

Running Head: HARM REDUCTION SUPPORT GROUP

Learning from our Mistakes: The Evolution of a University Harm Reduction Support Group

Geri Miller, Ph.D.

Diana Quealey-Berge, Ph.D.

Dale Kirkley, M.A.

Lisa Shuskey, B.A.

This article is a summary of one university's development of two abstinence-based, 12 Step model groups that evolved into a harm reduction support group on its campus. The authors describe their experiences in establishing and facilitating such support groups within a group development stage model. Specific guidelines are provided for the establishment of such groups based on the current literature and author experiences.

Harm reduction, a European practice (Stoil, 1993) is a pragmatic approach that encourages people to change high-risk behavior. There are at least five main concepts to this perspective. First, while harm reduction philosophy does not discourage abstinence, it does not make abstinence a sole, narrow focus for the addicted or substance abusing person. Therefore, the person may obtain abstinence, but it is not a requirement of this approach nor is abstinence viewed as the only successful behavioral change (Canadian Centre on Substance Abuse National Working Group on Policy, 1996). Rather, abstinence is one possible low risk goal that some individuals may achieve. Second, the goal is to help people reduce the harm they and/or others experience related to their alcohol or drug use (Canadian Centre on Substance Abuse National Working Group on Policy, 1996). An example of this is with addicts who share injection equipment (high risk behavior) to stop sharing their equipment with others (safer low risk behavior) thereby reducing the spread of infection and disease or avoidance of drinking and driving (Canadian Centre on Substance Abuse National Working Group on Policy, 1996). Third, there is an emphasis on dealing with practical problems experienced by the client due to their usage. An example of this is unemployment: the person is so involved with their drug use that they cannot hold a job. Fourth, this approach incorporates the belief that the individual experiences positive aspects of alcohol or drug usage that may help them meet their daily living needs such as self-medicating. The acceptance of this reality means that the counselor understands and may support at least the temporary use of the substance to assist the individual in coping. Fifth, this philosophy advocates strongly that the counselor begin treatment where the client *is* and then progress in counseling at the client's pace. Overall, then, the focus of harm reduction is pragmatic, humanistic, focused on harm related to use, determining priorities based on cost and benefits of interventions, and immediate goals (Canadian Centre on Substance Abuse National Working Group on Policy, 1996).

A counselor working from this perspective, then, may assist the client in attaining abstinence or may not. The focus of the counseling would be on reducing harm for the person or others in their life as it relates to their alcohol and drug use and/or dealing with the practical problems they experience due to their usage. The counselor also works with the awareness that the usage of alcohol or drugs may help them cope and will commit to begin and continue counseling working from where the client's perspective of their usage and how they want to change that usage.

This perspective is a contrast with the 12 Step model that may be used more typically in university counseling settings. From this perspective, abstinence is the goal for the individual and negative consequences or problems related to usage are reduced or eliminated by obtaining abstinence. The intervention by the counselor on alcohol or drug usage tends to be anchored in an all-or-nothing perspective: is the client abstinent or not? This focus guides the counseling approaches, interventions, and treatment.

The authors are not proposing that either one of these approaches is correct, but rather that some settings and some clients may be more receptive to one approach than another. Also, the authors believe that these perspectives are not absolute, separate schools of thought, but operate more realistically on a continuum. For example, a harm reduction counselor and his/her client may have abstinence as a goal, but view their work as building toward that goal. A 12 Step model counselor, focused on abstinence as a goal, may understand that the alcohol and drugs are helping the person cope, that the client may have problems that need to be addressed, that the person may have ambivalence about changing the alcohol and drug use and thus, encourage the client to gradually change the behavior while continuing to give consequences for the alcohol and drug use.

This article is about the process of beginning and facilitating a harm reduction support group in a university counseling center. The authors will describe how the groups operated and evolved from an abstinence-based, 12 step model to a harm reduction group. This description includes the developmental stages of the groups as well as the counselors' successes and struggles within the groups.

History of Alcohol- Drug-Related Support Groups

The first and third authors decided to start a support group on campus for recovering alcoholic/addicted students. Previously there had not been a group to support recovering students on the campus. The primary intent of the group was to provide support services to students on campus so they could meet other students who were committed to abstinence. This intent is supported in the literature in that social problems need to be addressed at the same time as health problems because they can play a mediating role between the user and his/her environment (ERIT, 1999). The third author, who worked in the university wellness center, contacted the first author about beginning the group because of her extensive

work as a counselor in the addictions field. They advertised the group through flyers and announcements to possible referral sources both on and off campus.

