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Special Feature Article

Learning How to Build Therapeutic Relationships by Employing Harm Reduction

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Abstract

If there is one piece of advice for treating addiction, it is "do not try to stop it". We are obsessed with addicts' alcohol consumption and drug use, forcing them to abstain and criticizing them if they relapse. However, sobriety is not something that can be achieved overnight. There are many addicts who need alcohol or drugs to survive; in other words, the problem is not "I will not quit", but "I cannot quit". Thus, the therapist cannot build a relationship of trust by blaming the symptoms. Drug addiction cannot be cured through "intolerance and severe punishment" -such an approach is anti-therapeutic and does not benefit anyone. The primary goal should be to enable addicts to be able to live a healthy life with as little harm as possible. Thus, what is needed is support, not punishment. Harm reduction prioritizes health improvement and maintenance over judicial intervention, ensuring human rights and providing necessary support to those suffering from the effects of drug use. Thus, drug use itself is not questioned-it does not matter whether the drug is legal or illegal, and patients are treated humanely and with dignity. Providing "support for everyday difficulties" rather than "support to stop addiction (coercion)" builds a relationship of trust; it empowers the patient, thus motivating them to stop using. Forcing people to do difficult things will not only fail but also promote prejudice and conflict. Addicts already struggle to survive and are further harmed by stigma. Introducing harm reduction would make it possible to provide "treatment and support that does not and cannot hurt anyone". Harm reduction eliminates the harsh punitive

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approach that promotes stigma, and supports those needing help by empowering them through trust-based relationships.

Thus, a consideration of harm reduction reveals the most important aspect missing in addiction treatment and support in Japan. It is a universal approach that is common in psychiatric medicine.

Keywords: harm reduction, drug addiction, therapeutic relationships

Introduction

If I were to name one key principle for dealing with patients suffering from addiction, it would be: "not to try to make them quit." This seemingly paradoxical approach reveals the very nature of addiction as a disease.

Patients want to quit, but, at the same time, they do not want to quit. If the therapist does not understand this ambivalence, they will respond incorrectly. For example, if the therapist strongly intends to make the patient quit, he/she will resist just as strongly, or even more so, to prevent being made to quit. This forces the patient in the direction of not quitting.

Conversely, simply by not forcing them to quit, it becomes easier to maintain a good relationship. Whenever a therapist or family member brings up the topic of alcohol or drugs, the patient reacts with a look of discomfort and becomes defensive. Simply refraining from doing this should alleviate the tension between them. It is contradictory to explain to the patient that "addiction is a disease that cannot be controlled by willpower alone" while simultaneously trying to force them to stop. Forcing sobriety/abstinence on a patient sends the mistaken message that this is a problem they must solve on their own. The patient will likely think: "I have no choice but to endure it."

When family members or therapists coerce patients into sobriety/abstinence, or reprimand them for drinking or using drugs, friction and conflict easily arise, causing the relationship between the two parties to deteriorate. This undermines the trust that is essential for recovery. Patients become even more isolated, their self-esteem is damaged, and, feeling cornered, they inevitably turn to alcohol or drugs. This is likely the phenomenon that has repeatedly occurred in homes and medical settings up to now.

Addiction is an illness. There is no illness that improves through punishment; rather, it worsens.

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Considering the current situation in Japan, where it is difficult to say that the basic human rights of patients with addiction are respected, the philosophy and practice of harm reduction, which respects patients' human rights, highlights the most crucial element currently lacking in Japan's addiction treatment and support: the establishment of a therapeutic relationship with the patient.

I. The Philosophy Underlying Harm Reduction

Harm reduction is a public health strategy that focuses on reducing the health, social, and economic harms caused by drug use rather than using harsh punishment to stop it. It is a realistic policy and program that addresses problems with tolerance toward drug users, their families, and the community.[1)] It does not matter whether a person is using drugs, or whether the drugs are illegal. The goal is to provide support for the individual's specific difficulties. It is based on the philosophy that even drug addicts have fundamental human rights and dignity that must be protected, and that they must not be harmed by stigma.

