BEDSIDE COUNSELING FOR MEDICAL INPATIENTS WHO MISUSE ALCOHOL

A dissertation submitted to the Caspersen School of Graduate Studies

Drew University in partial fulfillment of

The requirements for the degree,

Doctor of Medical Humanities

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Madison, New Jersey

May 2019

ABSTRACT

Bedside Counseling for Medical Inpatients Who Misuse Alcohol

Doctor of Letters Dissertation by

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The Caspersen School of Graduate Studies

Drew University May 2019

This dissertation addresses the process and results of a program implemented to motivate patients that are admitted to a medical center with diagnoses of alcohol misuse to seek addiction recovery.The primary research question is: How does bedside addiction counseling reduce the patient's number of readmissions and length of stay? This is a comparative, interventional mixed methods study. This study also examines the methods used to identify the inpatients at the medical center that are admitted with alcohol misuse, and how that identification process initiates treatment. The analysis of informants stating they will seek recovery after discharge from the medical center was used as a proxy, or predictor. As the predictor, the statistically significant finding of counseled informants stating they will seek recovery after discharge ($p \leq 0.001$) coupled with the statistical significance of the reduction in informant readmissions ($p \leq 0.001$) during the one year–post period suggests that bedside addiction counseling reduced readmissions. The total length of inpatient hospital days for the counseled informant group also decreased dramatically from the study period to the one year–post period. This research suggests that bedside addiction counseling may be associated with contributing to an environment in which the patient informant feels comfortable enough to discuss issues contributing to

their alcohol misuse. I found that the use of proper screening tools that provide adequate time to engage in therapeutic narrative supports a better understanding of the patient with alcohol misuse. Currently, narrative is not part of the identification process for alcohol misuse in patients. Narrative can support a greater understanding of alcohol misuse for both the patient and the healthcare team. I identified opportunities for improvement in the medical center's identification process of patients with alcohol misuse. I have recommended a national public education and awareness campaign modeled after the 2012 anti–smoking campaign conducted by the Centers for Disease Control and Prevention. I believe this type of national campaign can reduce stigma towards the individuals with alcohol misuse while, at the same time, increasing the antipathy towards the products that cause this particular addiction.

DEDICATION

This dissertation is dedicated to my mother and father,

Lucille Hessman Cooper and Foster Benedict Cooper, Jr.,

for their unending love and support.

ACKNOWLEDGEMENTS

I would like to acknowledge Mildred Ortu Kowalski, PhD for her support and guidance with the entire research process and Paul I. Kadetz, DPhil for helping me to appreciate my research and the dissertation writing process at a deeper and broader level. Morristown Medical Center and the Foundation for Morristown Medical Center supported my work and I hope that I have contributed to their vision of the healthiest communities in America. I could not have started this work without Brooke Donald, PsyD, who helped me create the protocol and arranged for the doctoral candidate interns that were the bedside counselors. Kathryn Osborne, PsyD, was the lead bedside counselor and helped to make sure the study protocol for the counselors was followed at all times. And thanks to all of the bedside counselors for contributing their time and effort towards making a difference in the lives of their patients.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

INTRODUCTION

In this dissertation I discuss the process and results of a program implemented to motivate patients that are admitted to a suburban acute care medical center with primary or secondary diagnoses of alcohol misuse to seek addiction recovery at discharge. The focus of this dissertation is alcoholism, since over 80% of the addiction–related admissions to the medical center are alcohol–related. The primary research question being explored is: 1) how does bedside addiction counseling reduce the patient's number of readmissions and length of stay? The secondary research questions are: 2) in what way can the medical center improve the process of identifying and treating patients with addiction? 3) what steps can be taken to improve awareness, and lessen stigma, of alcoholism in America?

The basis for this study began when I was caring for a dying patient who also had a highly resistant organism in her sputum, *Methicillin resistant Staphylococcus aureus*, which was spraying in a fine mist across the room with each of her dying exhalations. Years of chronic alcohol misuse meant she required a Morphine drip at 80 milliliters an hour to keep her comfortable; most individuals need only one or two milliliters an hour. Her breaths came so far apart at the end that I waited an entire 20 minutes after the last one before I said my final goodbye.

As I stood in her silence I wondered if, or how, her healthcare teams over her many visits had failed her. What could we have done differently? There had never been any effort made by the healthcare team to understand who she was as a person or what

her life was outside of the hospital, therefore, no attempt was made to understand why she drank or how to help her stop. She was labeled an alcoholic on her first visit. I remember this label, because I was one of the nurses that cared for her. I, and the rest of her medical team, did not take the time to know her; and every return visit that she made; we spoke of how much worse she looked. It was not until those hours of standing in a silent room, door shut, suctioning trickles of blood that I listened to my conscience. Maybe we could never have saved her, but we made no attempts. The medical dictum 'First, do no harm' is an action step, and yet, through the inaction born out of indignation and bias we had overlooked any offer of addiction recovery assistance. I wondered why I had empathy for her when she was dying but not when she was first admitted with medical problems related to her excessive consumption of alcohol. What were the social, political, and economic influences that thwarted the efforts of the medical staff from identifying her addiction and treating it in its early stages? And why did myself and my colleagues care for individuals like her, repeatedly admitted to the hospital with obvious addiction issues, and not question why those addiction issues were not clearly addressed? After that experience, I decided to understand the framing of addiction, particularly alcoholism, and see if I could find a way the healthcare team may more effectively help these patients.

The primary research question being examined is: 1) how does bedside addiction counseling reduce the patient's number of readmissions and length of stay? The secondary research questions are: 2) in what way can the medical center improve the process of identifying and treating patients with addiction? 3) what steps can be taken to improve national awareness, and lessen the stigma, of alcoholism in America?

