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Applying Social Work Approaches, Harm Reduction, and Practice Wisdom to Better Serve Those with Alcohol and Drug Use Disorders

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Abstract

- *Summary*: This article reviews, particularly with reference to USA sources, the empowerment perspective, the strengths perspective, and the harm reduction approach as they relate to clinical application in serving those affected with alcohol or drug use disorders.
- *Findings*: Social work practitioners have long been educated in applying empowerment processes and the strengths perspective to better serve their clients. However, applying the harm reduction approach, particularly to the population of those with substance use disorders, has only recently been discussed in social work literature.
- *Applications*: The purpose of this article is to provide social work practitioners with relevant information pertinent to the empowerment perspective, the strengths perspective, and the harm reduction approach as they apply to helping those with substance use disorders. It also proposes various strategies involved in the assessment process, treatment planning, and treatment derived from practice experience that integrates these important social work approaches to possibly better assist this population.

Keywords empowerment harm reduction practice wisdom strengths perspective substance use disorders

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Social work literature often presents information on theory and evidence-based practice. However, while integrating social work principles, the specific techniques that may emerge from clinical practice are noticeably absent from the reports. This is particularly true regarding clients affected with alcohol and drug use disorders. As an example, MacMaster (2004) aptly described the Harm Reduction model in conjunction with the transtheoretical model of change (specifically, the stages of change) (DiClemente and Prochaska, 1998; Prochaska and DiClemente, 1982). Notably, no specific clinical interventions applicable to assisting this population were provided.

This conundrum is further complicated by the fact that effective clinical interventions are apparently what practitioners need, as discussed in a study assessing the training needs of 303 social workers working in substance abuse treatment facilities in New England (Hall et al., 2000). The researchers found that social workers reported significantly lower knowledge and skill levels in the areas of assessment and advanced clinical techniques than their non-social worker substance abuse treatment provider counterparts, including use of specific screening instruments, brief treatment and motivational interviewing techniques, and manual-guided treatment approaches. It is hoped that if this study were replicated in today's workforce the results would be more positive for social workers.

Undoubtedly, a number of multidisciplinary works have been authored in response to this (Miller and Rollnick, 2002; Straussner, 2004; Wallace, 2005; Washton and Zweben, 2006). Notably, while few of these were written by social workers, we as practitioners often encounter clients suffering from substance use disorders. It is thus argued that we as practitioners need to be more involved in disseminating information and strategies that appear to be effective and which coincide with our core values.

In response, this article provides an approach to assisting those with alcohol and drug use disorders. Specific interventions developed over 15 years of serving this population is integrated with the empowerment and strengths perspectives and the harm reduction approach. Notably, the approach suggested in this article is a specific response reflecting a geographical, legal, and organizational context that may not be applicable elsewhere. Further, the assertions made about the models of, and approaches to practice may also not be applicable in other practice settings.

Social Work Approaches

Empowerment Perspective

The principles of empowerment have become fundamental and extensively used in the profession of social work (Dubois and Miley, 1999; Elliott, 1997; Gutierrez et al., 1998; Lee, 2001). Ackerson and Harrison's (2000) qualitative research study reported it as a process by some, a product or outcome by others,

and a perspective or approach to practice or aim of social work research by yet others. Gutierrez (1994) reported it was commonly conceptualized in three levels of functioning: 1) an attribute of the person, 2) interpersonal connection, and 3) political or governmental force. Bartle and associates (2002: 33), citing many sources, stated empowerment involved 'a personal sense of self-efficacy and competence, a sense of responsibility to change self and social conditions based on critical consciousness of conditions that are oppressive; . . . and planning implementation of social action efforts to remove power blocks and create liberating conditions'. Finally, Simmons and Parsons claimed it was a process of enabling clients to achieve self-determination and master their environments (cited in Peled et al., 2000).

Notably, empowerment involves the fundamental premise that the population served is in some way oppressed. It can be effectively argued that those affected by substance use disorders are in fact oppressed (see Csiernik and Rowe, 2003). Certainly, this population suffers from being under the influence and control of their behavioral choices. They also encounter the possibility of being placed on long waiting lists to enter treatment, a lack of parity in insurance coverage compared to other mental health disorders, and the stigma associated with addictive behaviors. This article follows Breton's (1994: 24) view that empowerment is 'gaining control over one's life, that is, gaining control over the factors which are critical in accounting for one's state of oppression or disempowerment'.