Through harm reduction programs, support reaches isolated drug users. This makes it easier for them to access appropriate information, counseling, medical care, and administrative services, thereby preventing drug-related problems from escalating. Given the current situation where people in need of support have long been left without assistance, it is essential to prevent the isolation of drug users and connect them with support services. Harm reduction aims to reduce prejudice and stigma against drug users and provide low-threshold support.

Japan has consistently pursued a zero-tolerance and punitive approach to drug issues, symbolized by the slogan "No! Absolutely No!" This stands in direct opposition to the view that "drug addiction is a disease." Clinically speaking, a zero-tolerance and punitive approach does not treat drug problems. On the contrary, it is counterproductive to treatment. Furthermore, it has the potential to foster prejudice and human rights violations, as well as reinforce stigma. Fundamentally, the zero-tolerance and punitive approach is a concept rooted in the criminal justice system, not in healthcare or social welfare.

Even developed nations around the world once relied on punitive measures. However, as the harmful effects of punitive drug policies became clear, these nations have historically made a major shift in direction. This shift is exemplified by Drug Courts, primarily in the United States, and harm

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reduction initiatives, primarily in Europe.

The key points are: "Providing support for a person's difficulties, regardless of whether they use drugs or their actions are illegal," and "Supporting the person's struggles in life, rather than simply trying to get them to stop using drugs."

This approach to support connects patients with the help they need, alleviates their difficulties in living, improves their quality of life (QOL), and encourages them to move toward giving up drugs. Isn't this kind of mindset lacking in Japan? I am not saying that we should introduce harm reduction policies in Japan. Rather, I hope that the underlying philosophy will serve as a catalyst to break through the current impasse in Japan's addiction treatment.

II. Harm Reduction Approach in Addiction Treatment

As an antithesis to the traditional "zero-tolerance and punitive approach," I would like to propose "addiction treatment that does not aim to make patients quit." This is the harm reduction approach in addiction treatment.[8)]

1. What is addiction treatment that does not aim to make patients quit?

"Addiction treatment that does not aim to make patients quit" refers to "addiction treatment that does not force patients to quit" and "addiction treatment that is not fixated on making patients quit." Regardless of whether drinking or drug use continues or has stopped, it provides patients with the treatment and support they realistically need.

Until now, we have been fixated solely on whether patients are drinking alcohol or using drugs. Consequently, our approach became one of impatience and coercion regarding abstinence from alcohol and drugs. It goes without saying that continued abstinence is desirable for patients with addiction. However, the drawbacks of short-sightedly forcing abstinence have rarely been examined.

Table 1 shows the advantages and disadvantages of "treatment that tries to make patients quit" and "treatment that does not try to make patients quit."[8)]

2. From a patient attitude survey at the outpatient department of Saitama Prefectural Psychiatric Hospital

This section presents the results of an attitude survey conducted by the author on patients with alcohol and drug addiction.[6)]

[Methods and Subjects]

A patient survey was conducted among addicts receiving outpatient treatment at Saitama Prefectural

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Psychiatric Hospital (hereinafter referred to as "the center"). Questionnaires were distributed to patients who provided consent between April and May 2016, and anonymous responses were collected. The survey included 103 participants (62 men, 41 women) with a mean age of 44.9 years (±12.6). By substance, the breakdown was 41 for alcohol and 37 for stimulants, among others.

[Results]

1. Regarding their feelings at the time of relapse, 57.0% reported "I intend to stop," and 20.0% reported "I tend to want to stop," meaning 77.0% were actively trying to stop on their own.

2. When pressured by family members to stop drinking or using drugs, 16.5% felt "somewhat inclined to drink or use," and 40.8% felt "inclined to drink or use," meaning 57.3% experienced an increased urge to drink or use drugs.

3. When told by hospital staff to "stop" drinking or using drugs, 44.7% reported an increased urge to drink or use drugs.

4. When blamed by family members for relapsing into drinking or drug use, 10.8% said they "tend to want to drink or use," and 50.9% said they "want to drink or use," meaning 61.7% were moving toward drinking or drug use.