1.1 Literature Review

1.2 The Framing of Alcoholism in America

1.2.1 Colonization to the Late 18th Century: Alcohol as an Issue of Moral Failing.

Alcohol misuse in early America was viewed from a multi-faceted perspective, influenced by moral underpinnings and normative social values. It had been common for Europeans to drink alcohol on a regular basis, instead of water, since the fermentation process lowered the risk of waterborne illness (Lender & Martin, 1982). During the early settling of the American colonies in the 1600s, Europeans brought with them this preference for alcohol (*Ibid*.). As the American colonies were settled, consuming alcohol was an integral part of business, social and political life. Drinking was an expectation and reward for working hard in the fields, casting a political vote, training for the militia, and even social events, ironically, even including church-related activities (*Ibid*.). Local congregations were considered the epicenters of community discipline, and actions against inebriation by both church and civil leaders displayed a concern for social harmony by lying balancing justice with compassion; congregants were welcome back to the church if they vowed to stop drinking (*Ibid*.). As time went on, taking a simple vow to stop drinking was not stemming the tide of drunkenness, church and civil leaders grew more concerned, and public opinion of alcoholism became less compassionate. During the early to mid–18th century, the public opinion of inebriation was generally reflective of clergy's pontifications about the moral defects of the alcoholic, who commanded that a

more disciplined personal constitution was the key to curtailing excessive drink (Moore & Gerstein, 1981).

However, by the late 18th century, rising crime rates associated with inebriation had become a greater public concern, and both church and civil leaders began to impart stricter penalties for drunkenness. With the church still the epicenter of social influence, excessive consumption of alcohol was considered a moral failing that required prayer, moral virtue, or even divine intervention to ease the compulsion to drink. In the first known published collection of essays on the topic, the excesses of alcohol are viewed as moral weakness and social aberration "It has often raised in me the most melancholy reflections, to see the virtuous and sensible, bound in such chains and fetters, as nothing less than omnipotent grace or the unrelenting grave could release them from" (Cheyne's work as cited in Benezet, 1774, pg. 5). Interestingly, the need for support and intervention to stem the tide of increasing numbers of inebriates was also discussed, albeit more in a context of morality and society, than health:

> "Let such lawmakers, governors, and rulers, who retain any love and pity of their fellow men; let these be earnestly requested seriously, and solemnly to consider, whether it is not their indispensable duty to use their utmost endeavours, that a stop may be put to this dreadful calamity…because there cannot any inconveniencies possibly arise from the redress of this grievance, which deserves to be named with those evils which will be the undoubted consequence of its continuance" (Benezet, 1774, p. 43).

In 1784, ten years after Benezet's published work, Pennsylvania physician Benjamin Rush began a public awareness campaign against the consumption of alcohol, stating "Its effects upon their [the public] industry, health, and morals is terrible" (Hawke, 1971, p. 303). Rush's widely read pamphlet concerning the dangers of alcohol consumption warned of it as a growing public health threat (Rush, 1819). Growing up,

Rush keenly observed small pox, yellow fever, and measles epidemics. Once he became a physician, Rush considered himself a "vanguard of medical reform" (Hawke, 1971, p. 90) and publicly challenged many of his profession's medical beliefs. Rush published his essays on a variety of threats to public health, such as the process of childhood immunization. Rush, as well as Benezet before him, helped shape the public voice of concern over excessive alcohol consumption, developing the temperance movement into a broader social movement. Yet, government was slow to respond to the growing concern over inebriation. After the Revolutionary War, one of the first acts of Congress was to impose taxes on imported liquors to recoup monies spent on the war (BATF, 2018). The government's immediate priority was the creation of revenue from alcohol sales, rather than a condemnation of excessive alcohol consumption. Ironically, the government's revenue from alcohol would increase with the rise in production and sales of alcohol, a counterintuitive stance when considering the undercurrent of concern for the public's temperance as written and published by both physicians and clergy.

1.2.2 The 19th Century: Alcohol from Moral Failing to Social Responsibility.

In the early part of the 19th century, alcoholism was perceived within a religious and social interpretation, in which individuals that imbibed were lacking a prerequisite level of morality and faith. Yet, it was also during this time period that the government viewed alcohol commerce as a revenue stream for America, which may have influenced how the government reacted to this morality movement. As the morality movement against inebriation continued to grow into a more comprehensive social movement,

temperance campaigns that began in the church expanded outwardly to include other groups and organizations.

The Presbyterian minister and co-founder of the American Temperance Society, Lyman Beecher (1833) opined that America's very existence depended on defeating the threat of intemperance "Intemperance is the sin of the land … and if anything shall defeat the hopes of the world, which hang upon our experiment of civil liberty, it is that river of fire" (Beecher, 1833, p. 7). Possibly related to the 1789 Congressional tax laws on alcohol, Beecher argues there is much financial capital involved in the production and selling of alcohol and enacting new laws may create antagonism between constituents and politicians. Beecher concludes that a national abolishment of alcohol commerce is the best solution and suggests the public join his American Tract Society. Thus, began the beginnings of the march from 1800s intemperance to 1920s prohibition. Interestingly, it appears that the march from temperance to prohibition takes place on a road paved more with money than with good intentions.