They set up the following rules for the group:

1. Each group member will be abstinent from alcohol/drugs for at least two weeks.
2. If a group member develops a pattern of relapses with what appears to be a lack of commitment to abstinence, they will be asked to leave the group.
3. Each group will be asked to make a commitment to attend the group at least 5 or 6 times.
4. If a group member decides to leave the group, they will be asked to return to the group to say, "goodbye."
5. Group members will be expected to come on time, stay for the entire time, or let the group know in advance if they are not able to hold to the time commitment.
6. Group members will be encouraged to not be sexual with one another because a sexual relationship can change the dynamics of the group.
7. Group members will be asked to make a commitment to confidentiality.

The abstinence-based, 12 Step model support group continued for two academic years. This model was chosen because of the healing power of catharsis, hearing another's story, and the emphasis of the subjective experience of the participant (Valverde & White-Mair, 1999). The following section describes the group development experience within Corey's (2004) stage model of group development.

Year One

The first year the group met weekly for an hour and a half from late October through February. There were 7 group members, five who remained committed to the group from the beginning. Four of the five committed group members were women and three of the committed group members were very involved in the local Narcotics Anonymous group. The group was open-ended in terms of admittance and individuals were interviewed for 15 minutes before the group for screening and to review the group rules.

The anxiety experienced commonly during Stage 2 of group development (Corey, 2004) was controlled by meeting members individually prior to group attendance and during group time through introductions and the reading of a daily meditation book. Group members displayed their anxiety in the

group by talking in extremes (too little, too much) or by giving advice. They also engaged in superficial conversation that focused on type and amount of drugs used.

After a month, group members showed evidence of Stage 3 (Corey, 2004), challenging leadership, by rejecting the meditation book reading ritual introduced by the co-leaders. Their rationale was that the readings had more to do with Alcoholics Anonymous (AA) than Narcotics Anonymous (NA) and that the meditation reading was too religious and too “preachy.” The co-leaders responded by reading from an NA meditation book brought by one of the members. As the group continued, this route of leadership challenge would periodically occur in that members would forget to bring their own readings. After a few months of this behavior, the group leaders responded to the challenge by announcing that the ritual of reading from a meditation book would be dropped.

This group evolved into Stage 4 of Cohesion and Productivity (Corey, 2004). They showed this in their behavior of attending weekly or letting the leaders or other members know that they could not attend. Members became more honest about their own recovery issues such as inappropriate touching/approaches by males in recovery groups, shame around past sexual behaviors, abuse issues. The group developed a sense of identity and common goals so strongly that one woman was asked to leave the group due to a pattern of relapses and her belief that she did not have a drinking problem. Group members also showed a beginning of a transfer of recovery knowledge as two of the women made a serious commitment to the local NA group in terms of attendance, sponsorship, and organization while the two remaining members made tentative commitments to local AA groups.

At Stage 5, Termination (Corey, 2004), all group members stated the group had been helpful to them personally. They all discussed their plans for continuing their abstinence in the communities in which they lived or planned to live. The co-leaders ended the group due to sporadic attendance by members after the group began to discuss the group’s ending. Members not present at the last group were contacted for their comments and suggestions.

Year Two

Again the group met again weekly for an hour and a half, was open-ended in terms of admittance, and members were met individually for pre-group screening and review of the same group rules. Although

this time there were 8 group members initially, again five members remained committed to the group from the beginning (three dropped out after attending two or three times).

The group had some differences from the first year. It met for a longer period (late October through April) and all 8 members were male, none of who had attended the group in the previous year. These group members were comfortable with both AA and NA meditation books so a reading was done from one of each of these books at the beginning of the group and members were not asked to bring a weekly reading.