5. Similarly, when blamed by hospital staff for relapsing into drinking or drug use, 12.9% felt "somewhat inclined to drink or use," and 41.6% felt "inclined to drink or use," meaning 54.5% were moving toward drinking or drug use.

6. The primary reasons for drinking or using drugs were: "to numb the pain" (58.8%), "because it makes me happy" (29.5%), and "other" (11.8%).

Treating professionals and support staff must not force patients to stop drinking or using drugs. Furthermore, they must not blame patients for their drinking or drug use. Sixty percent of patients cannot stop because they are suffering. Therefore, unless this suffering is alleviated, they will likely be unable to give up alcohol or drugs.

3. Patients are not "choosing not to stop," but rather "unable to stop"

The reason they cannot let go despite the suffering is that, for addicts, alcohol consumption and drug use have played a crucial role as a solitary form of self-treatment for those who have "struggled to find healing from others and carried the burden of a difficult life."[2)5)] For a patient, to give up alcohol or drugs is like trying to fight overwhelming stress completely unarmed. For a patient who has no coping mechanism other than alcohol consumption or drug use, giving them up must cause immense anxiety and fear.

In past addiction treatment, partly due to the prevalence of severe cases, patients were forced to give up alcohol and drugs immediately without any

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understanding of this background. Many patients, even if they recognized the problem, were not prepared to give them up and resisted desperately to avoid having them taken away.

Their families were dismayed by this attitude; they scolded them, lamented, and grieved. They repeatedly abandoned them, issued ultimatums, and vented their anger by wishing them dead. Therapists, meanwhile, have unquestioningly forced patients to give up their substances, blamed them for their indecision, scolded them for their failures, and mocked them for their denial. Then, exasperated by the patients' lack of change, they have threatened to abandon them. Blamed and increasingly isolated, patients have turned to alcohol consumption and drug use.

In this way, the rift between patients, their families, and therapists has deepened. Both patients and families have been left wounded and exhausted. The more the therapist tried to make the patient quit, the more they felt a sense of failure, lost confidence, had their self-esteem damaged, and developed negative feelings toward the patient. No one was saved. Everyone was hurt and drifted further away from building trust.

III. The Practical Application of Addiction Treatment Based on the Harm Reduction Concept

Next, I would like to explain specifically what the harm reduction approach in addiction treatment entails.

1. Harm reduction outpatient clinic

At the center where the author works, the addiction outpatient clinic is called the "Welcome Clinic," and we implement measures to prevent patients from dropping out of treatment.[7] We convey a sense of welcome to patients, do not force them to stop drinking or using drugs, do not blame them for their alcohol consumption or drug use, and focus on the problems they are facing. We never try to force them to quit. We stand by the patient's desire to improve their situation and maintain a positive, supportive relationship. We strive to acknowledge their daily struggles and worries while respecting their autonomy.

Additionally, we alleviate anxiety associated with seeking treatment by guaranteeing that patients will not be hospitalized without their consent and that we will not report them even if they relapse into stimulant use.[3]

Therapists routinely provide care that prioritizes treatment continuity to the greatest extent possible, while utilizing treatment tools such as workbooks to motivate patients.

As a result of these methods, while the reported outpatient retention rate (3

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months) for stimulant-dependent patients at specialized addiction clinics ranges from 36 to 39%, the center has been able to raise this rate to 87%. Furthermore, in a follow-up survey of 322 new drug-addicted patients, the treatment continuation rates were: 75.8% for 3 months or more, 61.5% for 6 months or more, 46.3% for 1 year or more, and 18.0% for 3 years or more, while the complete abstinence rate for 6 months or more was 43.8%. Participants in the LIFE program described below accounted for 4.6%, and DARC users for 5.9%, suggesting that a certain degree of effectiveness can be achieved through standard outpatient treatment alone.[6)]

2. Harm reduction outpatient program

At the center, we implement the outpatient drug dependence relapse prevention program "LIFE."[4)] LIFE consists of weekly group sessions using a workbook; while the program comprises 40 sessions in total, participation remains voluntary after completion. The target population consists of drug-dependent patients who have been unable to stop using drugs through outpatient care alone.

