
Harm Reduction Therapy With Families and Friends of People With Drug Problems



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This article describes and illustrates the ongoing development of a treatment for working with families and friends of drug users using harm reduction principles. The author was instrumental in applying harm reduction principles to substance abuse and has used these same principles to help families deal with the pessimism, pain, and grief that accompany their relationship to a person with an active substance abuse problem. The treatment involves learning decision-making processes based on both self-care and love for the substance abuser and is based on the values of harm reduction, caring, and incrementalism, rather than those of codependency, tough love, and abrupt behavior change. A long-term family therapy group and two family consultations illustrate the treatment and its applications. © 2010 Wiley Periodicals, Inc. *J Clin Psychol: In Session* 66: 164–174, 2010.

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Families and friends of people suffering from substance misuse are often given the same rules to live by as their drug-using loved ones: “Stop (now); turn it over; don’t make your own choices; follow the program.” Although more psychotherapists are using developmental models in their treatment of relational problems, many continue to view codependency in the context of the disease model and 12-step recovery. Even when clinicians use harm reduction-informed methods for drug users, the families and friends of these clients are frequently left with traditional self-help groups such as Al Anon and Co-Dependents Anonymous. They are often confused and upset by a “tough love” or “loving detachment” approach that may differ from their values of friendship, family, community, and love.

There is, however, a growing international movement whereby families are trying to support each other as they struggle to stay connected with their loved ones who are in trouble with alcohol or other drugs, while also struggling to take care of themselves. In this article, I present and illustrate a treatment that rests on not only on

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harm reduction principles but also the more general principles of community and connection in the healing process, as well as the dangers of detachment and alienation.

Being the loved one of a person with an alcohol or other drug problem can be excruciating. People experience profound helplessness, frustration, anger, and fear. Today's optimism, induced by fervent promises of "never again," is replaced by tomorrow's disappointment when those promises are broken. Loved ones struggle with extraordinary questions about loyalty, love, support, and limits. How much help is too much? How long should you put up with it? How many times should you cover for him and pick up the pieces? The question becomes: "Should I give up hope of her ever changing?"

Al-Anon, Al-Ateen, Nar-Anon, or ACOA (adult children of alcoholics) support groups offer support and guidance. Members of these groups are told they need to stop "enabling" and practice "tough love." This advice does not work for many people, who view it as overly harsh or restrictive. Our society has largely bought the idea that addiction is a disease and that immediate and total abstinence from all mind-altering substances, along with the support of the 12 Steps, is the only treatment. We've come to believe that surely a person must *want* to continue using, or else all the trouble he's had would have convinced him to give up his cocaine, heroin, alcohol, or other substance. It must be true that her denial is so thick that only "hitting bottom" will motivate her to get sober. Loved ones have been told to stop bailing her out, stop cleaning up the mess, and let her face the consequences of her choices. Eventually, we're told, she'll hit bottom. If she lives through it, maybe then sobriety will be possible. And only with sobriety will come a life.

Believing this set of ideas, spouses and friends urge their loved ones into treatment. But in spite of the universal acceptance and popularity of abstinence-based treatments in the United States, she has not gotten better. The belief that "going to rehab" will cure an addiction in 28 days is the stuff of "reality" television shows, not reality. Moving through a substance abuse problem often takes years and is characterized by many setbacks along the way. To imagine that anyone will dramatically change in one month is asking for disappointment. And it is asking also to participate in a cycle of hope, despair, and rage.

The problem is that tough love usually doesn't work. And it feels awful to everyone involved. People with substance abuse problems are complicated. Drug use is complicated; it involves a relationship with drugs developed over years. Most people use drugs for reasons, reasons that are related to far more than the nature of the drugs. Each drug user has a unique history, psychology, physiology, and motivations, as well as a social and cultural context for his relationship with drugs (Zinberg, 1984). It's unrealistic to expect people to change complicated behaviors *just like that*. Any treatment that limits one to an all-or-nothing choice ignores the reality of how people change. People change in incremental steps, practicing new behaviors and new ways of coping with life over time (DiClemente & Scott, 1977). The crucial ingredients to making lasting change are *understanding* and *support*. When we expect immediate change and refuse to be with a person during this process, we undermine the very goal we're trying to accomplish. Banishment seldom leads to reconciliation.

