall functional improvement are explored.

In recent years, major developments in the theory and technique of substance abuse treatment have emerged from the integration of the formerly disconnected world of psychology. The coming together of the two fields has led to the development of the theory of harm reduction (Marlatt, 1998) as it relates to substance abuse, the techniques of relapse prevention (Marlatt & Gordon, 1985), and the technique of motivational interviewing (Miller & Rollnick, 2002).

While this integration has been occurring, major developments in psychological theory and technique have also taken place that have focused more attention on the process of what happens in treatment in an attempt to make changes in patients' life outside of treatment. This has occurred in three theoretical areas of psychology: cognitive-behavioral therapy (CBT; Safran & Segal, 1990); behavior therapy, with the development of dialectical behavior therapy (DBT; Linehan, 1993); and psychodynamic therapy, with the development of relational analysis (Greenberg & Mitchell, 1983).

Roy Futterman, Maria Lorente, and Susan W. Silverman, Growth and Recovery Program, Behavioral Healthcare, North Bronx Healthcare Network, Bronx, New York.

Correspondence concerning this article should be addressed to Roy Futterman, Growth and Recovery Program, Suite 10A-11, North Central Bronx Hospital, 3424 Kossuth Avenue, Bronx, NY 10467. E-mail: Fudds@pipeline.com

These new developments in psychological theory and technique have made few inroads into substance abuse treatment, despite the fact that they appear relevant and powerful for this form of treatment. We thus make a case for the assimilative integration (Gold & Stricker, 2001) of these new psychological developments into a new model of substance abuse treatment, using the example of a clinic that is currently implementing this model.

IMPLICATIONS FOR PROGRAM DEVELOPMENT

The National Institute on Drug Abuse recently proposed guidelines (National Institute on Drug Abuse, 1999) for substance abuse programs to administer effective treatment. They recommended, for example, that clinics have a professional staff of clinicians who are trained in motivational interviewing and CBT and that comorbid psychiatric disorders should be diagnosed and treated comprehensively. Given that the program we describe had achieved those goals, we attempted to push the treatment model further by integrating more psychological theory and technique.

Using the mode of thinking behind this theoretical and technical integration leads to broader program development implications. Principles on which this model of treatment were developed are as follows.

1. Psychological and substance abuse treatment should be integrated and administered comprehensively.
2. Aggressive efforts at engagement and retention of patients for the long term is a priority.
3. The development of a sense of community, which creates a treatment alliance to the program as a whole, is critical for difficult psychological and recovery work to be done.
4. Full integration of vocational rehabilitation services and overall functional improvement maintain long-term sobriety.
5. Process orientation is crucial for treating prevalent characterological issues.
6. Support and ongoing training of a professional staff are necessary for clinical success.
7. Psychodynamic and cognitive-behavioral psychological techniques should be integrated in treatment.

We explore the model of treatment based on these principles using the example of a clinic currently using this model.

PROCESS ORIENTATION

In recent years, in various psychological theories, there have been pronounced shifts toward focusing more on the process within individual and group sessions. Psychoanalytic thought, for example, has had a dramatic shift with the development of relational analysis (Greenberg & Mitchell, 1983). The focus of relational analysis is away from the Freudian drive theory and the therapist as a blank slate and toward an emphasis on patterns of a patient's relationships exemplified in in-session behaviors with the therapist. Technically, the therapist and patient explore the process in the room to gain insight into the patient's relationships in his or her life outside of therapy. The transference, countertransference, and other aspects of the relationship within the session are the lively material used to bring about insight, behavior change, and symptom relief.

In addition, an emphasis on the process has been prominent in a psychodynamic, particularly in an interpersonal psychodynamic, framework in group therapy (Yalom, 1995), where the here-and-now focus has been seen as instrumental in promoting insight and behavior change.

CBT has similarly moved toward more emphasis on the process of sessions (Safran & Segal, 1990). Therapists began to see in-session behavior as clinically rich information that lends a great deal to the assessment of obstacles and successes in treatments; thus, clinicians integrated this area of the treatment, which had previously been the domain of psychodynamic therapy.