Beecher's American Tract Society was formed in Boston in 1814 as an evangelical nonprofit organization to promote godliness and good morals (American Tract Society, 1857). In 1814, for a one–time donation of $20, an individual became a lifetime member, and for a $50 donation was made a Director of the Society (*Ibid.*). By 1824, ten years into their existence, the Society had total donations of $485,888 and total sales of publications of $542,257, for a total of over $1 million (*Ibid.*). In today's economy that equates to roughly $25 million of purchasing power (CPI, 2016). While the Society's interests went beyond temperance, this impressive revenue demonstrates that the fight for temperance may have been as financially lucrative as alcohol commerce

itself. With the American Tract Society addressing drunkenness on a broader, yet still moralistic, scale, and the temperance movement focusing on morality, it was clear that moral fortitude and alcohol were seen as incompatible associates.

As had occurred after the Revolutionary War, by the 1860s and the Civil War, the United States (US) government became directly involved in alcohol commerce, as the evasion of paying the taxes on alcohol had become detrimental to revenue collection necessary to fund the war (IRS, 2018). As the Victorian era emerged in the late 1800s, the social interpretation of alcoholism had changed from being an issue of an individual's moral failing more towards an individual's responsibility towards society.

As American society became more industrialized, what worked on the farm did not necessarily translate into the factories (Shifflett & Balkin, 1996). Industrial work life was not guided by sunlight or seasons as farm life was, and alcohol as a means to entice hard work was counterproductive in factories, contributing to absenteeism and injuries (*Ibid*.). Victorian era industrialization also created the concept of a mass society as more people moved to the emerging industrial cities, which fueled a change in cultural identification and value systems (Howe, 1975). During this era there was also a growing women's movement, which fought for greater legal, education, and to protect the family unit, which put additional pressure on society to eliminate drunkenness.

As society industrialized, the challenge to eliminate drunkenness expanded to include the new cultural identification of modern cities. Yet, as seen with the American Tract Society in the early 1800s, the temperance movement appears to begin with good intentions, yet, for some, rapidly evolves into a lucrative money maker.

Beginning in 1879, the Keeley Institute was a commercial medical business that provided a "cure" for alcoholism. Based in Minnesota, physician Leslie Keeley wrote a book on "inebriates" and "chronic alcoholics" and discussed the impact of alcoholism on the individual and society, stating "the great cause of learning to drink is sickness and poor sanitation. The way to secure prohibition is to banish disease and disease infection from the earth." (Keeley, 1896, p. 136). Curiously, Keeley did not focus on societal advances by improving sanitation and banishing disease. With his slogan "Drunkenness is a disease and I can cure it," he focused on curing individuals using his original, proprietary remedy (Higby, 1982). Keeley never patented his cure, and, eventually, the ingredients were revealed as gold, alcohol, and strychnine (*Ibid*.). Keeley franchised his Institute, and the *Keeley Cure*, in over 190 cities across America and Europe, a forerunner to today's for–profit addiction recovery industry (*Ibid.*). Keeley and his Institutes amassed a profit of over $1.5 million between 1892 and 1900 (White, 2014). In today's economy, that equates to over $42 million of purchasing power (CPI, 2016). Keeley Institutes' model of group therapy, community identity, and helping others to recover, added knowledge and understanding of the social aspect of alcoholism, and is considered a forerunner to groups like Alcoholics Anonymous (AA) and alcohol treatment programs, including the standard four–week length of treatment (Higby, 1982).

1.2.3 The 20th Century: Alcohol from Social Responsibility to Individual Accountability.

1.2.3.1 Prohibition.

Through the turn from the 19th to 20th centuries, strict Victorian–era moral values existed. As industrialization increased into the 20th century, America was on a path towards "moral and material improvement" (May, 1959, p. 7), what Rothbard refers to as "postmillennial pietist Protestantism" (Rothbard, 1989, p.84). These Protestant pietists were the driving force behind the temperance movement developing into prohibition (Rothbard, 1989). When America entered World War I, these pietists urged Congress to write an amendment to the Lever Food and Fuel Control Act of 1917 that conserved grain for wartime food production and restricted its use for the production of alcohol (*Ibid*.). American efforts towards prohibition as a moral victory were still highly effective.

Coincidentally, as World War I ended in 1919, the Eighteenth Amendment to the United States (US) Constitution was enacted, banning all forms of alcohol manufacture, sales, and consumption. With this enactment, the Prohibition era began, and while it appeared that prohibition would be successful, it seemed to be for only a short time. What prohibition did accomplish was a strengthening of the old belief that alcohol consumption was an individual's amoral, or immoral, choice. Under prohibition, an individual that wanted to consume alcohol had to ignore the law, or knowingly break it, and was forced underground to illegitimate establishments and the secrecy of those locations. The underground–consumer demand for alcohol grew and, in turn, so did the rapid growth of organized crime and government corruption revolving around alcohol commerce (Rumbarger, 1989). The blatant crime and corruption not only strengthened the belief that

alcoholism was an individual's moral failing, but was now clearly seen, ironically through illegality, as a threat to public safety, as well as public health (BATF, 2018). By the Depression era of the late 1920s through the mid–1930s, once again, the US government recognized their need to regain revenue from alcohol commerce, and the 18th Amendment was, ultimately, repealed in 1933 (Rumbarger, 1989). Post-war US government decisions about alcohol were based on economic realities, rather than concerns over public health or morality.

1.2.3.2 Neoliberalism beginning in the Latter Half of the 20th Century.

In 1940s and 1950s post–World War II, the US capitalist system, known as Keynesian capitalism, flourished as production and sales were needed to help rebuild post–war Europe and Japan (Campbell, 2005). The booming American economy and a new sense of post-war American social identity encouraged religious leaders to seek collective values and politics (Wuthnow, 1988). However, religions' social influence began to diminish, along with denominationalism, while religious liberals and religious conservatives divided over post-war social issues (*Ibid*.). Also, with the advances in medicine occurring during the war, during the post–World War II era, alcoholism is seen more as a disease than moral failing. In 1950, The National Institutes of Mental Health established a distinct division to study alcoholism, and the American Medical Association created a committee with a focus on a better understanding of alcoholism (White, 2014).