As evidenced above, a universally accepted definition of empowerment or prescription for achieving it does not currently exist. However, Boehm and Staples (2002) noted there is considerable consensus as to the general responsibility of social work practitioners to serve as enabling and non-directive facilitators in the empowerment process. The most important factor for practitioners to remember is that 'People empower themselves; social workers should assist' and 'the principle of self-empowerment emphasizes the client's rights and responsibility in the process of human empowerment' (Lee, 2001: 60).

Solomon stated that practice in the empowerment process will facilitate the attainment of knowledge, skills, and resources of an emotional and material nature by which meaningful social roles are achieved (cited in Peled et al., 2000). To this end, practitioners must actively involve their clients in the healing process, developing a relationship based on mutuality while assisting in a two-way dialogue that mutually identifies potential alternatives and choices (Boehm and Staples, 2002). This is based upon the assumption that any individual or group served has assets, strengths, and expertise resulting from their lived experience that needs to be acknowledged and tapped into (Saleebey, 2006a). Lee (2001) claimed practitioners engaging in the empowerment process must use such skills for problem solving as consciousness raising, praxis, and critical education. Lee also suggested workers must maintain equality in the problem-solving process, observing the rules of parity and symmetry in communication. These skills speak to the various roles of social workers. In a study comparing

how clients and practitioners conceptualize empowerment, Boehm and Staples (2002: 457) reported practitioners need to 'tailor their empowerment approaches and interventions to the differential needs and outlooks of particular consumer groups accordingly' and warns that 'a one size fits all approach is inconsistent' with such a practice model. Notably, empowerment has often been referred to as the linchpin of the strengths perspective, particularly in the assessment process (Cowger, 1994; Cowger and Snively, 2002). It is viewed as central to clinical practice.

Strengths Perspective

The strengths perspective is a collection of ideas and strategies that seek to develop in clients their natural abilities and capabilities. It is based upon the assumption that clients come for help already in possession of various competencies and resources that may be tapped into that will improve their situation (Saleebey, 2006a). They are thus entitled to dignity, respect, and the responsibility associated with seeking help. All individuals are seen as having goals, talents, and confidence while all communities contain people, resources, and opportunities (Rapp, 1998). Strengths are viewed as what people have learned about themselves under positive and negative circumstances, even those self-inflicted (Early and GlenMaye, 2000; Saleebey, 1996, 2006b). They also evolve from personal qualities, traits, and virtues, what they have learned about the world around them, cultural and personal stories and lore, their natural source of pride, and the notion that spirituality is understood.

Basic to the strengths perspective is the assumption that all humans are capable of change and growth (Early and GlenMaye, 2000). All must be seen from a viewpoint of their capacities and capabilities, competencies, possibilities, talents, visions, hopes, and values, regardless of how altered and shattered they may have become due to their circumstances, trauma, and oppression (Saleebey, 1996). Even those typically viewed as intractable, hopeless, and resistant to accepting help are seen as capable of making significant progress in facing their difficulties when helped to reawaken their personal abilities (Brun and Rapp, 2001). Practitioners are called to see potential and possibilities rather than problems, options and choices rather than constraints, and wellness, albeit physical health or psychological, social, intellectual, or spiritual well-being, rather than sickness. Clients' strengths, resources, and environment need to remain the central focus of the helping process (Saleebey, 2006a).

The strengths perspective is premised upon several basic principles (De Jong and Miller, 1995; Early and GlenMaye, 2000; Kisthardt, 2002; Rapp, 2006). First, practitioners must focus attention upon clients' individual strengths rather than possible pathology. Next, the community is viewed as being a major source of resources, that is, different opportunities to connect with various social support networks. Interventions are individually tailored to the unique needs of each client based solely on self-determination whereby practitioners are to do nothing without their approval. The practitioner-client relationship is

primary and essential, one supporting confidence in clients' ability to engage in or cope with the multiple requirements of their surroundings and other people. The preferred mode of intervention is aggressive outreach whereby the traditional office-based practice is kept to a minimum and most interaction is engaged in where clients normally live. Finally, all people, even those with persistent and severe mental illness, are able to continue growing, learning, and changing. Clients are viewed as people *with disorders* rather than *being disordered*. This concurs with Saleebey's (1996: 298) assertions that 'Words do have the power to elevate or destroy' and they 'can lift and inspire or frighten and constrain'. Practitioners must thus analyze their personal vocabulary for providing assistance.