In behavior therapy, the development of DBT (Linehan, 1993) for the treatment of borderline personality disorder led to a sharp focus on the process inside and outside of sessions and the relationship between the patient and the therapist as being important areas to target to keep the therapy on track. Therapists target various clinical goals as well as specifically targeting what are known as treatment-interfering behaviors throughout the course of treatment. These behaviors include anything, large or small, that impacts a patient's ability to stay in treatment, from missing sessions to threatening the therapist in session to attempting suicide. The therapist is less interested in encouraging patient insight and more interested in the patient's commitment to changing these behaviors by way of the therapist's use of such behavioral techniques as blocking the behavior or commenting on the behavior to identify it for the patient.

This focus on the process, which has been found to be a fruitful element for the promotion of insight, behavior change, and symptom relief across psychological theories, has been missing in substance abuse treatment until now.

TREATMENT MODEL

At the Growth and Recovery Program, an adult outpatient substance abuse program at North Central Bronx Hospital and Jacobi Medical Center, this model of treatment, which assimilatively integrates (Gold & Stricker, 2001) a process orientation into modern substance abuse treatment, is used on a systemic basis, in group therapy and in individual counseling and psychotherapy sessions. This program treats members of a predominantly poor African American and Hispanic community in the Bronx in New York City who primarily use heroin, crack, inhaled cocaine, marijuana, and alcohol. Some are concurrently in methadone treatment at outside clinics. Patients often have mandates for treatment from the legal system, child custody, and/or public assistance services.

The clinical model of this program uses the more recent developments stemming from the reintegration of substance abuse treatment with psychological theory and techniques (Futterman, Sapadin, & Silverman, 2004). The program operates with a harm reduction (Marlatt, 1998) philosophy, which means, among other things, that patients are accepted into the program at various levels of substance use. Some patients declare their use to be problematic, and some complain that they are only coming in to please a judge. This contrasts with traditional substance abuse treatment, in which declaring oneself an addict is seen as evidence of one's readiness for treatment (Noordsy, Schwab, Fox, & Drake, 1996) and can thus be a requirement for receiving services (Marlatt, Blume, & Parks, 2001). The harm reduction practitioner seeks to reduce the negative effects on a patient's life of the patient's misuse of substances—that is, effects on the patient's medical health, mental health, and relationships—without abstinence necessarily being the goal of treatment. In the Growth and Recovery Program, however, patients are told clearly that the long-term goal is abstinence from all addictive substances, which thus assimilates abstinence-based treatment techniques into a harm reduction theory (Futterman, Lorente, & Silverman, 2004), conceivably to the chagrin of pure harm reductionists. Patients are taught about the 12-step model of treatment and are encouraged to become involved in Alcoholics Anonymous or Narcotics Anonymous (NA) groups outside of the program, but this is not a requirement of the program.

The theory and techniques of relapse prevention (Marlatt & Gordon, 1985), which are a set of cognitive-behavioral techniques, are also used. Relapse prevention is another, more low-key approach that assumes that relapse is a natural and predictable part of the recovery process. Given this, patients are encouraged to discuss each relapse to learn about how it happened so that they can prevent the next one. Patients discern what

thoughts and behaviors (also known as triggers) led up to the relapse and plan ways to notice them as they arise and intervene early.

The techniques of motivational interviewing (Miller & Rollnick, 2002) are used throughout the treatment as well. Motivational interviewing refers to a set of techniques and general stance toward the patient in which the therapist assumes that the patient is usually ambivalent about his or her use of substances. Rather than clearly choosing sides in the debate about whether to use drugs, the therapist encourages the patient to continuously weigh the argument in his or her own head. This contrasts with traditional substance abuse treatment, in which the therapist clearly states that the patient is in denial of the problem, partly because of the drug's ill effects on the patient's judgment (Bigg, 2001), and needs to see the reality of the problem immediately for the work to begin (Marlatt et al., 2001).