LIFE does not necessarily aim for abstinence. It places emphasis on breaking out of isolation and connecting with others. The priority is on creating a safe space where participants can speak honestly about their feelings and gain "trustworthy peers" and a "safe place to belong." Rather than acquiring specific techniques or knowledge, the primary goal is to foster a sense of camaraderie and find healing through continued participation in the program alongside members facing similar challenges.

At LIFE, participants are commended for coming to treatment even while using drugs and for honestly discussing their use. Honesty, rather than whether they have stopped using drugs, serves as the benchmark for recovery. We strive to make LIFE a warm and healing place.

Even if they cannot stop at first, by continuing to attend the program and connecting with others, they no longer feel alone. As they are healed by others and the difficulties of daily life are alleviated, they gradually become able to let go of drugs. It is important to ensure that participants do not drop out of the program, regardless of whether they are currently using drugs.

According to a follow-up study of the initial 45 participants, the rate of complete abstinence for at least three months was 61.5% among those who continued participation for nine months or more, compared with 25.0% for those who participated for less than nine months.[10)] This demonstrates the importance of continuing the treatment program.

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3. Harm reduction in inpatient treatment

Changes are also evident in inpatient treatment. Interventions based on supporting patients' specific difficulties differ from approaches that mandate program participation with the sole goal of abstinence from alcohol and drugs. Of course, if a patient wishes to abstain from alcohol and drugs, a treatment plan is formulated accordingly; however, the approach is no longer narrowly focused on abstinence alone. Patients are not reprimanded for alcohol consumption or drug use when they go out or stay overnight outside the facility. Instead, such behavior is viewed as a symptom and addressed as such. In this way, the concept of harm reduction is beginning to take root even in inpatient treatment.

IV. Specific Interventions for Patients

Thus far, we have outlined the approach to treatment based on the principles of harm reduction. Next, we will discuss specific interventions for individual patients.

For example, in the case of patients with stimulant dependence, the primary harms for them are likely to be arrest and causing harm to themselves or others while in a psychotic state. Similarly, for patients dependent on sedatives such as benzodiazepines, potential harms include injuries or accidents resulting from a dazed state, or respiratory depression caused by concurrent use with alcohol. If drug use cannot be stopped immediately, it is crucial to minimize harm. We propose specific measures, discuss them with the patient, and implement feasible methods (Tables 2 and 3). All of these are practical approaches that demonstrate care for the patient and aim to reduce harm.

Many people may feel uncomfortable with such proposals, as they suggest that the therapist is condoning the use of illegal drugs or overdose. However, when treating patients with drug addiction, if even the therapist insists or scolds them with a "No! Absolutely No!" attitude, it only corners the patient, isolates them, and drives them back toward drugs.

Forcing someone to do what they cannot is harmful. If a patient cannot quit, isn't it natural to first show concern for them and take steps to reduce the harm? Therapists must adopt an attitude of standing by the patient as an ally, rather than blaming and pushing them away. A relationship of trust is built through respectful and caring treatment, leading the patient to open up and speak honestly. Stability is achieved by increasing points of contact between the patient and therapist and maintaining ongoing involvement

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through a multidisciplinary team that shares a common understanding.

V. Key Considerations for the Harm Reduction Approach in Addiction Treatment

Addiction treatment based on the harm reduction philosophy offers significant advantages: 1. It is more likely to lead to treatment because it does not force patients to quit; 2. It is easier to build trust because support is provided with respect for human rights; and 3. It is easier to connect patients with support because services are readily accessible. Such an approach respects the patient's fundamental human rights and protects them from misunderstanding, prejudice, and stigma. The reasons why this is effective for addiction treatment are shown in Table 4.