Rapp (1998) identified several important functions relevant to the strengths perspective. From the initial interaction, the practitioners' goal must be to begin developing a collaborative helping relationship. In the assessment process, practitioners need to focus upon the clients' current situation, their wants, and information on what worked in the past so as to identify personal and environmental strengths applicable to resolving the present identifying problems. Regarding treatment planning, practitioners must work towards developing an agenda derived from input from both parties that focuses on achieving clients' self-determined goals, requiring the plan to integrate clients' strengths into all interactions, particularly during goal setting, even for those who suffer from severe mental illness (Brun and Rapp, 2001; Linhorst et al., 2002). In addition, practitioners must assist in securing the environmental resources the clients' desire so they may achieve their goals, thus enjoying the full range of their rights and increase their assets. Lastly, practitioners need to strive for collective, continuous collaboration, and gradual disengagement. Practitioners thus prove to be more interested in the clients' ability to creatively draw upon their own strengths and community resources to cope in ways that promote self-efficacy and community integration.

Harm Reduction

Harm reduction emerged as a significant shift in public health policy to providing assistance to those affected by substance use disorders whereby the negative consequences may be addressed while the negative behaviors continued (Des Jarlais, 1995; Plant et al., 1997; Riley et al., 1999). Viewed as a strategy that prioritizes goals rather than as a goal itself it is a public health alternative to the criminal, moral, and disease models of substance abuse and addiction (Roberts and Marlatt, 1999). Common examples include methadone maintenance programs, needle exchange programs to reduce the risk of HIV/AIDS transmission, and mandatory seat belt laws (Wodak, 2003).

It originated in the 1920s in the United Kingdom with the 'medicalization approach' (Roberts and Marlatt, 1999: 390). This called for prescribing heroin and cocaine to clients dependent on them to reduce the harm associated with their use and to help those affected live healthier more productive lives. Harm

reduction later emerged in the 1980s to address the rise in hepatitis C associated with injection drug use (MacMaster, 2004).

In the 1970s the Dutch adopted a 'normalization policy' (Roberts and Marlatt, 1999: 391) to better cope with their substance abusing population. Their policy called for removal of criminalization and stigmatization of this population in lieu of a public attitude that accepted them as they are but of whom they could make 'normal' demands of and provide 'normal' opportunities.

Harm reduction is a humane and pragmatic philosophy for techniques used to provide service for individuals, the environment, or to shape public policy. It is principally a 'bottom-up' approach based on client advocacy rather than 'top-down' public policy approach (Marlatt, 1998; Weingardt and Marlatt, 1998). For those with substance use disorders it provides a clinical framework for clients willing to partake in services but who are not prepared to commit to total abstinence (MacMaster, 2004). The techniques broaden treatment from exclusively those on the most severe end of the alcohol or drug use disorders continuum to those engaged in mere problematic substance use (Wodak, 2003). By definition, it is any program or policy designed to decrease harmful health, social, or economic consequences of substance use while not insisting upon abstinence (Plant et al., 1997; Riley et al., 1999; Single, 1995). Thus its primary goal is to reduce or minimize harmful consequences associated with active or ongoing substance use. As such, it is consistent with the social work values of commitment to clients and self-determination (MacMaster, 2004).

Strategies associated with the harm reduction approach are based on the assumption that habits humans engage in fall along a continuum of detrimental consequences (Roberts and Marlatt, 1999; Tatarsky, 2002). The overriding goal of harm reduction is to help clients move along this continuum from the more severe end of harmful consequences to the lesser end. Thus, practitioners are asked to help clients help themselves engage in more positive behaviors to reduce potentially harmful consequences of their behavioral choices.

Two central principles characterize the fundamental underpinnings of harm reduction (Marlatt, 1998; Roberts and Marlatt, 1999; Weingardt and Marlatt, 1998). First, harm reduction is a public health alternative to the traditional models of substance abuse. Most importantly, it shifts focus away from the detrimental behaviors itself and its legal or moral implications to the effects or consequences of said choices. As such, behaviors may be evaluated on the basis of whether they are helpful or harmful to clients and the larger society. Second, it recognizes abstinence as a distal, ideal endpoint while accepting alternative outcomes that result in reduced harm. This 'one step at a time' (Weingardt and Marlatt, 1998: 347) approach allows clients to reduce harmful consequences, attain small successes, and lends towards development of increased motivation to take further positive risks to accomplish their ultimate life goals.