Used together, these more psychologically oriented modes of working ease a great deal of the countertransferential anger that often arises in traditional substance abuse treatment (Kaufman, 1989; Weiss, 1995). This facilitates a generally more laid-back atmosphere than is found in traditional substance abuse treatment (Bigg, 2001), despite the aggressive treatment being administered. In addition, patients report that they feel that they are treated more respectfully and that the treatment feels more individualized, which has profound effects on their engagement in the treatment and retention.

Traditional substance abuse treatment, by contrast, tends to be more confrontative in approach in an attempt to break through patients' defenses and give them a raw look at the reality of their disease of addiction (De Leon, 1995; Hartel & Glantz, 1999). Technically, attempts are made to break the patient down, teach him or her to become humble, and then build him or her back up as a sober person with a sober lifestyle. One technique used to break through defenses is the confrontation group, in which a patient is seated in the center of a circle of group members, who confront the patient on perceived character defects that interfere with the patient getting a realistic look at his or her problems. Patients are expected to declare that they are addicts for any work to begin, and relapse is often a sign that the person is not ready for treatment. The person may thus be discharged from treatment as an aid to helping him or her make the decision to eventually reseek treatment when he or she is more ready to begin (Marlatt et al., 2001).

In the Growth and Recovery Program, each patient is assigned to a social worker, known as the person's care coordinator, who engages the patient and helps him or her with social service issues, medical follow-up, and other areas of his or her functioning as well as providing substance abuse and other counseling. A psychiatrist prescribes medication, and psychologists provide individual psychotherapy in addition to the social

worker's counseling, as indicated. A vocational rehabilitation counselor sees patients individually and in groups. Patients attend the program from 9 AM to 1 PM 3 to 5 days a week on the basis of such factors as the intensity of the treatment needed (because of the intensity of the drug dependence) and reasonable scheduling demands of work or child care. Patients attend three groups a day, run by staff of various disciplines, which include vocational groups, recovery groups (either didactic groups about the 12-step model of treatment and relapse prevention techniques or psychodynamic therapy groups about recovery issues), group psychotherapy (including a men's and a women's group), community meetings, cognitive-behavioral skills training groups (e.g., anger management and stress reduction), and ear acupuncture. This schedule is customized to the individual needs of the patient, allowing for flexibility to coordinate outside medical or social service appointments. Supervised urine samples are taken daily, and breathalyzers are used as indicated. When this is described at intake, patients are often understandably concerned about sharing potentially shameful material in groups, having pins inserted into their ears, and being watched while urinating. We have found, however, that if staff members explain these seemingly odd practices in a matter-of-fact manner and transparently and copiously, if needed, describe the reasoning behind these techniques, patients quickly become amenable.

Patients stay in the program from about 6 months to 1 year before entering an aftercare program, which can consist of weekly or biweekly sessions with their care coordinator, perhaps combined with an aftercare group, individual therapy, or visits with the vocational counselor as needed.

TREATMENT-INTERFERING BEHAVIORS

In this model, on a systemic level, aggressive efforts are made to engage and retain patients in treatment. Toward this end, there are as few rules as possible in the Growth and Recovery Program so that patients have a clear understanding that the rules are designed only to be sure that the patients and staff are safe (e.g., no violence, no threats of violence) and that the groups are as productive as possible, without distractions (e.g., no late admittance to groups, no eating in groups). A firm external structure is set, however, in that patients are informed of the program rules and the schedule of groups and the staff holds the structure unwaveringly. Rules against such things as bringing in street behaviors (e.g., no hats in the program) are absent to reduce battles with staff about authority issues (and, in the hat issue, because the clinical director felt that he could not admonish someone for wearing a hat while keeping a straight face).

The idea behind this is that we found that patients often seemed to be attempting to pick fights partly to easily, angrily leave treatment and continue using drugs. Some amount of this behavior is, of course, unavoidable, and no amount of clarity and reasonableness from staff is going to eliminate all effrontery toward authority, but a large amount of early treatment dropout was found to be avoidable if staff paid close attention to bypassing some of the more common reasons for premature termination. This systemic focus on maintaining engagement is borrowed from the DBT concept of aggressively targeting treatment-interfering behaviors (Linehan, 1993), which encompass such disparate behaviors as arguing with staff, failing to attend, actively seeking disrespectful actions by the clerical staff, arriving late for groups, and disputing program rules. It also echoes motivational interviewing techniques for rolling with resistance (Miller & Rollnick, 2002), which involves therapeutically evading some defensive behaviors.