Stage 3 behaviors were similar to the first group in extreme behaviors and in terms of talking about superficial concerns (type and amount of drugs used). Again, individual interviews and meditation book readings seemed to help members relax. The challenge to the leadership (Stage 3) took two different forms in this group. While the first group challenged the leadership through the opening reading, this group challenged the meeting time of the group after three months of meeting. Five of the members had made a commitment to local AA groups and they asked the leaders to change the meeting time of this support group because of their AA commitments. The co-leaders agreed to the time change. Also during this time frame, the second challenge to the leadership emerged in relation to the attendance rule. The members did not want to make a commitment to attend regularly or feel that they needed to notify the co-leaders with regard to their attendance. The co-leaders responded by making the group a drop-in group during late February because only two or three members were able to commit to a regular weekly meeting and wanted the consistency of meeting because they found the group helpful.

The issues of Stage 4 were different in this group also. Members here worked on issues such as coping with boredom, roommate problems, and their social lives. Again group members were committed to abstinence and attended 12 Step meetings outside the group.

At Stage 5, all five members were attending AA regularly and had sponsors and two of the members were attempting to set up their own AA group on campus. Each felt strong in their sobriety, but concerned about the stress of the upcoming summer. They stated they enjoyed being able to talk openly in a group setting.

There were significant differences between this group and the two previous groups. Because of the sporadic contacts from students who conveyed an interest in the group, the third author interviewed the group members alone as they made contact with the university wellness center. Also, the group did not meet until mid-November so only three meetings could be scheduled before the semester ended. This group was also different in that it had mixed gender (four males and one female).

This third group marked a shift in focus from an abstinent-based, 12 Step model to a harm reduction model. This shift began for two reasons. First the group had difficulty getting started even though it had been advertised in the same manner. Second, one of the members was returning from the previous year's group and he had begun experimenting with alcohol again and two of the interested group members (both male) were committed to abstinence. These differences in usage led the leaders to believe that a harm reduction focus might facilitate the group's development.

This shift matches the harm reduction philosophy of attempting to communicate a message of reduction of a risky practice with a population that might be reticent (ERIT, 1999). Also, the leaders believed that the members committed to abstinence could assist the relapsing individual in experiencing an atmosphere of support which was guilt-free such as in a 12 Step model (Valverde & White-Mair, 1999) and that a college aged population might be more open to a harm reduction approach than an abstinence based one (Duncan, Nicholson, Clifford, Hawkins, & Petosa, 1994). In addition, the leaders believed that a common theme among members might be their expectations about the effects of alcohol (alcohol outcome expectancies, AOE) on their behavior, feelings, and thoughts (Wall, Thrussell, & Lalonde, 2002). Finally, the leaders thought that a harm reduction approach would assist a client in moving through the stages of change (precontemplation, contemplation, preparation, action, maintenance, relapse) (Prochaska & DiClemente, 1983).

Due to the recruitment difficulties, the mixed motivation of group members with regard to abstinence, and the desire of the leaders to provide support to anyone interested in attending the group, the leaders changed the group from an abstinence-based, 12 Step model to a harm reduction model with the logic that a harm reduction model could include abstinence. The hope was that this shift would allow the individuals who were committed to abstinence to mix and possibly provide role models for those students

who wondered if they needed to make a commitment to abstinence. The shift in focus resulted in dropping the first two previously listed group rules (abstinence requirement, lack of commitment to abstinence).

Although all of the group members reported that they found the group helpful, the group never moved beyond Stage 2 or continued into the next semester. The two students committed to abstinence, when contacted by phone to determine schedules for next semester, stated that they found it hard to come to group and hear other members discuss their current alcohol and drug usage. The leaders decided, on the basis of this member struggle, to return to an abstinence-based, 12 Step model for the support group and offer individual counseling for all group members. Unfortunately, the group did not meet the next semester to resume the abstinence-based, 12 Step model.

Recommendations

Based on the authors' experiences with these groups, the following suggestions are made for the abstinent-based, 12 Step model groups on college campuses:

1. Watch for signs of Stage 2 regarding topic concerns, readings, attendance, and time conflicts.
2. Allow for poor impulse control early in recovery specifically as it impacts attendance and relapse.
3. Consider working with attendance issues by developing a drop-in group.
4. Work with relapse on an individual basis rather than asking people to immediately leave the group.
5. Encourage extensive community networking among members either on or off campus.
6. Be aware of possible termination difficulties for early recovery members.

The main suggestion regarding a harm reduction focused group is to avoid mixing abstinent individuals with those who are currently using alcohol or drugs.

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