Notably, harm reduction is not anti-abstinence. Rather, it accepts that many will continue substance use whereby consequences may be reduced while still receiving services. It recognizes that a drug-free society is idealistic but

unrealistic (Des Jarlais, 1995; Goldstein, 1994). Also, while harm reduction appears to be 'soft' on drug use, it is not synonymous with nor advocates for the legalization of illicit mood-altering drugs (MacMaster, 2004).

The harm reduction approach primarily relies on three different strategies to promote clients' movement along the continuum of detrimental consequences (Marlatt, 1998; Roberts and Marlatt, 1999; Weingardt and Marlatt, 1998). This approach calls for using low threshold services, that is, those that offer easy access. Low threshold services address clients' needs in the context of health care and social services while practitioners serve and support them. Treatment goals are negotiated between the clinical parties with clients free to set specific objectives (Wodak, 2003).

Second, practitioners are called to engage in enhancing motivation for change through motivational interviewing (Center for Substance Abuse Treatment [CSAT], 1999; Miller and Rollnick, 1991, 2002). Following the stages of change, now considered to be evidence-based practice (CSAT, 1999; Dunn, 2000), this approach is designed to encourage positive actions towards reducing risk of harm among those who are not committed to abstinence. Thus, practitioners are to simply start where clients are at that moment in time.

The third basic strategy of harm reduction is reframing the concept of relapse prevention to the more reasonable notion of relapse management (Roberts and Marlatt, 1999; Weingardt and Marlatt, 1998). While recurrence of use is not mandatory, it is 'normal' (Dunn, 2000). Whether chronic or episodic, returning to old behaviors is a natural part of human voluntary change (DiClemente, 1999; DiClemente and Prochaska, 1998). Viewed in this light, practitioners must reject the idea that recurrence of use is equivalent to treatment failure but rather accept that clients are 'in the midst of a long and difficult learning process' (Weingardt and Marlatt, 1998: 338). Managing relapses works towards reducing the frequency and intensity of using episodes while motivating clients to renew their efforts to make positive change (Roberts and Marlatt, 1999). Thus, recurrence is used strictly as a tool to learn from rather than a weapon with which to beat clients or for them to beat themselves (Dunn, 2000; Weingardt and Marlatt, 1998).

Clinical Interventions

Having provided a brief synopsis of the empowerment and strengths approaches common to social work practice, and that of harm reduction, an 'emergent ideology of care' (Burke and Clapp, 1997: 552), what follows are discrete interventions used by this practitioner to serve those with alcohol and drug use disorders. These interventions have evolved from practicing in the field of substance use disorders for over 15 years in the USA. Educational training occurred in a state-funded program and several hospital settings and with populations from all levels of socioeconomic status. Skills were later honed working in a privately owned treatment program, one specifically designed for medical

professionals, and a private practice dedicated to working with professionals in the medical field, specifically, nurses.

Notably, these interventions do not work for all who are affected. Yet, as was reported by the Project MATCH Research Group (1998), three different treatment modalities (Twelve Step facilitation therapy, cognitive behavioral therapy, and motivational enhancement therapy) were found to have similarly favorable effects on alcohol use despite following different philosophies. In fact, it was found that only psychiatric severity needs to be considered when matching clients to various outpatient treatment modalities (Project MATCH Research Group, 1997).

Initial Contact with the Client

It can be argued that every interaction provides an opportunity for intervention. Potential clients' initial contact offers such an opportunity. Listening attentively and reflecting back their story assures clients they were heard and ensures a correct assessment of their presenting problems. After clearly understanding their situation, offering choices for the meeting time that goes beyond the conventional 9 to 5 office hours empowers clients to take control of scheduling the appointments. Working with this population requires availability on the part of practitioners. This flexibility in availability was found to be a key to successful helping relationships (Ribner and Knei-Paz, 2002).