The design of the program is for these issues and behaviors to arise within group and individual treatment, where staff can deal with them therapeutically, rather than in the halls between groups (although the halls are used powerfully and frequently for informal clinical work). In other words, an attempt is made to channel authority issues and other issues that frequently lead to early termination out of the larger system and hallways and into the group room and, thus, the clinical arena. These issues are, in fact, encouraged to flourish in the groups by the design of three groups a day with a mix of heavily and lightly structured groups. In addition, a community meeting is held weekly in which all staff and patients can discuss issues that are impeding treatment. This not only helps in dealing with logistical, administrative issues and changes in group process but serves to give patients a feeling that they are being heard by the staff, whether or not tangible changes come about because of issues that arise. Some risk-taking behaviors outside of the program that lead to arrests or romantic disputes that lead to patients moving out and far from the program can at times be dealt with as broader treatment-interfering behaviors as well.

The principle of being vigilant for treatment-interfering behaviors is similarly applied to care of the staff in this model, which, in turn, promotes better patient care. The model asserts that any staff divisiveness will quickly appear in the patients' group process, which means that, unlike the staff of a bank, for example, clinicians need to work diligently and consistently on intertherapist cohesiveness. Toward that end, the clinical director regularly meets individually with staff for clinical supervision but also to discern issues that are interfering with clinicians' ability to work together fruitfully. Clinicians are told that they are expected to find ways to work together by any means necessary, with or without the director's interven-

tion or systemic changes. With this clear expectation, clinicians in this program have found it easy to resolve issues that impede their work. The resulting collegiality among staff is a positive model for patients, who see many informal and formal interactions among staff and are able to learn about negotiating differences. Staff divisions can often form in programs in which varying theoretical approaches are being integrated. It is unfortunate but not uncommon to find a wide crevasse between the staff from a psychology–social work background and the staff from a 12-step background. These approaches are, in fact, highly compatible (Futterman, Lorente, & Silverman, 2004). The Growth and Recovery Program has attained integration by having staff members cross-train each other formally and informally by way of co-led groups, thrice-weekly staff meetings in which patients and viewpoints are discussed profusely, formal trainings, and individual supervision.

A by-product of this model's attention to treatment engagement in the context of the harm reduction message to patients that they should keep attending the program whether they have recently relapsed or not (i.e., "keep coming back," in 12-step terms) is that patients feel a strong sense of community in the program. This serves to make the program itself become a secure base (Bowlby, 1969) from which a patient is able to explore difficult issues. Patients develop a trusting treatment alliance (Greenson, 1967) with the program as a whole that becomes a fundament for their tolerance of interventions that are harder to swallow, such as process-oriented interpretation.

PSYCHODYNAMIC EXPOSURE THERAPY

Patients in the substance-abusing population often have a particular discomfort with their own emotions (Khantzian, 1979, 1981; Krystal, 1982; Krystal & Raskin, 1970). A consistent trigger to using substances is frequent feelings of anger, sadness, happiness, and boredom. One patient, for example, attempted to describe his need to use drugs after feeling an excruciating nothingness, which he found hard to define until his psychologist described the generally innocuous feeling one has when riding a subway with little on one's mind. "Yes, that is it exactly!" the patient said.

With these phenomena in mind, both didactic groups, in which patients were taught about their emotions, and psychodynamic therapy groups were developed and repeatedly expanded on as a result of patient requests (Frieder, Futterman, & Silverman, 2004). With the psychoeducation that normalized the experience of their emotions and taught about the importance of feeling emotions instead of trying to avoid them, patients had the

confidence to experience their emotions in the dynamic groups. In this way, patients were able to gradually expose themselves to their emotional life in a safe, controlled manner, in much the same way that people learn to tolerate more concrete feared things (e.g., spiders, heights) in behavioral exposure therapy. This integrative technique was heretically referred to as psychodynamic exposure therapy, meaning the gradual exposure to one's own emotions. This is similar to the psychodynamic idea informally known as "sitting with" one's emotions without the therapist or patient trying to fix or eliminate the emotional state. Thus, the program includes more standard dynamic groups (e.g., group therapy, women's groups) but also recovery groups in which patients are prompted to discuss anything they like related to their recovery.