By the 1960s and 1970s, with the rebuilding of post–World War II Europe and Japan nearing its end, US profits, and the value of the US dollar, began to fall and inflation began to rise, ushering out Keynesian capitalism and ushering in neoliberalism

(Campbell, 2005). Neoliberalism ushered in a paradigm shift that filtered into society, and individuals were now responsible for themselves and their actions. Alcoholism was, once again, the individual's choice and responsibility to overcome; government was no longer accountable for social, political, or economic factors that contribute to alcoholism.

Under neoliberal politics, "ethics, morality, and social ideals are the responsibility of each person, not the state and certainly not private enterprise . . . nowhere in neoliberalism is there a legitimate role for the welfare of people, communities, or societies" (McGregor, 2001, p. 94). Once again, alcoholism is viewed as an individual's personal failing, and the public health impact is centered on blaming the individual alcoholic rather than focusing on overarching social, political, and economic circumstances that contribute to alcoholism rates or trends (De Vogli, 2011.).

1.3 Recapping the Framing of Alcoholism in America

Throughout American history the consumption of alcohol has been a social expectation, while excessive consumption of alcohol has been interpreted in various negative ways through the social lens of the time period. In the 17th and 18th centuries alcoholism was seen as a lack of godliness which allowed the individual deliverance through rigorous prayer and redemption from the church. During the 19th century, alcoholism was shifting to a responsibility of society to save the sufferers for the good of the country. There were also entrepreneurs who created the first alcohol recovery programs and made addiction recovery a profitable business. The responsibility for alcoholism began to drift back towards morality as America entered the First World War,

and prohibition had a short but strong hold on American society. Alcoholism was definitively defined as a disease by both the medical and psychiatric professions. Medicalizing alcoholism reduced moral failing and lack of godliness as causes. However, medicalization also reduced social responsibility. After two World Wars, America entered a new era of denominationalism and neoliberal politics, and the sole accountability for alcoholism, and recovery, shifted to the individual.

1.4 Alcoholics Anonymous

In 1935, Bill W. met Dr. Bob, a recovering alcoholic, in Ohio and the two eventually formed Alcoholics Anonymous (AA). These two men discovered that helping another alcoholic to achieve sobriety also helped themselves to remain sober. AA's transformative book bearing the same name as the fellowship, referred to in recovery groups as "the big book", was first published in 1939. AA started as a grass roots movement and is known today as the first 12–step program, listing suggestions as a guide to alcoholism recovery (*Alcoholics Anonymous*, 2001).

Dr. Silkworth, a prominent physician specializing in the treatment of alcoholism and Bill W's one-time physician, was asked to give a medical opinion of alcoholism. His response was added to AA's big book to legitimize the new AA program. When first structuring the AA program, the founder Bill W. relied heavily on the religious basis of the Oxford Group. Interestingly, AA views alcoholism as a combination of moral turpitude as well as medical recovery from disease. By crafting a group identity with

individual accountability, AA has created a social environment which reports two million members in 150 countries (AA, 2001).

While AA's program has religious undercurrents, the social environment of each meeting and the sponsor-member relationship is based in narrative. AA groups meet for one hour to engage in conversation as a group. The success of AA suggests that narrative used in a safe environment, where vulnerabilities can be revealed and mutual respect and trust is provided, can be a successful therapeutic manner in which to promote and maintain addiction recovery. While AA supports the definitions of alcoholism as both a medical disease and mental health issue, it is the narrative foundation of the AA program that is at its successful core. And, while the American Medical Association and the American Psychiatric Association have refined their positions on alcoholism over the years, AA has repeatedly refused to change the foundation of their program, keeping narrative and spirituality as its main tenets.

1.5 Diagnostic and Statistical Manual of Mental Disorders

In the early 20th century, the American Psychiatric Association (APA) worked with the American Medical Association (AMA) to formalize a classification system for mental disorders, including alcoholism, which was included in the first edition of the *American Medical Association's Standard Classified Nomenclature of Disease* (AMA, 1932). After World War II, the Army began working with the Veterans Administration (VA) to develop a broader classification system of mental illness, which included alcoholism. During the same time frame, the World Health Organization (WHO)

published its sixth edition of the *International Classification of Diseases, Injuries, and Causes of Death* (ICD–6), which included ten categories of psychoses, neuroses, and other mental disorders, of which alcoholism was included.

The APA used the ICD–6 and the work of the VA to develop the first *Diagnostic and Statistical Manual of Mental Disorders* (DSM) which was published in 1952. What set the DSM apart from the ICD–6 classification system was its intent to provide clinical treatment guidance to practitioners (APA, 2018). The first edition of the DSM was influenced by Adolf Meyer's concept that mental illness had social, psychological, and biological components and an individual's experiences in life, by use of the term "reaction", needed to be considered when forming a specific diagnosis and treatment plan (*Ibid*.). After a comprehensive review of the first edition, a need for more medicalized definitions of mental disorders was identified and Meyer's psychobiological view was no longer influential (*Ibid.*). By the fifth edition of the DSM, in 2013, alcohol abuse and alcohol dependence diagnoses were merged into one diagnosis, allowing for the diagnoses to be seen along one continuous spectrum called alcohol use disorder (AUD), and was classified into three levels: mild, moderate, or severe (NIH, 2016).