Science has yet to study the effects of these groups, which, like their parent organization AA, embrace anonymity and is reluctant to let outsiders study their membership. The methods suggested in this article also have not been studied in a randomized controlled trial, primarily because such highly individualized treatment does not easily lend itself to quantitative research. Hopefully, someone will find this treatment interesting and begin a study of outcomes.

The Codependency Movement

The popular literature overflows with books and articles on the difficulties of people who love people abusing drugs and alcohol. The names associated with these self-help publications (e.g., Melodie Beattie, John Bradshaw) are well-known. The overwhelming attitude is that the people closest to addicted individuals are themselves diseased, caught in a parallel process that is invariably unhealthy and unhelpful.

According to many self-help authors, codependency is characterized as a parallel disease to drug addiction. The codependent bases her identity and self-esteem on the well-being of their addicted loved one and becomes hypervigilant and controlling. Self-help books offer lists of codependent characteristics that run, in one case, to 10 pages. Low self-esteem, difficulty expressing anger, and passivity are all components of this disorder. The lists are so extensive that most people, especially women, could easily check off a number of the characteristics and be diagnosed as codependent.

Many of these books point to cycles of behavior and feelings that are termed codependent in that they are unhealthy for both the person misusing drugs and their loved ones. This cycle has been described by many people, most notably in the original *Codependent No More* (Beattie, 1987). Beattie states that any rescuing results in the helper feeling angry and persecutory, but ultimately leads to feeling victimized. Her, and others, advice is detachment and abstinence (from helping the person). Although it is true that many people involved with a person with a serious substance disorder do engage in this type of controlling cycle, the literature leads one to believe that it is invariably unhealthy and leads to a delay in the addicted person hitting bottom.

In essence, the standard definition of codependency has two components: failure of self-care and protecting/enabling the drug user (Beattie, 1990). Although the first component is an important point and a source of suffering for the loved one, the latter means standing in the way of the drug user suffering harm. You are codependent if you stand in the way of a drug user's suffering. Anything you do that protects the drug user from suffering the harms of their addiction is seen as pathological. There is no room for self-sacrifice, and no room for trying to manage a loved one's addiction to prevent job loss or other events that could further damage the family. Suffering is seen as the logical and necessary outcome of addiction. No professional argues against exposing interactions between loved ones that are fraught with conflict, secrecy, attempts to control, and attempts to hide. But it is imperative to understand the motivation for such interactions and to be open to the possibility that not all such coping strategies are pathological. A different perspective is that people are trying to maintain attachment, family, and/or community in the face of a disabling problem. Demonizing a person who is reacting to a pathological situation with less than perfect responses creates an entire family system that is pathologized. This, in turn, creates a need for intervention, a need for long-term and often expensive treatment (Gordon & Barrett, 1993).

Harm Reduction Principles

How can we bring harm reduction principles to bear on the difficulties of loved ones? Some of the principles are as follows:

- A primary injunction to *do no harm*.
- Addiction is not a disease, but rather a maladaptive pattern that has biological, psychological, and sociocultural origins.

- Denial is not a primary dynamic: We all have our smoke and mirror defenses and we all try to avoid pain and punishment, even if we have to lie.
- People generally do not respond well to punitive sanctions.
- People know what they need to take care of themselves.
- People's behavior makes sense and is always adaptive in some way.
- People can and do make rational decisions even while using.
- Ambivalence is normal; life and its problems are seldom black and white.
- Change occurs gradually with many setbacks.
- Come as you are: Start where the person is (not where you want him to be).

Friends and family members share the ambivalence about how best to relate to a loved one who is struggling with substance abuse. With a broader view, the questions become: "How can one be altruistic amid accusations of codependency?" Why have we relegated sacrifice to the land of psychopathology? Are parents not supposed to sacrifice for their children? Are we all not to shoulder the burden of caring for sick family or friends? And, on the other hand, "How can we address the real harm and suffering of the families and friends of people with serious alcohol and drug problems?"

