Alcohol screening and brief counseling interventions for trauma unit patients

As I (Laura) prepare to see another patient, I read the quick details indicating he has an alcohol-related injury. His blood work showed an alcohol level of .16, two times the legal limit of intoxication. He fell off a ladder and has a mild concussion with a nasty cut above his swollen and bruised right eye. He probably won’t be here in the hospital trauma center long. He is in the “day” hospital and represents one of the 1,000 people we have seen for alcohol screening and brief counseling interventions in the past five years at Wake Forest Baptist Medical Center.

So, I walk toward him — toward hope that maybe, just maybe, this will become a memorable, teachable moment for him. And maybe, just maybe, this amazing set of professional counseling skills that I have acquired and honed over 30 years will be there for him in just the right way, at just the right time, to help him as he explores changing his risky drinking patterns. He is not diagnosed as an alcoholic, but he does infrequently overdo drinking and is assessed as a risky drinker.

My route takes me past the waiting area for the intensive care unit (ICU). At least 30 people are here, speaking in hushed tones. I know intuitively why they left their cozy family homes so early on a Saturday morning to assemble here in these sterile concrete hallways where there is nowhere to suffer silently under the harsh lighting. I am struck by the sheer force and heaviness of their worry and pain.

So many young faces are in this waiting area. They are here not for one of their own but for two teenagers, ravaged, lying in beds, surrounded by prayers and forever changed, the focal points of all the heroic efforts our highly specialized trauma surgeons and medical team can provide.

The trauma surgeon’s medical notes, written upon her initial exam of the teenage driver, rattle back and forth in my mind, like gravel pinging loudly in a tin can. They are reverberating words that cannot be erased or forgotten: “Skull fracture, severe.” The prognosis is dire.

I can imagine the pure, carefree, wide-open joy this 19-year-old felt the previous night as he entered that twisting curve, the wind in his face, and popped the top as he rode that powerful rocket into the night. Knowing he had such power at his fingertips, heightened oh so sweetly by those liquid kisses from that last ice-cold blue can.

Such total freedom — then.

Now, he and his rider, an 18-year-old friend, lie in tubes and plastic in the ICU. Their connection to this day is tenuous at best. Will this be a teachable time for any of the caring neighbors, the classmates, the church members, the community leaders, the parents? So little is spoken about the drinking.

Both the driver and his passenger had alcohol levels far exceeding the .08 legal limit to operate a vehicle, and both were under the legal drinking age. What do we make of this? Do we keep our silent vigil?

We have learned through extensive research that approximately half of the patients admitted to hospital trauma centers have alcohol-related injuries. Now, as I go to see the man in the day hospital to provide alcohol screening and a brief counseling intervention, what will he see? How willing will he be to see the connection between his injury and his risky drinking? Will he be open to exploring change?

There is an enormous weight attached to my work here at this hospital, teaching many counseling student interns and doing what many say shouldn’t be done by counselors. Naysayers question whether anyone will really make changes to their drinking habits after just one counseling session. Yet quietly, and frequently, we see trauma unit patients making these healthier changes. Our own research, as well as the research of others, confirms that many of these individuals sustain those changes.

So, I walk on. I walk on this Saturday morning, just like many other days, toward this injured person and toward hope that maybe, just maybe, this will be another memorable, teachable moment.

The purpose of this article is to introduce counselors to a community context — the hospital trauma unit — in which counselors historically have not been represented. We believe, however, that counselors, because of their unique set of skills, can provide an invaluable service in these units. The individuals depicted in this account are based on composites rather than on any actual cases.

Negative effects of alcohol

According to statistics from the National Institute on Alcohol Abuse and Alcoholism (NIAAA), approximately 65 percent of U.S. adults drink alcohol. An estimated 9 percent of U.S. adults drink in an addictive or abusive pattern, while an additional 19 percent drink in risky patterns, often involving binge drinking; 72 percent of U.S. adults either do not drink alcohol or do not exceed the NIAAA risk limits when drinking.

NIAAA has indicated that males younger than 65 who drink more than four standard drinks in one day and 14 or more standard drinks in one week are more susceptible to alcohol-related harm, such as violence, accidents and alcohol dependence. (A standard drink equates to one 12-ounce beer or one 5-ounce glass of wine.) For females, NIAAA has indicated that more than three standard drinks in one day or more than seven standard drinks in one week constitutes “risky drinking” behavior that may lead to alcohol-related harm. NIAAA also has a resource for those exploring changes to their drinking habits, called Rethinking Drinking, which outlines a number of negative effects from alcohol.