1.6 Research on Alcoholism and the Alcohol Industry

1.6.1 Research on Alcoholism.

Beginning with 1774's collection of essays on demon alcohol, through to Magnus Huss' description of alcoholism in 1849, the franchising of the *Keeley Cure* in 1892, and the enacting and subsequent repeal of Prohibition in the early 20th century, alcoholism has continued to vacillate between the concepts of moral failing, public health concern, and individual disease. By the 1930s, concerns over the larger public health threat of alcoholism coupled with the goal of coordinating and disseminating research to address this problem, resulted in the formation of the Research Council on Problems of Alcohol, as an associated society of the American Association for the Advancement of Science (AAAS) (Hirsh, 1947). The council's primary concerns were to better coordinate research and education of both professionals and the public "to establish public acceptance of the medical nature of problem drinking and of the need for research and medical action" (*Ibid. p. 231*). The council worked with many medical and governmental agencies, and provided informational and technical services, a monthly journal subscription, and provided "an opportunity of participation in a major public health movement" (*Ibid. p. 231*). In 1941, E. M. Jellinek became the AAAS journal's managing editor. Almost two hundred years after the first known publication on excessive alcohol consumption, and with the ebb and flow of discussions between morality and disease as a cause of alcoholism, E. M. Jellinek defined alcoholism in a multifactorial way that included many possible contributing factors to the disease.

Jellinek was the first to extensively write about the multifactorial disease of alcoholism having highly individualistic causes, rather than a commonality of causes rooted in religiosity and morality. Jellinek (1946) defined the disease concept of alcoholism as a viewpoint; indicating his belief that alcoholism is a disease with economic, social, cultural, physiological, and psychological factors all playing a role in its development.

Jellinek (1946) reports on the findings of a questionnaire (Appendix A) issued in AA's monthly magazine *The Grapevine*, in which the AA organization was gathering information on the progression of alcoholism in its members. Jellinek points out many limitations to the data collected from the AA survey, including a small response rate specific to one population only (white males attending AA meetings), and the lack of proper design without forethought to its potential analytical value. Regardless, with extensive work in the field, Jellinek conceived a disease concept of alcoholism consisting of five types of alcoholics (Jellinek, 1960).

Jellinek's five types of alcoholics are given Greek alphabet names to avoid social labeling and for ease of differentiation: alpha, beta, gamma, delta, and epsilon (Jellinek, 1946). Curiously, of the five alcoholic types Jellinek defines, only three are considered to have the disease of alcoholism: Gamma, Delta, and Epsilon. The Gamma drinker exhibits physical dependence on alcohol and a loss of control of drinking (*Ibid.*). Delta differs only from the Gamma in the inability to stop drinking (*Ibid.*). And the Epsilon drinker is considered the most advanced in the stages of alcoholism of the groups, although the defined parameters of "most advanced" are not clearly stated (*Ibid.*). These

descriptions were used to create the Jellinek Curve (Appendix B), from which Jellinek later disassociated himself (Valverde, 1998).

Valverde argues that by not "providing a single, objective, universally valid clinical definition of alcoholism" Jellinek's typing of alcoholics is limited by the cultural norms in which they are defined (*Ibid. p. 112*). Ironically, Jellinek's curve is still used today, not because it demonstrates the variety of interacting factors contributing to alcoholism, but because it clearly describes the progression of the disease of alcoholism. Many members of AA will tell you that each person has their own story of how they got to AA, but everyone's story of the progression of their drinking is the same, and that is what Jellinek's curve so adeptly demonstrates.

Building on Jellinek's work, during the 1960s, researchers worked to further operationalize a definition of alcoholism (Knupfer, 1967). In research, operationalizing a definition is employed to effectively measure things that are not easily quantifiable. Beyond the quantifiable finding of positive blood alcohol content, other symptoms of alcoholism such as self–reports of obsession and compulsion regarding alcohol are not directly measurable, yet exist as a set of phenomena and, therefore, can be measured across a representative sample of a population of alcoholics (*Ibid.*). Knupfer's work demonstrates the difficulties in defining alcoholism within a strict medical context because, as Jellinek (1960) pointed out, the causes are multifactorial, conceptual, and differ from individual to individual. In terms of research, defining excessive drinking patterns may be easier data to collect and validate than the root causes of the excessive drinking.

1.6.2 The Alcohol Industry and Research.

The alcohol industry admits to participating in its own private industry research in an effort to improve their products by improving aspects such as drinkability, while critics say they are really focusing on attracting younger consumers (Babor, 2009; Johns Hopkins, 2007). Regardless, with public image to consider, the alcohol industry turned to more public research to demonstrate a social conscience through a pretext of commitment to public health (EUCAM, 2018; McCambridge & Mialon, 2018).

In a stunning investigative report, the integrity of the alcohol industry and a division of the National Institutes of Health (NIH) known as the National Institute of Alcohol Abuse and Alcoholism, was placed under scrutiny when it was discovered, through the Freedom of Information Act, that "documents … show that the institute waged a vigorous campaign to court the alcohol industry … strongly suggesting that the study's results would endorse moderate drinking as healthy" (Rabin, 2018). NIH lead–investigators claimed that a long–term randomized controlled trial was necessary to produce the level of evidence needed to recommend moderate alcohol intake as part of a healthy diet (*Ibid.*). A now–retired member of the NIH team admitted to urging the alcohol industry to fund the study so it could be followed to its completion (*Ibid.*). The NIH wanted funding to finish their study and, once it was determined that a large enough sample may be able to supply data to benefit the alcohol industry they approached the alcohol industry with those expected results as an enticement for funding the project.