In harm reduction psychotherapy, working with families must involve working within the grey areas, the not knowing, the struggle to define what is best to do, the limits to set, the concessions to make.

Rather than viewing codependency as a disease that runs parallel to the disease of addiction, harm reduction therapy views these behaviors through the same biopsychosocial lens as addiction. Loved ones may develop problematic behaviors or develop ineffective coping strategies in the face of a loved one who is abusing alcohol or other drugs. Helpful interventions can, thus, follow the same process as with the drug-affected person: analyze the conflict, respect the ambivalence, and forge a solution from realistic expectations, compassion, and patience for the process of change.

Harm Reduction Family Treatment

There is a fine, poorly identified line that separates healthy caretaking from destructive helping. I choose to explore this line in each individual rather than make a priori judgments about the ways loved ones cope. Reliance on the self-determination theory is a cornerstone to this approach (Ryan & Deci, 2000). The strength to change is based on one's sense of power to effect change, and the motivation for change is most powerful when it is intrinsic rather than extrinsic.

Harm reduction principles uphold people's right to make decisions, even if those decisions lead to harm (Denning, 2000). Family members have to come to grips with this reality for themselves as well as for their loved one. Understanding does not mean, however, that you do not set limits. You set limits with a two-year-old and you set limits with an adult. But you are setting limits on *behavior*. Limits keep a child from running into traffic, touching a hot stove, and eating poison. Adults need somewhat different limits. "You can't yell at me" and "I won't let you take all of our money and spend it on drugs" are some of the limits a person might need to set. It is more useful clinically to separate a person from her behavior: we are not the sum total of our behaviors, although we can come pretty close sometimes! Running into traffic, touching a hot stove, or eating poison doesn't mean a child is stupid. Spending all of one's money on drugs doesn't mean she is a stupid adult. They may just be ignorant of the consequences, curious, or overcome by need.

The Harm Reduction Family Support Group

A harm reduction family support group has been active for almost 5 years. It has had anywhere from three to six regular members, some of whom have been in the group from the beginning. I started it because of numerous requests for consultation and advice from family members whose loved ones were struggling with severe alcohol and drug problems. It meets every other week in the evening for 1.5 hours and requires no time commitment, but it is understood that people will generally participate for at least a few months. Shorter help is usually offered on an individual or family basis.

The goals of the group are multiple:

- To use harm reduction therapy principles to help not just drug users but also people in their immediate community.
- To assist loved ones in making choices that are healthy for themselves.
- To increase the ability of friends and family to support the efforts of their loved ones in practicing harm reduction themselves.
- To offer an alternative to Al-Anon in the same way that we offer an alternative to AA and NA.
- To counteract the culture of the codependency movement.

The group was meant as a support group, not a therapy group, and so I expected that the members and I would offer quite a lot of comfort and advice about what they might do or not do in dealing with their loved ones. What happened was that the members quickly focused on their own internal dynamics, their own histories that they knew to be the backdrop of their conflicts and decisions about how to help. In short, this support group also quickly became a therapy group. Discussions about strategies and limits with loved ones were interwoven with stories of the members' own histories and struggles.

Everyone in the group shares similar emotional conflicts and roller coaster experiences: guilt, worry, shame, resentment, duty, confusion, and hope alternating with hopelessness. In many ways, their experiences mirror the internal world of their addicted loved ones; the cycle of promises, hope, broken promises, anger, and despair are not that different from the person struggling to overcome an addiction.