For the initial intervention, it will be helpful to ask clients to write out their expectations of therapy and their treatment goals to be discussed at the first session. This will impress upon them that what they say and want to accomplish are of prime concern and the driving force of the relationship. It offers an opportunity to explore any previous experiences with therapy, possible irrational beliefs about treatment, and their true hopes. Conversely, clients' compliance alert practitioners as to where they fall within the stages of change. Comments of 'I forgot' or 'Oh, I have the answers in my head' suggest they are in the contemplation or, at best, preparation stage while written answers suggest they are further along in the stages, that is, the farther end of preparation or in early action. This information is useful in assigning future interventions. It provides the key as to whether to employ experiential approaches to enhance motivation or to initiate behavioral interventions.

Assessment

The assessment process is the key to developing a helping alliance between clients and practitioners. Problematic alcohol or drug use can be defined as when one's consumption 'repeatedly interferes with occupational or social functioning, emotional state, or physical health' (Maxmen and Ward, 1995: 144). This definition focuses on the impairments and consequences rather than frequency and quantity of their substance use. It is also important to recognize that substance use disorders fall along a continuum ranging from simple problematic behavior (minimal consequences) to hazardous (that which

increases risk of psychological or medical problems), to harmful (psychological or medical problems), to abuse and dependence (physical, psychological, or both) according to DSM-IV-TR (American Psychiatric Association, 2000). This continuum has been supported by CSAT (1999), the Institute of Medicine (1990), and the US Preventive Services Task Force (1996) and is consistent with harm reduction's assumption that human habits fall along a continuum of detrimental consequences (Roberts and Marlatt, 1999; Tatarsky, 2002).

Practitioners must suspend all judgment associated with alcohol and drug use. Most importantly, eliminate all negative words and phrases, that is, denial, resistance, unmotivated, uncommitted, and labels associated with these disorders (Miller and Rollnick, 1991, 2002). For example, reframe defense mechanisms as care strategies (D'Angelo, 1982). Frame substance use in a positive light (Tatarsky, 1998); a care strategy they learned to help deal with life that is no longer working. Also, for most clients, treatment will not be about rehabilitation; rather, it is about habilitation. Rehabilitation suggests that earlier in their lives they learned more appropriate coping skills. However, it can be easily argued that most of those affected have not learned these skills, but are capable of doing so over time. This follows the assumption that all clients possess various competencies and resources they may tap into (Saleebey, 2006a). Conveying this to clients offers hope and provides many with the initial motivation to fully engage in the treatment process. Clearly, offering hope and reframing that allows for the development of attitudes and language about the nature of opportunity and possibility are key components of the strengths perspective (Saleebey, 1996, 2006a).

The assessment process 'provides an early and ongoing opportunity for the client/social worker partnership to name and rename the problem, shifting perspectives from deficit to strengths and providing the client opportunities to have voice in shaping the method for problem remediation' (Cowger and Snively, 2002: 107). When possible, open the conversation with, 'The proverbial question in therapy is "Why Now – What causes you to seek help now?"' This allows clients to test practitioners' reactions while initially presenting their story in their own words.

Next, conduct a thorough assessment and assure clients this process is only to learn about possible impairments and consequences associated with their substance use and its level of severity (Brown, 1995; Miller and Rollnick, 1991; Straussner, 2004). The assessment explores alcohol and drug use, the longest period of abstinence, psychiatric history, family history of substance use and psychiatric problems, and medical, social, employment, and legal problems associated with their substance use.

The last section of the assessment consists of several key points. Have clients report their current stressors and, on a scale of one to ten, how serious they see their current stress level. This aids in determining clients' impressions of their problems and their probable stage of change. Complete the assessment by asking clients to identify their assets and goals. Always remember that the

strengths perspective believes clients, no matter how serious their current situation, have positive assets in their lives and are capable of identifying personal goals (Brun and Rapp, 2001; Linhorst et al., 2002).

Because of the nature of substance use disorders, the assessment must go further than the normally accepted questions generally asked. Thus, in the context of substance use, ask about possible exposure to Alcoholics Anonymous or other Twelve Step programs. If clients have had previous exposure, ask 'How was it for you?' To prompt openness, assure them that their frank, honest answer is what is being sought. Allowing for such frankness strengthens the helping alliance. Next, ask clients how they are about being labeled an alcoholic or addict. Again, ask for nothing but total honesty. Once they have responded, de-label the disorder and simultaneously provide them with an opportunity to empower themselves by accepting responsibility for their recovery and by taking control of it (Ford, 1996). Introduce the handout entitled *To Have or to Be* (Karoll, 2003) (see Appendix) to clients and allow them time to read it. Once clients have finished reading the handout, ask if they are more comfortable viewing their disorder in such a light and invite them to begin doing so.