McMillan (2018), reports that annual wine consumption has grown from 370 million gallons in 1993 to over 770 million gallons by 2017. There is an intriguing coincidence between the investigative report regarding the NIH, "healthy" moderate

alcohol consumption, and the dramatic growth of the wine industry. While the investigative report into the NIH does not indicate the types of alcohol being studied at the time, there are many studies regarding resveratrol, an ingredient in red wine that contributes to the heart–healthy benefits of moderate red wine consumption (Klatsky, 1999; Mokni, Limam, Elkahoui, Amri, & Aouani, 2007; Ray, et al., 1999; Sato, et al., 2000; Shigematsu, et al., 2003). Unfortunately, I could not uncover the funding sources for any of these studies.

The Alcoholic Beverage Medical Research Foundation (ABMRF), an organization of the brewing industries of the United States (US) and Canada, "describes itself as a nonprofit independent research organization that provides support for scientific studies on the use and prevention of misuse of alcohol" (Babor, 2009, p. 36). ABMRF research priorities include: drinking patterns, mechanisms underlying the effects of alcohol, the etiology of alcohol misuse and effects of moderate alcohol use on health and wellbeing (*Ibid.*). Annually, the ABMRF gives up to 20 grants with each a maximum of $50,000 and lasting two years (*Ibid.*). Their Board of Trustees does not allow alcohol industry members to hold majority seats or participate in the grant selection process (*Ibid.*). While this nonprofit describes itself as an independent research organization, it clearly states it is a "supporter" of scientific studies (*Ibid.*). In other words, although it may have a structured grant approval process in place, there may still be bias present in the final choices of which studies receive industry funding (*Ibid.*).

There are several concerns about industry self–funding research (Babor, 2009). To limit bias, research facilities need to create and strictly adhere to grant application processes, and industries such as alcohol, tobacco, and pharmaceuticals, need to be

limited in their influence of research design and methodology (*Ibid.*). Professional and personal relationships between industry insiders and researchers must be transparent so conflict of interest is clear; and any conflict of interest should have its own process of correction by either removing the researcher from the project or removing the grant application from the list of funding candidates (*Ibid.*). Most importantly, researchers need to ask themselves if the funding for the project, or the project itself, is going to add to the current body of knowledge, and if not, why it is being funded or conducted in the first place. The ABMRF gets less than one percent of its funding from the US National Institute on Alcohol Abuse and Alcoholism, one of the largest government funding organizations for the industry (Babor, 2009). However, 99% of ABMRF's funding is coming from other sources, which may include alcohol manufacturers supporting their own private research or supporting institutions in need of capital to grow their own programs (*Ibid.*). This gives the industry an opportunity to present a positive concern–for–public–health image with the potential for increasing market share at the same time (*Ibid.*).

1.6.3 Research into Alcoholism Screening and Brief Intervention.

It is important to my research to identify strategies utilizing brief intervention for alcohol misuse. Many studies rely on self-reports of reduced alcohol consumption, which limits the value of the findings. Goldberg, Mullen, Ries, Psaty, and Ruch (1991) found when a clinic's nursing staff was able to combine a two–item alcoholism screening tool into the patient intake process, 90.4% of patients were screened, with 35.6% of those patients having a positive alcoholism screening. These nurses had autonomy to directly

refer patients with a positive alcoholism screen to addiction counselors. Unfortunately, cancellations or no–shows for the counselor appointments occurred at the same rate regardless of how the patient was referred (*Ibid.*).

Wallace, Cutler, and Haines (1988) gave physicians a brief training for alcohol screening and counseling and then had those physicians counsel their patients that screened positive as heavy drinkers. After a 12–month period there was a reduction in self–reported alcohol consumption of nearly 20% (*Ibid*.). The more often a patient returned to the physician and received another screening and counseling the greater the reduction in self–reported alcohol consumption (*Ibid*.). However, only about 60% of the patients with a positive alcohol screen actually attended the counseling sessions. Also, self–reports of a reduction in alcohol consumption were also reported in the control group.

Goldberg et al., (1991) and Wallace et al., (1988) both demonstrate a weakness in the brief intervention and counseling combination. Many individuals will not return for counseling if it is not available immediately after a brief intervention. Other limitations must also be considered in the self-reported reductions of alcohol consumption; such as the Hawthorne effect.

A 1992 study using the World Health Organization's (WHO) Health and Lifestyle questionnaire during an interview process with individuals, included questions about drinking behavior mixed in with questions about weight, smoking, and exercise (Babor et al., 1992). Of the 2,700 individuals screened, 82% of those screening positive for alcohol misuse agreed to participate in the study (*Ibid*.). Results from a six–month follow–up demonstrated that individuals receiving a brief intervention reduced their alcohol

consumption. Extended alcohol counseling, as compared to a 15–minute brief intervention, demonstrated no additional benefit of a further reduction in alcohol consumption by participants (*Ibid*.). This study demonstrates that a brief intervention immediately after identification of alcohol misuse, as was conducted in my research, may be as effective as extended counseling.

The first step in providing a brief intervention is in the identification of the individual with alcohol misuse. Frequently, this identification process is the responsibility of the physician. Investigating the rates at which physicians detect alcohol use disorder (AUD) during hospital admission, Smothers, Yahr, and Ruhl (2004) found discrepancies between physician diagnosis of AUD and positive screening results on the Alcohol Use Disorders Identification Test (Appendix C). Patients with a positive score on the Alcohol Use Disorders Identification Test (AUDIT) represented 41% of screened patients, yet their admitting physicians only provided an intervention or referral to treatment for half of those identified (*Ibid.*). These results suggest that physicians would benefit from additional training in the identification of AUD (*Ibid*.).