It originally took some work to teach patients who had been in previous treatment in other, more traditional substance abuse programs or in 12-step groups to become psychodynamic group members. Patients initially tried to raise their hand and give the monologues typical of 12-step programs, one after the other, admonishing each other not to cross-talk, not to express self-pity, to "keep it on the I" only. They were taught by Growth and Recovery Program staff to cross-talk freely and engage each other in discussion. They were encouraged to describe and feel their emotions. Group leaders worked to pace them if patients were seen to be overwhelming themselves with emotions by going too fast into self-disclosure and exploration of deep emotional issues. In other words, program therapists are more interested in exposure than in insight. The clinicians do not allow the groups to become confrontation groups, nor are the patients encouraged to delve suddenly and deeply into painful issues to break through or achieve some cathartic experience.

Patients have enthusiastically responded, stating that they had rarely been able to set the agenda of discussions in traditional substance abuse treatment, that they felt free to discuss how substance abuse affected various factors of their life, and that they felt free to discuss what they missed about using drugs without being admonished.

PROCESS ORIENTATION IN SUBSTANCE ABUSE TREATMENT

In this model, in which state-of-the-art psychological techniques have been assimilated into traditional substance abuse treatment, the staff pays close attention to and comments fervently on patients' behaviors in the program, in groups, and in individual sessions and on small variations in these behaviors. This process orientation to larger issues, such as atten-

dance, and smaller issues, such as the patients' treatment of others in groups, is used to illuminate and work on characterological issues that are prevalent in this population whether or not the patient has a diagnosable personality disorder.

Patients often report, on the basis of what they have been told in previous, more traditional substance abuse treatments, that they have character defects such as anger issues, issues with authority, or wanting things now. They have usually been given the idea that this is something they have to work on, somewhere, somehow. These so-called character defects, however, are the meat and potatoes of the present model.

Much of the therapist's relation to these issues is based on whether he or she believes the characterological issues can change. In more traditional substance abuse programs, these issues are seen as work to be done elsewhere or on one's own. In the psychiatric community, personality issues are often seen as being intractable. Recently, however, with developments in such areas as relational analysis and DBT, a process orientation has been seen as mutative with characterological issues.

In this model, therefore, patients' behaviors toward the group leaders and individual therapists are highlighted and explored. Patients are told things about immediate issues, such as, "When you raise your voice, it makes it harder for me to work with you," or broader issues, such as, "When you only come to the program in a crisis, nothing is likely to help much." Patients are given plentiful feedback on how they present themselves verbally and nonverbally and how that affects their relationships and job status. This is done in a respectful, nonconfrontational, yet often unrelenting manner (e.g., "Maybe I'm being unclear. Let me try to explain this in another way") to describe what the therapist sees in a way that is most palatable for the patient, so that the patient can integrate the comments, elaborate on them, and make use of them. Patients are often able to stay with the interpretation and chew on it, because they have a positive, trusting alliance with the community feeling of the program.

This is an extension of aggressive attention to patients' attendance and of the construal of tardiness as a sign of relapse or the approach of relapse. Attempts are made to intervene quickly at any of these potential markers of emerging problems, because once a relapse is in full swing, the patient is far less receptive to any clinical intervention. In the same way that individual psychotherapists typically speak to patients about missed sessions as potentially emblematic of a larger issue, clinicians in this model can approach patterns of behavior in the process. An initial patient response of "Why are you making such a big deal out of being late?" later becomes an understanding of behavior patterns and unconscious processes related to substance abuse. By the same mechanism, these interpretive comments can promote understanding of characterological issues in which patients can

gain an awareness of dysfunctional patterns in their relationships, with resulting behavior change.