Not having hope is not the same as being hopeless. One member was talking about the rollercoaster of feeling hopeful when her sister was in treatment and not drinking and then feeling devastated and angry when her sister relapsed, which she did repeatedly. I asked what it would be like if she didn't hope. She questioned this: "You mean give up hope?" I said, no, not give up or be hopeless, just not hope in the first place. This was a watershed moment for her; it was a way to be involved, to actively help at times, to care, and detach from the outcome (which is what harm reduction therapists do with their drug-using clients). This nugget became a recurring theme in the group as new members joined. Not having hope means not allowing oneself to celebrate or feel relieved when their loved one is being "good" (not using, going to work, etc.). The celebration comes from a false belief that the problems have been resolved. It is more practical to realize that today may be a good day (and be grateful for that), but that tomorrow may bring a return of the same old problems. It may not feel as good to halt such false beliefs, but it effectively stops the cycle of hope and despair that is so wearing on the loved one and so guilt-producing for the person with the substance abuse problem.

Family members experience an enormous amount of guilt about their actions, whether helping or refusing to help. They also experience shame when it becomes apparent that their compassionate response has been used by their loved one to manipulate or “get over on” them. When one group member was recounting an incident in which she was totally oblivious to the manipulation that other group members could see in her son, she grabbed her coat and put it over her head to indicate that she knew she was falling for whatever line her son was feeding her. She spoke of great shame at being “stupid, duped, didn’t see it coming again.” My reaction was to normalize her experience by giving her permission to not get it right.

The group members’ reactions made her experience universal; they all could see themselves in her behavior *and* in her reaction to herself. This became part of the group culture as well: people grabbing her coat when they were about to share some experience where they, too, felt duped. The laughter as this happened was the perfect antidote to shame and forged a sense of common humanity as we all struggled with figuring out what in the world to do. Not getting it right, making mistakes, and wishing we had the courage to do it differently is not an indication of an underlying pathology or disease. It is the human condition.

The sustaining guiding principle of the group is as follows: There are no rules except the ones you make. This is where the parallels with the harm reduction principles for drug users become most apparent. Just like drug users have the right to make their own decisions about their drug use, loved ones get to decide what they want to do, can do, will not do, what limits to set, and what consequences to impose. And just like we harm reduction therapists challenge our drug-using clients to be curious about why they may make certain decisions about their drug use, we challenge loved ones to examine their motives and compulsions. As a therapist, it’s my job to help people explore, to point out unhealthy choices, to challenge them to look at themselves, and to stand out of the way (but ready to help) while people make their own life decisions (Denning, Little, & Glickman, 2004).

One group member agonized about her brother becoming homeless and getting injured or dying in the cold of an east coast winter. Her brother had, over the years, taken money that she offered and bought drugs, then claimed he lost it. He routinely said that he had been mugged and lost his belongings and needed money for clothing. The group member was angry at her brother and wanted to decline his next request, but she knew from her past behavior that she would probably not do that. They had grown up in an extremely violent home, and her brother often shielded her from some of the physical abuse. Despite years of feeling taken advantage of, she felt that she had yet to repay that debt to him. Rather than label her as codependent and urge her to stop giving him money, the group spent considerable time empathizing with her dilemma of being angry and yet being unable to abandon a brother who may have saved her from worse events. I questioned her over the course of many groups about what she most feared. She finally pinpointed that what kept her awake at night was the image of him lying on the street, drunk and freezing.

I suggested that perhaps she could come up with a solution to her realistic fears. She laughed and asked, “Bring him out to sunny California?” To which I replied, “Why not?” The group was stunned at first, but after much discussion, she decided that it just might be the solution. And she did just that: she told her brother that she would pay his rent on a hotel room if he moved to her city. No strings attached. She also said that he was on his own for cash and other things he may need, but that she would pay his rent whenever he needed her to. Her brother took her up on her offer and as yet has not made any attempt to change his substance use. But she now has no trouble sleeping and

feels proud of herself for finding a solution that would not have been acceptable to many others. She made a series of decisions that allowed for both her altruism and her anger.

These are the kinds of dilemmas and solutions that group members struggle with. How much to give, how much to help, and how to say no when they want to. One man made the decision to divorce his wife of many years because he came to recognize that physical danger to himself was imminent. Another chose to stay married because his wife was a wonderful mother three weeks of the month (in between methamphetamine runs). He made arrangements for the children to be cared for by other relatives as soon as he saw the early signs of her becoming high. He felt satisfied with the compromise because it allowed him to keep his family together while protecting the children. A father decided to not allow his daughter to come into his house because she always stole from him. But to continue a relationship with her, he took her out to dinner every week.