While harm reduction policies do not make abstinence from alcohol or drugs the primary goal, in the harm reduction approach to addiction treatment, therapists must always maintain a vision of working toward abstinence. This does not mean that the therapist is giving up on the patient's ability to abstain from alcohol or drugs. In this respect, it is not in conflict with treatment that sets abstinence as a goal, but rather complements it. If a patient wishes to abstain, support toward that end is provided promptly.

Rather than directly supporting cessation, the focus is on alleviating the difficulties and negative factors surrounding the patient, such as feelings of loneliness, loss of confidence, self-blame, shame, distrust of others, anger, anxiety, depressive mood, sadness, loss of joy, loss of hope, and loss of trust, as well as financial problems, housing issues, living environment problems, employment issues, and family problems.

Thus, the focus is on the patient's difficulties. Even if the patient is unable to quit, the therapist's stance remains unchanged, and necessary support continues. Table 5 lists points for the therapist to keep in mind.

If past approaches have created friction or conflict between the therapist and patient, causing mutual hurt and a cycle of disappointment and burnout, they must be re-evaluated. Methods that force patients to confront their problems, cut off support, and make them give up in order to comply with treatment are not only unsupported by evidence but also dangerous and ethically problematic.

Recovery from addiction occurs through relationships with healthy people. A healthy therapist is someone who can treat patients with respect and warmth, without harboring negative emotions toward them. It is someone who can empathize with the patient. To

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achieve this, it is essential that the therapist has established trusting relationships with important people in their own lives, such as family, friends, and colleagues, and is being healed by others. Only a therapist who has such trusting relationships can unconditionally believe in addicts who suffer from deep mistrust of others. It is necessary for therapists themselves to have been healed by others and be healthy and emotionally resilient.[9)]

Conclusion

Harm reduction originated when needle exchange programs were initiated by those directly affected, amidst a situation in Western countries where authorities were promoting measures to arrest and imprison drug users in an attempt to force them to stop using. As its effectiveness gradually became recognized, it came to be adopted in many countries.[10)] The origins of harm reduction, in terms of being user-led, overlap with the practices of self-help groups such as Alcoholics Anonymous (AA) and recovery facilities like DARC. This reaffirms the importance of a user-centered perspective.

Addicts struggle to live their lives and have been further wounded by stigma from society, support providers, and themselves. Rooted in the background of harm reduction is an approach to support that rejects the intolerance and punitive measures (zero-tolerance and punitive approach) that perpetuate stigma, instead connecting people through trust and empowering them. This concept is the most crucial element that has been lacking in addiction treatment and support in Japan.

Furthermore, if we view alcohol consumption and drug use as manifestations of various problematic behaviors and symptoms, a new perspective emerges even within general psychiatric care. Rather than forcibly suppressing the problematic behaviors or symptoms that appear on the surface, we continue to provide support for the underlying difficulties and struggles the patient faces, fostering a relationship of trust. As patients build a trusting relationship with their therapist and find healing through human connection, these problematic behaviors and symptoms will subside.

Harm reduction highlights a crucial principle that underlies not only addiction treatment but psychiatric care in general.

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Hirakawa Hospital) as the representative.

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表１ 「やめさせようとする治療」と「やめさせようとしない治療」のメリットとデメリット

	やめさせようとする治療	やめさせようとしない治療
メリット	〔患者〕 ・断酒・断薬に焦点づけられる ・断酒・断薬を迷っている患者に決心する後押しになる ・同じ目標を共有できると一体感をもてる 〔治療者〕 ・同じ目標を提示できるので対応しやすい ・断酒・断薬を前提に一律のプログラムを組める	〔患者〕 ・治療に抵抗をもちにくい ・安心して治療を受けられる ・本音を言いやすい ・再飲酒・再使用をしても傷つきにくい ・結果を出そうと焦る必要がない ・治療にストレスを感じにくい ・信頼関係を築きやすい ・治療が継続しやすい 〔治療者〕 ・治療に導入しやすい ・治療を継続しやすい ・患者との対立が起こりにくい ・治療にストレスを感じにくい ・余裕をもって対応できる ・治療同盟を築きやすい ・信頼関係を築きやすい
デメリット	〔患者〕 ・治療者との対立が生まれやすい ・治療にストレスを感じやすい ・患者の抵抗を強める ・治療中断しやすい ・本音が言いにくい ・嘘が多くなる ・再飲酒・再使用を症状と捉えにくい ・再飲酒・再使用すると失敗と感じて傷つく ・自分でやめなければならないと感じてしまう 〔治療者〕 ・再飲酒・再使用を責めてしまいやすい ・対等の関係でなく上下関係になりやすい ・断酒・断薬を焦って強要してしまう ・本音を話してもらえない ・治療にストレスを感じやすい ・信頼関係を築きにくい	〔患者〕 ・断酒・断薬の焦点づけがされにくい ・現状維持でよしとしやすい 〔治療者〕 ・特になし