According to NIAAA, alcohol is a contributing factor in 60 percent of deaths resulting from burns, drowning or violence; 50 percent of severe physical traumas and rapes; and at least 40 percent of fatal car crashes, suicides and deadly concussions.
from falls. In addition, heavy drinkers often have a greater risk of physical deterioration such as cirrhotic liver failures, heart attacks, vascular strokes, insomnia, depressive disorders, gastric bleeding, numerous cancers and sexually transmitted diseases. Additional alcohol-related complications thwart effective management of diabetes, hypertension and anxiety. Drinking by pregnant women can cause serious brain damage and other complications to the unborn infant.

In summary, negative effects from alcohol use are seen throughout the spectrum but particularly among the 28 percent of individuals who drink excessively or addictively. Our alcohol screenings and counseling interventions are focused on these individuals.

**The teachable moment**

A Level I accredited hospital trauma center provides the best in trauma care and is required to provide alcohol screening and brief intervention to patients when clinically indicated, such as when patients enter the unit intubated. *Note Given the context of this article and the language used by hospital staff, we will most often be referring to "patients" rather than to "clients."* In many hospitals, nurses and other staff complete these screenings and interventions. Our particular hospital is one of a very few in the nation engaging counselors to provide this service. We thought that counselors would be effective in this role because of their training in active listening, rapport building and empathy, their attention to multicultural considerations and their skills pertaining to alcohol and substance abuse.

The motive behind providing this service in trauma units is simple. Faced with a crisis (in this case, the realization of being seriously injured and in a hospital as a result of alcohol use), patients may be more amenable to the idea of making healthy changes regarding their consumption of alcohol. Counselors can help patients explore their alcohol use and connect the dots between their alcohol use and their health risks. Without the screening and brief interventions, however, many patients may not consider the connection between their alcohol consumption and the injury that brought them to the hospital.

Our *Teachable Moment* research study was funded by the Robert Wood Johnson Foundation. The research team, led by physician Mary Claire O’Brien, also included co-investigators Beth Reboussin, Laura Veach and Preston Miller. The primary goal of the project was to analyze the effects of two brief counseling interventions on patients’ alcohol consumption: a quantity/frequency intervention and a qualitative intervention. An auxiliary goal was to determine the potential role counselors could play in providing brief alcohol screenings and interventions to patients in hospital trauma units.

The quantity/frequency intervention consists of counselors focusing on how much alcohol patients consume (quantity) and how often they consume it (frequency) in a typical day and week. A key element of this intervention is providing education about risky drinking behavior based on research conducted by NIAAA.

The qualitative intervention consists of counselors eliciting information about instances when patients have "drunk too much" or have "overdone" their drinking. Patients are also asked what they believe might have contributed to these instances of overdoing it or drinking too much.

With both interventions, counselors provide patients with screening results, explore patient perspectives regarding their drinking behaviors, help patients to formulate goals for changing their alcohol behaviors (when desired) and emphasize the patient's options in making changes, if any. Screenings and brief interventions, which generally last between 20 and 40 minutes, are done in the patient's hospital room, usually at the patient's bedside. Patients with more serious or advanced problems associated with alcohol, such as alcohol dependence, are encouraged to seek additional help and are given referrals to licensed counselors who specialize in alcohol dependence.

**Cultural considerations**

Multicultural considerations are key in our hospital trauma center, which serves a vast geographical area and a diverse patient population. For example, one patient might be airlifted from rural Appalachia with severe stab wounds; another patient might be a gang member severely injured in a car crash who is transferred from an urban hospital; yet another patient may be a college sophomore from a local private university who was admitted through the Emergency Department after a serious fall. Each will have sustained life-threatening, alcohol-related injuries, and each will be offered alcohol screening and brief...
Rugged individualism places value on the individual; one's sense of meaning and worth comes from one's individual accomplishments. A common phrase used in the United States that illustrates the value placed on individual responsibility is "He needs to pull himself up by his bootstraps." Thus, in individualistic cultures, the smallest unit of society is the individual.

Collectivism, on the other hand, places value and responsibility on the collective, or group. In many cultures, the group is synonymous with the family. One's value and worth comes from honoring one's group or family. *Familismo*, a strong bond within a family, is common in Latino cultures. In a collective society, the smallest unit is the group, because individual values cannot be extricated from those of the group.

Most counseling theories and interventions have been developed by and for people who espouse an individualistic worldview. Thus, when working with trauma unit patients who valued collectivism, we had to modify our approach slightly. Rather than discuss individual goals in isolation, we would help patients tailor their goals to fit those of their family or group. We also asked all patients if they had people on whom they could count to support them in their goals.