The harm reduction family group provides needed support and empathy to people engaged in a struggle to satisfy conflicting feelings. What they brought to the surface speaks eloquently about the complex nature of attachment and the importance of connection in our lives. We therapists will do best to respect and honor these connections rather than cast them as pathological.

Case Illustrations

I routinely receive calls from friends and family members concerned about a loved one's alcohol or other drug use. Some are certain that the person is addicted and in dire straits. Others are worried or suspicious but can't quite put their finger on the exact concern, and their loved one isn't helping by being uncommunicative. Still others are looking for an alternative to the Al Anon group they have been attending or the self-help books they have been reading. Their loved ones continue to suffer despite numerous treatment episodes, and they have grown suspicious not only of their spouse, brother, friend, but of the treatment profession itself. Here, I present two cases of family consultations to shed further light on the principles of harm reduction as applied to friends and family members of substance abusers.

Case of Brenda and Her Friends

Brenda was wearing out her friends. She had always been a party girl, but so had they. They spent the weekends clubbing and recovering in time to start the week of work without much damage. At age 27, they didn't worry about the long-term effects of their lifestyle. Over the past year, however, Brenda had started spinning out of control. She routinely got blind drunk and was using both cocaine and Ecstasy as well (although she wouldn't readily admit to the cocaine). She resisted her friends' attempts to talk with her and avoided them after bad weekend binges.

One of Brenda's friends called for a consultation and arrived with two others. Ted and Bob had known Brenda since college, and Laura had known her since childhood. They were roommates after college until relationships resulted in different living situations. Recently Laura had wondered if it might help to have Brenda move in with her. They all expressed worry that Brenda was reacting badly to some setbacks over the past year. She was laid off from a job and was having trouble finding anything but part-time work. Her cat had gotten cancer, and she had to put him to sleep. And a man that she had hoped to marry decided that he wasn't ready. The friends assumed that these events were to blame for Brenda's erratic behavior with alcohol and drugs. But Brenda wasn't talking.

We reviewed several options for their involvement, including having Brenda move in with Laura. They decided on a direct approach, one that was in keeping with their slightly “in your face” style with each other. They went out for drinks and talked to Brenda about what they noticed, how worried they were, and asked if she thought she ought to get psychotherapy. She wasn’t totally opposed, but didn’t acknowledge her increased drug use. Surprisingly, she accepted Laura’s invitation to move in rent-free for a few months, saying that she was feeling lonely a lot since the breakup.

After weeks of making and breaking appointments, Brenda began individual therapy with one of our staff. During a period of 6 months of weekly sessions, she revealed other significant sources of stress that she hadn’t shared with her friends. At first, she talked little about her substance use, but as she relaxed and realized that her therapist was not going to force the issue, she opened up and admitted that she wasn’t happy with how she was partying lately. Brenda was engaged in working on the other sources of stress and became interested in making a “party plan” so she wouldn’t embarrass herself. She stopped using cocaine altogether, limited her Ecstasy use to once a month, and learned how to moderate her drinking by attendance at Moderation Management self-help meetings. Her friends kept in phone contact with me and reported that they felt much relieved that she was in good hands and confirmed the changes that Brenda had made.

This approach has some similarities to Network Therapy (Galanter, 2002): A friendship group was formed to support a woman in trouble with drugs. But there are several important differences. The friends made no demands on Brenda to change and offered unconditional support. Brenda’s psychotherapy was segregated from the friends’ consultations, and Brenda was never confronted by her individual therapist with any information that came to her via the friends. This allowed a confidential relationship that was independent of other’s worries and wishes and, I believe, contributed to her willingness to continue in treatment. After 6 months, she reigned in her alcohol and drug use significantly and is now able to concentrate her therapy on other important issues in her life.