Research into AUD screening and brief intervention in both hospital and primary care settings has been occurring for decades, with the majority of research suggesting positive outcomes when screening and brief intervention are practiced. Yet, with the evidence at hand, adding routine AUD screening and brief intervention to routine physician practice, in both the hospital and primary care settings, continues to be a challenge. Over the past few decades, the medical establishment has emphasized the importance of prevention and early detection and treatment of many illnesses (Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults,

2001; Global Burden of Disease Cancer Collaboration, 2018; The US Burden of Disease Collaborators, 2018). Research indicates that the cost of providing AUD screening and brief intervention is significantly less than the costs associated with the treatments of chronic or acute alcohol–related illnesses or injuries (Gentilello, et al., 2005), yet the medical establishment, which has labeled alcoholism as a disease, seems to ignore the importance of early identification and treatment of alcoholism and its overall impact on public health.

1.6.3.1 Programs for Alcoholism Screening and Brief Intervention.

Considered the first of its kind in the United States, in 1993, Boston Medical Center began a program, Project ASSERT, in which psychiatry residents and social workers used motivational interviewing techniques based on Miller (1983) to identify substance misuse patients, which includes alcohol, in the emergency department, intervene and offer resources (Bernstein, Young, & Leary, 2017). The goals were to improve addiction services, education, and referral to addiction treatment, as well as reduce healthcare system–based stigma (*Ibid*.). At Boston Medical Center, healthcare system stigma is described as a form of social rejections and isolation within the healthcare system which interferes with the individual seeking treatment (*Ibid*.). Reducing stigma among healthcare professionals was also a goal and a challenge of the project; this stigma was found to be based on a lack of understanding of substance use disorders (SUD) among healthcare professionals (*Ibid*.). SUDs include alcohol. Boston Medical Center's Project ASSERT team needed to create a collaborative environment

with healthcare staff and reduce the use of negative labels for SUD patients, such as drunk, junkie, and frequent flyer (*Ibid*.).

In 2013, twenty years after Boston Medical Center's Project ASSERT, Yale–New Haven Hospital in Connecticut offered what was considered the second of its kind in the United States (US); a program in which recovering alcoholics with at least two years of sobriety provided bedside counseling to individuals admitted and identified as having alcohol withdrawal (Doyle, Abel, & Tratynek, 2016). Yale–New Haven found that patients counseled by these recovering alcoholics demonstrated a 50% reduction in 30–day readmissions as compared to 30–day readmissions for alcohol–related illnesses one year prior (*Ibid*.). Yale–New Haven recovering alcoholic volunteer counselors followed the 12–step program of Alcoholics Anonymous (AA), which reflects many of the tenets of motivational interviewing (*Ibid*.). Both AA's 12–step program and motivational interviewing rely on positive reinforcement and avoid negative personal connotations in an effort to reduce stigmatization that may act as a barrier to treatment (*Ibid*.). Yale–New Haven found that the staff involved in the program had an increase in their job satisfaction as their awareness of alcohol misuse increased by engaging with the recovering alcoholics who were volunteer counselors, giving the staff more empathy towards the addicted patients and a feeling that they were truly making a difference in others' lives (*Ibid*.).

Both the Boston Medical Center and Yale–New Haven Hospital programs are based on motivational interviewing conceived by Miller (1983). But, in 1993, as Miller became more involved in alcoholism research, he expressed concern that the disease model of alcoholism was being seen as an all–or–nothing biological aberration, and that

treatment and prevention based on this view may have a corresponding limited efficacy (Miller, 1993).

1.7 The Conundrum of the Medicalization of Alcoholism

Interestingly, while 19th century America viewed inebriation as both a moral and social issue, it was a Swedish physician, Magnus Huss, who first defined a collection of symptoms within a medical framework, naming it *alcoholism* in 1849 (Andrade, Anthony, & Silveira, 2009). Although sobriety circles, sober houses, and inebriate asylums existed in America for a century before him, Huss is considered the first to frame the phenomena in medical terms (*Ibid.*).

Medicalization is the pathologizing of a normal human process and may or may not, apply to alcoholism, depending on alcoholism's social and cultural interpretation. Curiously, many articles exist, and are referred to in this dissertation, which discuss the medicalization of alcoholism, yet alcohol consumption hardly seems to be a normal human process. If we view the concept of a normal human process through a social lens, then documentation since late 17th century America demonstrates that the consumption of alcohol has been consistently socially acceptable, while excessive consumption of alcohol has not.

As defined by Maturo (2012), medicalization is a "process by which some aspects of human life come to be considered as medical problems, whereas before they were not considered pathological" (Maturo, 2012, p. 123). Schneider (1978) describes disease as a human condition based more in political and social interpretation than medical

delineations. Singer (2004) considers the medical establishment's conceptualization of disease as an entity separate from the human body, and, as medical technology advances, disease begins to be distanced from the social contexts that may be important contributing factors. Viewing disease as its own entity minimizes the patient–physician relationship in which both can agree on the illness and treatment, thus causing exclusion of the patient's participation from the disease identification process (*Ibid.*). Singer refers to advances in medical technology as biomedicine, and states biomedicine is "scientifically grounded and thus uncontestably authoritative", meaning the more scientifically–based medicine becomes, the less the human factor of patient participation may play a role in diagnosis and treatment planning (*Ibid, p. 14*).