I (Nathaniel) speak Spanish and provided alcohol screenings and brief interventions to Spanish-speaking patients. However, fluency in Spanish was not enough to be effective with these patients. It also was important to take into account high-versus low-context communication styles.

In *Beyond Culture*, Edward T. Hall postulated that White Americans engage more frequently in lower-context communication than do ethnic minorities in the United States. In other words, White Americans often focus on what is being stated verbally and less on nonverbal and context. High-context communicators, on the other hand, place less emphasis on words and more on the context of the conversation, the paralanguage and the nonverbal being used.

Latino immigrants, who made up the majority of the patients I served, often communicate from a high-context perspective. Thus, it was very important for me to assess the nonverbal, the tacit messages and the nuances these patients used in addition to the actual words being...
spoken. For example, it is considered rude in many Latino cultures to say no to a request or to refuse something outright. Because we were running a study as well as providing a service, we had to describe the study in detail and ask patients if they would consent to participate. In a few instances, patients verbally consented but, when presented with the informed consent form, decided they “weren’t feeling well” or “would prefer to look over it and get back to me later.” In one case, a patient chose not to participate after giving verbal consent because he was not comfortable placing his signature on a white piece of paper (the informed consent form). Having lived in a Spanish-speaking country and having experienced high-context communication firsthand, I recognized that these comments, especially when coupled with the paralanguage and nonverbal, were polite ways for the patients to express they were not interested in participating in the study.

Personalismo, the valuing and cultivation of an interpersonal relationship, also influenced our work with Latino patients. Personalismo often is developed through mutual sharing. Thus, a good way for counselors to foster personalismo is to open up and share aspects of their lives with clients. This is important because, regardless of the context, one’s alcohol use is usually not a subject that people feel readily comfortable discussing. To help patients feel more comfortable discussing private, intimate and guilt-laden topics, we found it helpful to take a few minutes to connect with them by asking patients about themselves. With our Latino patients, that oftentimes meant sharing things about ourselves with which we felt comfortable, such as where we were from, where we learned Spanish, hobbies we might have in common with the patient and so on. Those few minutes were very helpful in breaking the ice and creating a sense of connectedness and trust that encouraged patients to discuss their drinking habits.

**Conclusion**

In providing this service to more than 1,000 individuals in an intense medical setting, it has become clear that offering alcohol screening and brief counseling interventions has substantial benefit to the recipients and to their loved ones. There is also benefit to the health care system in the form of reduced medical costs and reduced rehospitalizations for alcohol-related injuries. Then there is the benefit to society. Studies spanning several different trauma centers show a 50 percent reduction in subsequent DWIs when alcohol screening and brief interventions are provided.

The majority of those receiving our bedside alcohol screenings and brief counseling interventions have never spoken with a counselor previously, yet they overwhelmingly rate these sessions as positive and beneficial. Further, in our six-month follow-up phone calls, former patients report substantial improvement in their quality of life (this result corresponds to other screening and brief intervention studies). The majority of individuals also report a substantial reduction in drinking, showing trends of drinking below at-risk levels or abstaining.

We continue to increase our counseling services in a medical setting, placing emphasis on cultural competence, while also providing research, exemplary professional counseling and counselor education training opportunities.

"Knowledge Share" articles are based on sessions presented at American Counseling Association Conferences.

Nathaniel N. Ivers is a licensed professional counselor, national certified counselor, human services board certified practitioner and assistant professor in the Department of Counseling at Wake Forest University. Contact him at iversnm@wfu.edu.

Laura J. Veach is a licensed professional counselor, licensed clinical addiction specialist, certified clinical supervisor and associate professor in the Department of Counseling at the University of North Carolina at Charlotte and in the Department of Surgery at the Wake Forest School of Medicine.

Letters to the editor:
ct@counseling.org

---

**STUDY GUIDE**

**for the NCE & CPCE**

**GUÍA DE ESTUDIO**

**PARA**

**NCE y CPCE**

Dr. Andrew Helwig’s very popular Study Guide for the NCE and CPCE (2011, 6th ed.) is also available in Spanish. This book has all eight CACREP content areas as well as information about the NCE and CPCE. Included are exam-taking tips, study strategies, 2 practice exams and the ACA Code of Ethics. This user-friendly Study Guide has 400 pages (430 Spanish).

**PDF FORMAT FOR DOWNLOAD TO YOUR COMPUTER**

**NOW AVAILABLE**

For more information or to purchase the Spanish or English editions of the Study Guide ($79.95) or Workshop DVDs, visit: www.counselor-exam-prep.com. E-mail Dr. Helwig at: ahelwig@sprintmail.com.