Case of Alice and Her Family

Greg and John live out of state and are worried about John’s mother who is local. When they last visited, they noticed that she was drinking more than her usual glass of wine with dinner. Although they only saw her drink two glasses, they suspected that she was sneaking more when alone in the kitchen because she appeared drunk a number of times. The mother, Alice, had lost her husband several years ago and seemed to have made an adequate recovery from that loss. She continued to work, but saw her friends less frequently and has stopped calling John and Greg as regularly as she used to. When John calls, she sounds rushed and isn’t willing to talk for more than a few minutes.

John and Greg called for a consultation via telephone. During that conversation they went into greater detail about their worries. Alice had always been a big part of their lives, accepting that Greg was John’s partner and involving him in all family activities and holidays. Over the past year, however, Alice didn’t ask much about Greg and seemed disinterested in her son John’s work or social life. Several friends noticed her increased drinking and also reported to John that she wasn’t going to her usual club meetings in the evenings. They strongly suggested that an intervention was in order. She was obviously drinking too much and needed to be confronted and was pushed to enter a 28-day rehabilitation program. John was calling for me to arrange such an

intervention. I spoke with John and Greg for over an hour and let them know that these types of interventions could be counterproductive, leaving their mother feeling betrayed and ganged up on, and further alienating her from their concerns (first, do no harm). In addition, I pointed out that such drastic measures could be held in the wings while they planned a series of “mini-interventions,” conversations that were designed to be interested and supportive rather than confrontational. It always amazes me that family members who haven’t even had a conversation will go to the extreme of an intervention. Such, I believe, is the strength of the message being delivered in our culture: a person with a substance abuse problem is in denial and must be forced to see reality.

It was important to assess whether there were other serious problems in Alice’s life. I asked about Alice’s age, general health, and any known medical conditions. Since she was in her 70’s, she may be on several medications or have conditions that could increase her risk when mixed with even small amounts of alcohol. John wasn’t sure, but thought that her health was generally good except for high cholesterol, for which she took medication. I let them know that concern about her health would need to be a part of any action they decided to take. But in the short run, they had no information that indicated a need for immediate action.

I then helped both John and Greg craft a conversation with John’s mother, since she had always spoken to them together over the phone. I suggested that they start by telling Alice that they missed her and wished that they could renew their usual phone conversations. They could also ask if there’s something going on that maybe they could help her with.

I encouraged them to start where the person is. So many well-meaning family members and friends close off communication by starting with accusations or with concern that goes beyond what their loved one is revealing. This represents a mismatch of empathy and usually results in defensiveness. Just as in a therapeutic relationship, it is important to match the level of concern to engage the person in a real conversation. Most people’s tendency is to point out the most extreme examples of behavior or our worst fears when the person is still only dimly aware that there may be a problem.

The result of their initial phone call with Alice was that she acknowledged that she had been remiss and for some reason just didn’t feel as talkative as usual. They reiterated their interest in keeping up the relationship and planned for more phone contact. After several other phone calls that did not lead to self-disclosure, I suggested a visit for them to witness Alice’s life and her drinking first-hand and take any opportunity to notice out loud about her state of mind when they suspected that she was intoxicated. During this visit, she seemed defensive and would not enter into a conversation with either John or Greg about her drinking, but she did reassure them that she was seeing her primary care physician regularly. She told them not to worry.

The next step was to involve Alice’s friends who were also worried and tempted to strongly intervene. We set up a phone conference with John and Greg and with two of her friends who came to my office for the consultation. Together they talked about what they had noticed and what worried them. I asked how they would like to be treated if the conversation were about them. This helped increase their empathy for the complex nature of the problem rather than their worry (ambivalence about change is normal). We decided that these friends would attempt to engage Alice in quiet, social dates and express their concern that they don’t get to see her as much. Once again, Alice was defensive, but did set up subsequent visits they requested. I specifically directed them to not avoid having alcohol at these events, because that was their normal lifestyle. Alice appeared intoxicated once when they visited her at home, but not when she went out with them.