VOCATIONAL INTEGRATION

With the full integration of vocational rehabilitation services with the other clinical aspects of the program (Futterman & Bartz, in press), the implications of these highlighted characterological issues becomes clearer for the patients. Patients are told that everything that happens in the program is prevocational, meaning that attendance, tardiness, and the quality of their participation are important for the referral to outside vocational and educational services and for their ability to maintain employment or school.

In this model, staff begin the vocational assessment and preparatory work immediately rather than waiting for a stable period of sobriety to be the starting point. There is full integration of services in that all clinicians value and echo the same behaviors. All therapists define the development of vocational and educational goals and the achievement and maintenance of these goals as being critical for the maintenance of sobriety postdischarge. This echoes the DBT idea of the development of a life worth living as being crucial for stability.

FUNCTIONAL IMPROVEMENT

In the Growth and Recovery Program, it has been consistently found that patients are able to begin having significant stretches of sobriety within their first 90 days of treatment. If not, a detoxification and 28-day rehab may be indicated before the patient continues in the program. Alternatively, it often becomes clear in this early period of treatment that a referral to a different form of outpatient program would better serve the patient—for example, a drop-in type of program for patients who are unable to consistently attend, or a program with on-site child care. Because of the relative ease with which many patients attain a period of sobriety, patients expend the majority of the work on the maintenance of sobriety. They do this by working directly on standard relapse prevention techniques but also by working on other areas of functioning. This is particularly work on characterological issues, but also on stabilizing a person's mental health, medical issues, and housing issues and on vocational attainment.

One of the most discouraging aspects of this work is repeatedly listening to patients in intake list the various programs from which they have

graduated. Our attempts to improve all aspects of a person's functioning are designed with the chronicity of addiction in mind. The idea is that if patients make significant characterological changes, they will be better able to stabilize themselves in the case of a future relapse, even years beyond treatment. We thus hope that patients will learn various relapse prevention skills, CBT skills having to do with anger management, and more direct communication and will develop a healthier relation to their own emotional life. This is what the patients report. They repeatedly state that the program helped them learn tools to use to keep themselves sober but also to improve their relationships with their family and to keep themselves calm. They consistently report that their ability to sit down and do this difficult work is based on their positive regard for the communal feeling in the program.

CASE SUMMARY

Jack was a 40-year-old man referred by his primary medical doctor following a heart attack. His doctor told him that if he continued to smoke crack and drink beer, he would die. He had never been in psychiatric or substance abuse treatment before but exhibited some symptoms of borderline personality disorder in terms of having a chaotic interpersonal style, impulsivity, difficulty controlling his anger, and some hypomanic symptoms, particularly racing thoughts.

Jack was ambivalent about treatment, showing up drunk for his physical examination during the intake process, stating that we were not going to make him stop drinking. Contrary to traditional substance abuse treatment, in which he might not be accepted for treatment without admitting that he needed the help (Marlatt et al., 2001), this behavior was accepted as part of the natural ambivalence of someone seeking treatment for substance abuse. Staff consciously failed to take the "excessive drinking is bad" side of the argument. He was told that he could not appear at the program while intoxicated but was encouraged to discuss any use occurring outside of the program, and he complied with this.

Jack made fervent attempts to have a stormy relationship with authority figures, whether they were the clinical director or the leader of any group he was in. He initially used groups to rant about the staff's perceived attempts to make all patients conform. His style of speaking was sarcastic, indirect, and convoluted. In traditional substance abuse treatment, this type of disruptive behavior is not tolerated. Patients who exhibit such behavior are taught immediately about how to act appropriately to become

humble, give up their character defects, and act like a sober person (De Leon, 1995). In psychodynamic group treatment, however, this type of behavior is work being done live and is thus encouraged. The clinical interventions at this point were for staff to be empathic to Jack's ambivalent feelings toward his substance use instead of enacting our part in his struggles with authority figures and to aggressively point out when his speaking was unclear. When he went off on a tangent about the government controlling substance users (e.g., "They want us all to be well behaved!"), a group leader might simply reflect back to him an empathic statement such as, "It must be hard to feel like you are being told what to do all the time," which visibly calmed Jack because it seemed to help label his feelings for him and make him feel understood. It also brought a here-and-now focus and encapsulated a feeling with which many other group members could identify, thus sparking a wider discussion and helping to normalize Jack's feelings and allow him to feel less isolated. Alternatively or in addition, the leader might comment on the process by stating, "It is hard to follow you when you go off discussing the government. Can you tell us how you are feeling here in the room?" which again brought a here-and-now focus and taught him about the power of communicating directly. This intervention was echoed by cognitive-behavioral skills training in an anger management group, where he was concurrently taught improved and more direct communication skills. In that context, the skills help patients become more persuasive and thus less likely to have to resort to screaming or violence to get what they want. These communication skills are then practiced in community meetings when patients suggest changes to the program and need to be persuasive to staff.