Treatment Planning

Once completing the assessment, present the findings in a non-confrontational, matter-of-fact manner according to the information provided (Miller and Rollnick, 1991, 2002). Remember not to use labels; rather, refer to the disorders as something they have to help them deal with life as the strengths perspective suggests. Finally, using the goals clients identified during the assessment, formulate a treatment plan in a way that helps them achieve their desired outcomes.

This is outpatient treatment for working with substance use disorders. It considers these as chronic conditions needing extended care similar to other serious medical disorders such as heart conditions, diabetes, or tuberculosis (McLellan et al., 2000) and chronic brain disorders, for example, stroke, schizophrenia, or depression (Leshner, 1997). It is an individualized, long-term commitment between clients and practitioners, not a 'one size fits all' approach requiring Twelve Step participation or total abstinence.

The first weeks of treatment are crucial. Propose seeing clients twice weekly the first two to three weeks to maintain a clinical eye for medical complications while they stabilize. Further, if they have one, practitioners must make clients aware that they have a good working relationship with a psychiatrist knowledgeable in the addictions who is quick to respond to practitioners' or clients' calls if the need arises. If possible, have clients maintain daily telephone contact to reinforce accountability. Follow this with weekly sessions for nine to 12 weeks until 90 days of abstinence has been achieved (if it was a stated goal).

Another possibility is to offer weekly separate gender group sessions that are to be attended regularly for at least the first year to provide additional social support. Separate gender groups are recommended because of the varying

order of alcohol-related life experiences resulting from alcohol use (Karoll and Memmott, 2001) and gender-related differences linked with its use (i.e. effects in blood alcohol concentrations, reproductive system factors, abuse histories, help seeking patterns, and possibility of women's greater likelihood of suffering from a co-occurring mental illness) (Karoll, 2002). This type of group therapy format allows for greater safety and frankness for both genders.

In addition, explain to clients they are the best text book they have on themselves or that we have to work with (Miller and Rollnick, 1991, 2002). This promotes personal strengths and wisdom. If abstinence is their goal, suggest they write out 'what worked' during their longest period of abstinence, even if it was only one day (Beck et al., 1993; Brown, 1995; Berg and Reuss, 1998). If clients hesitate, it may be useful to remind them that, for that particular time, they engaged in different behaviors than usual. This assists in developing alternative behaviors to using by reviving former interests (Ford, 1996). Further, help clients by suggesting that in addition to other things, they *chose* not to obtain the substance or engage in its initial consumption.

If controlled substance use is the goal or if clients desire stopping the use of one substance while continuing to use others, build the treatment plan accordingly. If numerous unsuccessful attempts at abstinence have occurred, make the suggestion to work only at controlled use (Miller and Rollnick, 1991, 2002), thereby taking off the psychological pressure of being 'perfect' at this time. Help clients define controlled use or identify the substance(s) they wish to cease and substance(s) they plan to continue using, the way to monitor their behaviors, and their initial primary goals. As harm reduction allows, seek to help clients achieve their goals while keeping them engaged (Bigg, 2001). Building upon previous successes will help to increase self-efficacy, self-confidence, and self-motivation to continue moving forward. The key to this approach is that with engagement there is an opportunity to assist change while absence of engagement provides no such chance to help.

Treatment

Human volitional change is an ongoing process of recycling through the stages of change (DiClemente and Prochaska, 1998; Prochaska and DiClemente, 1982). Practitioners must understand the stages and how people tend to move through them in a spiral-like fashion. Of greater import, practitioners must be familiar with the processes of change (Grimley et al., 1994; Prochaska et al., 1997) to be prepared to introduce appropriate interventions applicable to the specific stage of change clients may be in. Let these principles guide all interventions. If clients do not follow recommended interventions, usually of the behavioral type, do not blame them for not doing what you or the world expects them to do (Freeman and Dolan, 2001). Rather, re-evaluate the suggested interventions. Practitioners are probably too far ahead of clients and need to change their approach based on earlier stages of change and experiential rather than behavioral interventions (Miller and Rollnick, 1991, 2002).