We decided that it was time to introduce the specific worry about Alice's drinking. Her friends decided to share with her how they can't "hold their liquor" as well now that they're older and let her know that she seems to be having that same difficulty. Surprisingly, Alice responded well to this observation, and they joked about getting older. Alice also disclosed how it seems to be worse when she's alone. That led easily into a brief conversation about grief, and they shared memories of her late husband.

At this point, John and Greg were hoping to convince Alice to talk to a professional. I pointed out that she hadn't given them any reason to suspect that she wanted or needed to. They had to decide whether to increase their communication about what they were worried about. We discussed the pros and cons of doing so. They decided to get more focused at their next visit and to continue phone contacts for now. They reported to me that she seemed distracted during some of these calls, especially if they happened after 8:00 p.m. During their next visit, Alice and her friends were all gathered at Alice's house, and John mentioned that he was aware that it was close to the anniversary of his father's death. He talked some about his sense of loss and gently helped his mother express some of her feelings as well. One statement that she made, "It doesn't really seem to get easier and I thought it would," resonated with everyone.

I then recommended that John address *his* problem rather than Alice's. He could let his mother know that he can't stop worrying and that he could ask if she would do something for him to lay his mind at ease. John followed up this visit with a phone call, during which he explicitly laid out his concerns about her loneliness and her drinking. She was shocked and tried to minimize her distress, but agreed to talk with someone if that would allow him to relax. John disclosed that he had been talking with me to sort out his feelings and suggested that I might be a good candidate because I already knew some of the family. Alice would not have to start from zero. She agreed to a consultation with me and, after putting it off for a month, John made the appointment for her and asked her to show.

Alice came in rather perplexed and concerned that John and Greg were working too hard, reacting to the distance they had to travel for visits, and overreacting. I agreed that all these might be true and asked her what it was like to be a mother of an adult child. After talking some about the odd shift in "worry roles," I offered to be a sounding board for her if she had things she wanted to talk about. She said no, but I pressed about her sense that her grief wasn't getting much better. I offered to see her again in a couple of week's time and asked her to think about anything that she has wanted to talk to someone about over the past few years. I indirectly suggested that maybe she'd come up with an agenda for our conversations.

John and Greg were pleased with Alice's response to my consultation, and she told them that I "seemed like a nice person to talk to." Over the next few months, with infrequent visits, Alice finally talked about her drinking. She acknowledged an increase, but also noticed that it didn't take her much to feel "out of it." She disclosed that she had a bit of trouble sleeping, and so I inquired about medicine that she might be taking. She was routinely taking Benadryl because it makes her drowsy. I let her know that it didn't interact well with alcohol and could make her seem drunk. She was surprised, but agreed with me on a plan to only have one drink on the nights that she would take a pill. When she found that her sleep was still disturbed, she elected to not drink at all during the week and get rested for her weekend activities, which often included wine with dinner out. Her friends reported increased contact with her and that she seemed more engaged and more "like herself."

What began as a request for an intervention and intensive treatment was channeled into a more relaxed series of consultations. I spoke with Alice's son four times, her

friends twice, and had six sessions with Alice over a 5-month period. This situation was resolved by a combination of empathy and engagement that were tolerable to all concerned. Greg and John were glad to avoid a confrontation that might have alienated Alice from them. Alice brought her drinking under control and gained a support team with which she could discuss her feelings without fear of criticism.

Clinical Issues and Summary

Just as working with active drug users requires tolerating anxiety and uncertainty, and so does working with their friends and family members. People struggling to find their own way and unwilling to use traditional 12-step approaches frequently find the principles of harm reduction useful in clinical consultations and family support groups. As shown in the cases of Brenda, Alice, and their families, harm reduction allows a team to craft an individual or family approach that feels doable as well as consistent with their core values. Loved ones are encouraged and taught to use their strengths rather than viewing their efforts as weak or their own disease. These harm reduction-informed methods do not usually result in easy, immediate plans. However, the results are most often decisions that feel empowering. The decisions that loved ones make in regards to their caretaking activities need to be respected first, challenged second, and crafted differently only if they wish. The power of connection is a vital force that helping professionals can nourish and should only be challenged at risk to individuals and families, and society at large.

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