A month into his treatment, amid much complaining, Jack stopped using crack and began reducing his beer drinking. This reduction at the patient's pace is in keeping with a harm reduction philosophy rather than a more traditional approach, which demands an immediate stop to the use at the start of treatment (Marlatt et al., 2001). As Jack struggled with this, he began attacking other patients who were involved in NA meetings outside of the program, calling them "NA Nazis," which led staff to intervene, stating that patients could disagree fruitfully but could not disrespectfully attack each other (many patients who fail to respond to process comments respond and understand immediately when the behavior is put in terms of respectful vs. disrespectful behavior). The other patients, however, partly modeling the staff's style and the harm reduction approach, stayed out of the fray, dealing with these attacks with nonchalance, telling Jack to use whatever worked. Jack was thus allowed to wrestle aloud with his ambivalence, and, sure enough, within a few weeks, he had become fully involved in outside NA meetings, laughing with his peers at the storminess that led to his turnaround.

As Jack's sobriety became more stable, he focused more on his psychiatric issues. This was done in-house, which is all too often impossible in traditional substance abuse treatment, where, until quite recently, it was often hard to find comprehensive integrated services for substance abuse and psychiatric care. In typical fashion, Jack dragged himself ranting and yowling to individual psychotherapy and through a successful trial of psychiatric medications, and he followed up with his cardiac issues, with his care coordinator monitoring all of it. His individual and group therapists did insight-oriented therapy with him while commenting profusely on his in-session behaviors. For instance, he began to discuss sexual preoccupations that disturbed him. The therapists clarified for him that the appropriate place to discuss these issues was individual therapy and the men's group. When he was sexually provocative in coed recovery groups, leaders chose not to discuss the content and instead made such comments as, "I wonder why you are discussing this here. Did something happen in this group that made you want to keep people away from you by being provocative? Or are you feeling like you are not getting enough attention?" Jack was thus able to understand the matter as an interpersonal issue and not as an "if you cannot handle my honesty, that is your problem" issue. If this behavior continued, he was told merely that he had to stop it if he wanted to continue being in groups or individual treatment, because the work became unproductive when he discussed inappropriate topics. In other words, firm external parameters were set, so that he knew that he had an ample but clearly defined space in which to work on his emotional issues.

Jack made considerable improvement in that he became sober and able to speak clearly and calmly. He was in good control of his anger and impulses. Alternating with his often contradictory complaints about all aspects of the program (e.g., "Stop trying to control me," or "I should have more time with the staff") were heartfelt thanks to staff members for teaching him to live in a new way that he had not known was possible.

After months of foot dragging and howling (and complaints about the government), Jack suddenly dove into the vocational rehabilitation, after deciding that he needed to develop a more structured, fulfilling life after leaving the program. He went to school to work in the social services, despite staff elbowing him that he had conformed so much that he had become one of us. After a year of treatment, he and his care coordinator developed an aftercare plan and scheduled a graduation date, with Jack repeatedly telling the clinical director, "You better bring a big towel, because you are going to cry a lot about how proud you are of me!"

CONCLUSION

We have proposed a model of treatment currently being used in the Bronx as a step beyond the current integration of psychological and substance abuse treatment techniques, incorporating recent developments in a variety of theories focusing on aggressive process orientation. This process orientation can lead to significant changes in patients' characterological issues that are prevalent in substance abuse treatment. We propose that these changes will lead to greater stability in a person's maintenance of his or her sobriety for the long term and overall functional improvement.

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