Following the stages and processes of change (DiClemente and Prochaska, 1998; Prochaska and DiClemente, 1982) it is vital that we assist clients in learning to express their feelings early in the helping relationship. This includes the more volatile ones of depression and anger, even if the anger is directed towards God (Warren, 2002). As practitioners, learn to identify and inquire about the 'knot' in their stomach and do not allow clients to leave the session with it still evident. Rather, help clients work through it by having them speak of positive and pleasant things in their life. Helping clients become aware that they have actual control over how they feel by changing what they think about provides an effective tool for everyday living. Also, by helping clients accomplish this during the session gives them cause to rejoice about their tangible therapeutic success and strengthens their hope that full recovery is possible. Thus, assisting clients to identify, express, and cope with their emotional states serves to both enhance their trust in the helping relationship and to develop healthier coping skills to reduce or eliminate recurrences of use.

Regarding knowledge that clients have experienced a recurrence of use, it is suggested practitioners not overtly confront them (Brown, 1995; Miller and Rollnick, 1991, 2002). Rather, direct the discussion to the subject of trust and honesty. It may be verbalized that 'a client may on occasion lie to me but my sleep isn't affected. However, typically theirs' is greatly disturbed by this action.' This gives clients the dignity of choice and self-determination to decide if and when to share about their recurrence of use. Most important, when clients choose to divulge the information about the recurrence, practitioners must avoid judging, shaming, or belittling them. Practitioners are to note that the recurrence serves an important function in their recovery process, that of a tool to learn from. Proposing to do an 'autopsy' on their recurrence process will help clients see how they did not 'just do it'. Rather, it will allow them to see they often had minutes, hours, or days advance warning. Clients can be assisted to become more aware of their earliest warning signs to a possible recurrence, albeit feelings, stressful events, using triggers, or, quite possibly, anniversaries that were events they may not have seen as relevant at the time (Beck et al., 1993; Marlatt, 1998).

Do not reject clients who return to using on a regular basis. Many traditional treatment programs may do so due to denial or lack of motivation. Sadly, when clients need support the most is when many such helping agencies let them go. At this stage of recovery, practitioners may be the only source of positive support. And, following harm reduction and the stages of change, this is to be simply treated as a normal part of the process. Be there for clients no matter what their choices are. If they in fact reject you, there is a very good chance they will return to you at a later date due to the trust and respect you showed them.

The traditional Twelve Step programs have not appealed to many clients nor met their needs. Do not berate or disrespect clients because they found those programs not to their liking. Instead, be prepared to provide alternatives. Helpful social support networks may include healthier family members, church

affiliation, Women (Men) for Sobriety (Kirkpatrick, 1977), Rational Recovery (Trimpey, 1996), Self Management and Recovery Training (SMART; Lemanski, 2000), Secular Organization for Sobriety/Save Our Selves (SOS; Christopher, 1988, 1989), or other social groups which are known to be available in the USA.

Finally, as noted earlier, it may be helpful to promote telephone contact outside the helping sessions. In some countries practitioners make themselves available on a 24-hour basis, similar to caseworkers engaged in the Assertive Community Treatment approach (see Sands, 2001). Healing relationships with practitioners may be the only positive support clients have and they must be nurtured throughout the recovery process. While rarely will clients take advantage of calling practitioners when they are desperate, for those who do the likelihood of a recurrence of use at that moment is greatly reduced.

Conclusion

Practicing social workers have long embraced and promoted empowerment processes and clients' strengths to motivate them to take control of their lives, even while in difficult situations. The harm reduction approach has only recently been added to the arsenal of tools useful in helping clients, particularly for those afflicted with substance use disorders (MacMaster, 2004). To better serve the needs of this population, it is advantageous to combine these approaches. This article has provided various strategies for practitioners to consider integrating into their clinical practice.

Appendix

To Have or To Be, That Is the Question, Brad R. Karoll, PhD, LCSW

At any meeting of Alcoholics Anonymous (AA) or other Twelve Step Program, listen to the way people introduce themselves. The vast majority typically open with 'My name is – and I'm an alcoholic (addict, sex addict, incest survivor, etc.)'. One of the underlying principles of Twelve Step fellowships is one's ownership of being affected, that is, '*it's what I am*'. This author contends that for many seeking recovery, labeling oneself only continues to erode one's self-esteem, self-confidence, and self-efficacy.

