Counselor's Corner: The Missed Conversation in Primary Care

By Nita Byrne, LCSW

Recently I began seeing a new primary care provider. As an ovarian cancer survivor, I realize that I am not the easiest new patient to accept. Not only am I a cancer survivor, I am a psychotherapist. Right off the bat, I was very impressed by the provider's combination of clinical expertise and genuine care and concern. Most of all, she maintained eye contact and listened to me. She created an environment in which I felt as if I could have disclosed most anything. I am thankful that providers and patients have done such an incredible job at destigmatizing cancer.

After I left her office, I was reminded of the enormous responsibility that healthcare providers carry in the world. I view a primary care provider as an "air traffic controller" to a larger healthcare system. PCPs are often the first point of contact for many patients, and their role is essential to all of us.

In my practice, I specialize in treating addictions. I rely heavily on healthcare providers

who are identifying patients with a substance use disorder (SUD). I have all the respect in the world for them because I realize that this is not an easy population to treat. They have the ideal opportunity to positively impact patients through screening, feedback, and referral. You may have heard the acronym SBIRT (Screening, Brief Intervention, Referral, Treatment).

I spent ten years as a Licensed Clinical Social Worker (LCSW) in a Level I Trauma Emergency Room in San Antonio, Texas. Many patients were referred to me because providers felt they lacked the knowledge and the necessary communication skills to address addictive disorders. They were more comfortable treating the physical manifestations of these disorders. It was my experience that some providers had a strong bias against people with addictions, viewing these patients as weak and immoral. Some providers also perceived them as manipulative and difficult to treat. No doubt, a high relapse rate and the complexities of co-occurring mental health disorders make this population challenging to treat. Due to the missed opportunity to effectively address addiction, I began to research ways for providers to reach these patients. I began providing in-service education to teach providers effective techniques to boost confidence in treating the underlying addiction as well as the presenting condition.

Education included teaching motivational interviewing and a brief, patient-centered approach that helps individuals overcome ambivalence and build motivation for treatment. Patients struggling with substance abuse are experiencing conflicting emotions, and motivational interviewing concentrates on improving and strengthening the patient's individual motivators for change. It involves being empathic through reflective listening and avoiding arguments or direct confrontation, thus helping the patient recognize the discrepancy between their goals and their current behavior. This modality is not a psychotherapy session and can be conducted effectively in a short period of time. The guiding principle for this intervention is represented by the acronym RULE.

Resist the righting reflex

Understand the patient's motivations

Listen with empathy

Empower the patient

The righting reflex is the human tendency to "try and make things right" but debating the seriousness of the substance use with an ambivalent patient typically ends in a pointless dialogue. I remember when the consensus recommended providers be directive and confrontational with patients with substance use disorders. I was working in an outpatient treatment center, and this method felt like the wrong approach. Because this is a shame-based disease, I could not comprehend the effectiveness of berating patients with SUD. Most of them have already been confronted and criticized by loved ones, friends, and many others without a positive effect on them. Thankfully, this mindset has shifted now to a more compassionate and supportive model, assisting patients in finding internal

motivations for their own recovery.

I now work in private practice and try to suggest ways that providers can best screen their patients for substance use disorder. I recommend ways to begin that conversation with patients. Some providers tell me they use behavioral questionnaires that the patient completes upon arrival. This is helpful, but I still believe it is essential to have that all-important conversation with patients. They might lie or underestimate their use of substances. It is common for people with such problems to face stigmatization and discrimination if their problems become public knowledge. There might be other adverse consequences if they are fully truthful.

I encourage providers to empathically ask a few questions about the patient's use of alcohol and drugs and whether they think that they could benefit from counseling or treatment. Patients are more likely to be honest if they feel that their responses will be kept confidential. Consider keeping business cards of therapists specializing in addictions to hand to your patient. I find it essential that you meet these providers in person before referring your patients to them. This will help you, and it will help your patients.

Clients often tell me that their provider didn't ask any initial questions about substance use at all. I believe that providers have an ethical responsibility to treat their patients with substance use disorder with dignity and respect and to try to establish a therapeutic alliance with them. This all begins with having the "missed conversation with patients" to assess substance use and readiness for treatment. It also involves familiarizing themselves with resources available in their community that will allow them to effectively refer patients for treatment. Treating addiction is complicated and unique to each individual who has different needs. Developing cultural competence will also benefit your patients. There may be significant racial and ethnic disparities in treatment centers, and cultural competence is part of the solution.

Helpful Tips I've Learned the Hard Way

1. 12-step meetings support many individuals but are not a “one size fits all” solution. Some people do not connect with the 12-step philosophy. They might need alternative recovery support such as Women for Sobriety or SMART (Self-Management and Recovery Training)
2. Not everyone needs medical detox.
3. Not everyone needs inpatient treatment. Research shows that outpatient treatment can be just as effective for many. There are intensive outpatient programs that are beneficial.
4. Develop or enhance cultural competence in your practice.
5. Not all complaints are drug-seeking behavior.
6. Recovery doesn’t mean that a person has stopped using alcohol/drugs.
7. Addiction is a brain disease, not a moral failing or a lack of willpower.
8. Addiction has both biological and behavioral components.
9. Many patients have co-occurring mental and substance use disorders. Depression and anxiety disorders often present as fatigue, headaches and pain.

Public awareness that addiction is a disease that can be successfully treated and managed offers a vital opportunity for healthcare providers to have the “missed conversation with patients.” Begin by familiarizing yourself with resources available in your facility or community. Assess patients for substance use and readiness for treatment. Become comfortable discussing referrals with your patients. Both you and your patients will reap the benefits of recognizing and effectively addressing addiction.