（文献 8 より引用）

Table 1: Advantages and disadvantages of “treatment aimed at cessation” and “treatment not aimed at cessation”

Advantages

Treatment aimed at cessation

[Patient]

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・Focuses on abstinence from alcohol and drugs
・Helps patients who are hesitant about abstinence make the decision
・Fosters a sense of unity by sharing the same goal

[Therapist]

・Easier to manage because the same goal is presented
・Allows for a standardized program based on the premise of abstinence

Treatment not aimed at cessation

[Patient]

・Less likely to resist treatment
・Can receive treatment with peace of mind
・Easier to speak honestly
・Less likely to feel hurt if they relapse
・No need to rush to produce results
・Less likely to feel stressed by treatment
・Easier to build a trusting relationship
・Easier to maintain treatment

[Therapist]

・Easier to initiate treatment
・Easier to maintain treatment
・Less likely to cause conflict with the patient
・Less likely to feel stressed by treatment
・Can respond with a sense of ease
・Easier to build a therapeutic alliance
・Easier to build a trusting relationship

Disadvantages

Treatment aimed at cessation

[Patient]

・Conflicts with the therapist are more likely to arise
・Treatment is more likely to feel stressful
・Increases patient resistance
・Treatment is more likely to be interrupted
・It is difficult to speak honestly
・Lies become more common
・Relapse is difficult to recognize as a symptom

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・Relapse is perceived as failure, causing emotional distress
・Patients feel they must quit on their own
[Therapist]
・It is easy to blame the patient for relapse
・Relationships tend to become hierarchical rather than equal
・May rush and coerce abstinence from alcohol or drugs
・Patients may not share their true feelings
・Tendency to feel stressed by treatment
・Difficult to build trust

Treatment not aimed at cessation
[Patient]
・Difficult to focus on abstinence from alcohol or drugs
・Tendency to be satisfied with maintaining the status quo
[Therapist]
・None in particular

(Cited from Reference 8)

表 2　覚せい剤使用患者の害を軽減するための提案例

・事故のリスクをさけるために使用時は出歩かない.
・注射で使用するときは回し打ちをしない.
・使用してセックスをする際はコンドームを使用する.
・C 型肝炎などの感染予防に配慮し感染時は治療を行う.
・使用後は睡眠を十分とる.
・覚せい剤の追い打ちをしない.
・処方薬を適切に使えるよう担当医と相談しておく.
・アルコールや他の薬物と併用しない.
・自暴自棄になって使わない.
・食事や水分の摂取を意識して行う.
・使用前，使用時に相談できる支援者を決めておく.
・使用時は安心できる人と一緒にいる.
・勘ぐりや幻聴が激しいときは治療者・支援者に連絡する.

Table 2: Examples of proposals to mitigate harm in stimulant users
・Avoid going out while using to prevent accidents.
・Do not share needles when injecting.
・Use condoms when having sex after using.
・Implement infection prevention measures, such as hepatitis C, and seek treatment

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if infected.
・Get plenty of sleep after use.
・Do not take additional doses of stimulants.
・Consult with your doctor to ensure you can use prescription medications appropriately.
・Do not use in combination with alcohol or other drugs.
・Do not use the drug out of despair.
・Be mindful of your food and fluid intake.
・Designate a support person you can consult before and during use.
・Stay with someone you trust while using the drug.
・Contact your therapist or support person if you experience severe paranoia or auditory hallucinations.