I prefer to view substance use disorders as simply a chronic brain disease with biophysiological components that is best treated as any other chronic illness. Further, this includes how we refer to those affected by the disorder. For example, does someone *have* diabetes, tuberculosis, cancer, or heart disease or *are they* a diabetic, tuberculosic, canceric, or heart attackic? While this may be overly simplistic, is it something they *have* or something they *are*? I vehemently argue it is something they *have*, and thus something they can *do* something about. I suggest clinicians and those affected focus on the premise that one *has* an alcohol or drug use disorder rather than *are* the disorder. I believe *having* rather than *being* the disorder carries a very powerful unconscious message. As

a result, I suggest that those seeking recovery from a substance use disorder consider the following analogy:

TO HAVE THE DISORDER	*TO BE* THE DISORDER
1) I have an alcohol or drug use disorder.	1) I'm an alcoholic or addict.
2) I engaged in behaviors naturally associated with having the disorder.	2) I did what I did because I'm an alcoholic or addict.
3) I have a right and responsibility to feel guilt and remorse about the behaviors I engaged in.	3) I only feel shame because it is what I am and what I do.
4) I *can* and *am* doing positive things to combat the disorder I have.	4) I can't do anything about what I am or do, so – *WHY BOTHER*?

Before applying the logic of the table, I must explain how guilt and remorse differ from shame. Guilt and remorse are gifts. I view them as a Higher Power's way of directly communicating with us when we cross certain boundaries. Some may refer to this as our conscience or intuition. Thus, we feel guilt and remorse when we *do* certain things. These feelings tell me that the behaviors I just engaged in were unacceptable and inappropriate. Conversely, shame is a useless and destructive emotion. It is a feeling or sense of *being* bad, broken, defective, useless, less than, or worthless. Others to control our actions often use it as a weapon. After repeated exposure to shame heaped on us by others, we tend to internalize it to the degree that we perpetuate it upon ourselves. The major difference is this: guilt and remorse are about *doing* things that are unacceptable and inappropriate; shame is about *being* unacceptable and inappropriate.

It is my personal belief that I am not powerless over alcohol as Step One of AA prescribes. As one who has recovered from my substance use disorders, I feel that as long as I do not take that first drink or drug, I have the potential to be fully in control of my thoughts, feelings, behaviors, actions, reactions, and all else related to me. However, if I take the first drink or drug, I personally give up that control (which I won't do because I am a control freak!). And, because I accept the fact that if I take the first drink or drug I will give up control over it, I view this powerlessness as my strength.

Now, refer back to the table above. If I consider alcohol and drug use disorders as simply something I have or am affected by, then it naturally follows that it is something I can *choose* to do something about. I am much more comfortably able to internalize that I engaged in certain behaviors associated with having the disorder. I need to accept and experience the guilt and remorse feelings relating to those behaviors. In concert, these concepts are empowering acts for me. It carries a much stronger, positive message than considering myself an 'ic', acting on behaviors because I'm an 'ic', and then taking on the shame of being less than and defective. All this will simply get me thinking, 'screw it, why bother trying since this is what I am!' and then return to alcohol and drug use.

As an aside, I see blaming my actions on being an 'ic' as simply choosing to live in the problem rather than the solution. If I say that I do what I do because I'm an 'ic', I am only deflecting responsibility for my actions. Quite frankly, no disorder can make me do anything. I do what I do because I choose to do it, whether it is an unconscious thought process, ingrained habit, or conscious choice. I do what I do because I choose to do it, *period*. That being true, I must accept responsibility for my actions, feel any guilt and remorse associated with the behaviors, and then choose new, healthier behaviors. When I pick up this gauntlet, I begin choosing to live in the solution, not the problem!

I believe I have an alcohol and drug use disorder from which I have recovered. During early recovery, I accepted and worked through my feelings of guilt and remorse associated with the various behaviors I engaged in throughout the many years of drinking and drugging. I saw that feeling shame about those actions would only keep me thinking negatively about myself. More importantly, I am now *doing* what is necessary to prevent me from taking the first drink or drug. Thus, as long as I do not ingest the first drink or drug, I am guaranteed to retire for the evening totally drug and alcohol free.

I INVITE READERS TO CONSIDER THESE CONCEPTS CAREFULLY. THEY MAY POSSIBLY HELP YOU SAVE YOUR LIFE BY TAKING CHARGE OF IT!

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