表 3　鎮静薬使用患者の害を軽減するための提案例

・より安全な処方への移行を話し合う.
・致死性の高い薬剤は中止する.
・残薬・手持ち薬をため込まない.
・屋外で過量服薬しない.
・過量服薬して外出しない.
・アルコールや他の薬物と併用しない.
・転倒の危険回避のため物を片づけておく.
・救急搬送を要する基準を知っておく.
・過量服薬時の対応を具体的に決めておく.
・過量服薬時は水分を多めにとる.
・過量服薬時は決めておいた支援者に連絡する.
・過量服薬前に決めておいた支援者に連絡する.
・不自然な姿勢で寝てしまわない.
・タバコなどの火の始末に注意する.

Table 3: Suggested measures to reduce harm in patients using sedatives
・Discuss switching to a safer prescription.
・Discontinue highly lethal medications.
・Do not hoard leftover or personal medication.
・Do not take an overdose outdoors.
・Do not go out after taking an overdose.
・Do not use in combination with alcohol or other drugs.
・Keep the area tidy to avoid the risk of falls.
・Be aware of the criteria for requiring emergency transport.
・Establish specific procedures for responding to an overdose.

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・Drink plenty of fluids if you take an overdose.
・Contact the designated support person in the event of an overdose.
・Contact the designated support person before taking an overdose.
・Avoid falling asleep in an unnatural position.
・Be careful with sources of fire, such as cigarettes.

表4　ハームリダクションが依存症治療に有効な理由

1．対立が起きず治療（信頼）関係を築きやすい．
2．スティグマを軽減できるため患者を傷つけない．
3．治療への抵抗を軽減できる．
4．敷居の低いさまざまなサービスを提供できる．
5．患者の自主性を尊重できる．
6．患者への偏見を軽減し人権を尊重できる．
7．患者をエンパワメントできる．
8．患者の望む方向への支援を柔軟に提供できる．
9．患者の健康被害を低減できる．
10．治療・支援が継続し回復が生まれやすくなる．

Table 4: Reasons why harm reduction is effective in addiction treatment

1. It helps build therapeutic relationships (relationships of trust) without creating conflict.
2. It reduces stigma, thereby avoiding harm to the patient.
3. It reduces resistance to treatment.
4. It allows for the provision of a variety of low-threshold services.
5. It respects the patient's autonomy.
6. It reduces prejudice against patients and respects their human rights.
7. It empowers patients.
8. It allows for flexible support tailored to the patient's wishes.
9. It reduces harm to the patient's health.
10. Treatment and support are sustained, making recovery more likely.

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表5　ハームリダクションアプローチの心得10ヵ条

1．患者中心のスタンスを常に維持する．
2．患者に敬意をもって誠実に対応する．
3．患者との信頼関係づくりを優先する．
4．患者の現状をそのまま肯定的に受け入れる．
5．患者の問題行動は症状によると理解する．
6．治療目標を断酒・断薬に焦点づけしない．
7．患者の飲酒・薬物使用を責めずに受け入れる．
8．患者が困っていることに焦点づけする．
9．飲酒・薬物使用にとらわれず害の軽減に努める．
10．患者に陰性感情をもたずに寄り添っていく．

Table 5: Ten principles of the harm reduction approach

1. Always maintain a patient-centered stance.
2. Treat patients with respect and sincerity.
3. Prioritize building a trusting relationship with patients.
4. Accept patients' current situation as it is, in a positive manner.
5. Understand that patients' problematic behaviors are symptoms of their condition.
6. Do not focus on treatment goals solely on abstinence from alcohol or drugs.
7. Accept the patient's alcohol consumption or drug use without blame.
8. Focus on the patient's current difficulties.
9. Strive to reduce harm without fixating on alcohol consumption or drug use.
10. Support the patient without harboring negative feelings toward them.

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