Like Singer (2004), Frankenburg also discusses biomedicine's influences over the shift of power from patient to physician, "biomedicine requires of its adherents a universalistic recognition of the abilities to control disease of all the members of specific categories who are labelled by name and symbol" (Frankenburg, 1980, p. 2). Frankenburg further explains that "the task of the patient is to learn to read the signs, accept the symptoms and understand the symbols which, correctly read, reveal the limits not only of healing ability but the power and control derived by the individual" (*Ibid.*). What Frankenburg refers to as "name and symbol" are the identifying initials of MD after one's name and an identifiable medical symbol, such as Caduceus, found on many medical business cards, buildings, and lab coats. Therefore, what Frankenburg is saying is that biomedicine has essentially caused a power shift, moving the control over an individual's illness from the individual to the physician.

With all of the medical advances towards the realm of biomedicine, the struggle continues to be clearly defining the point where an individual's alcohol consumption moves from the arena of social acceptability into that of disease. Singer explains "Doctors, after all, practice medicine, not social change, and hence, their recommendations are overwhelmingly medicalized. . .nor do they necessarily address what often is 'really' bothering patients (e.g. economic woes, tensions on the job, interpersonal conflicts, victimization, discrimination)" (Singer, 2004, p. 14). Yet, with today's technological advances in medicine, it remains that the most effective way to determine if an individual is an alcoholic is to have a conversation with that individual about their thoughts before drinking, their actions during drinking, and the related consequences after drinking. Self–reports of an individual's drinking patterns and consequences are still the most efficacious method to determine the presence and extent of the disease of alcoholism, hence the importance of narrative in the identification and understanding of alcoholism.

1.8 The Social Expectation and Cost of Alcohol

Social formation in the United States (US) still includes a stigmatization of addiction, and yet, in the case of alcohol, alcohol products are heavily advertised and moderate consumption as an adult is a social expectation (Schneider, 1978). The social expectation of drinking during social activities is a positive stigma attached to sharing in identity and community. Yet, alcohol consumption also carries the negative social stigma when an individual's drinking becomes uncontrollable.

Even with the negative social stigma, adolescents still look forward to their legal drinking age. Studies suggest a correlation between childhood awareness of positive drinking depictions and intent to drink in adolescence, suggesting that recurrent encounters with positive alcohol advertising may cause a lasting and strengthened change on a child's opinion about consuming alcohol (Grube, 2004; Martino, Setodji, Collins, D'Amico, & Shadel, 2018). It is not difficult to understand this phenomenon, given that alcohol advertising frequently presents a group of happy friends or family simultaneously expressing mutual love of each other and an alcohol product. Growing up with these images may make an adolescent look forward to the time he or she can legally consume alcohol. It is quite possible that the repeated exposure to positive media images of alcohol throughout youth may eclipse any perceived potential stigmatization associated with its overconsumption in adulthood.

According to a 2017 National Institutes of Health (NIH) report about United States (US) healthcare system costs, in 2010 alcohol's cost totaled $27 billion. But that is simply the cost to the US healthcare system. Annual US costs related to crime and lost work productivity related to alcohol was $249 billion (NIH, 2017). In a report on the costs of chronic disease to the US economy, released by the Centers for Disease Control and Prevention (CDC) in February 2019, heart disease and stroke is estimated to have an annual total cost of $330 billion, cancer is estimated at $174 billion, diabetes at $237 billion, obesity at $147 billion, and arthritis at $268 billion. Upon review of the NIH (2017) and CDC (2019) reports, addiction is comparable to chronic disease in its impact on the US economy. Interestingly, the CDC (2019) lists excessive alcohol use at the bottom of its list, and fails to include any reporting for illicit drugs or prescription drugs.

These omissions in the 2019 CDC report suggest the CDC's underappreciation of addiction as a chronic disease, which may be indicative of the underlying neoliberal apathy towards addiction and the lack of public awareness campaigns for alcoholism.

1.9 Theoretical Framework

Narrative is introduced in this research as a means by which to elicit information for the collection of data, and to begin to understand its impact for both the patient and the clinician. For patients, a sense of human connection to the clinician can initiate a more comforting and trustful experience. For the clinician, narrative can guide a more effectual understanding of the illness and the underlying individual causes.

The philosopher Martin Buber identifies two methods of human interaction, referring to two separate contextual human experiences, I–Thou and I–It (Buber, 1923). In Buber's I–Thou encounter, an individual experiences another individual within the framework of the other's experiences. Each person in the I-Thou encounter is seen as the subject of the encounter, being respected as a beautiful and unique individual and treated with empathy.

In Buber's I–It experience, individuals relate to each other as objects. Within the I–It experience, one disengages with the other on an empathic and divine human level (Buber, 1923). The I–It encounter is more of an observation than an experience. By keeping humanity at arm's length, Buber's objective experience of I–It is predictable and safe, and biomedicine and technology provides the basis for this interaction between clinician and patient. As medicine moves towards technology and away from the I–Thou

encounter, patients have become objects in the I–It realm, as demonstrated through the screening tools used in this research. Similar to Buber's "I-It" is Foucault's "clinical gaze". Foucault conveys the core of the clinical gaze as disease "perceived fundamentally in a space of projection without depth, of coincidence without development." (Foucault, 1973, p. 6). Singer (2004) discusses the importance of narrative in uncovering the silent troubles of an individual.

In one of his poems, physician and poet, Rafael Campo (2013) expresses what Singer (2004) suggests; how the physician's ability to seek out patient narrative can be important to healing:

> You say, '*It's snowing, Doc*.'
> The snow, instead of howling, soundlessly comes down.
> I think you think it's beautiful
> I say, '*This isn't all about the snow, is it*?

In this stanza, Campo is demonstrating that the physician must use his whole self, his own humanity, to pick up on the unspoken need of his patient and prompt narrative that can contribute to healing. Encouraging patient narrative can be achieved in other ways as well.

The simple act of sitting at a patient's eye level while communicating has demonstrated that patients perceive the clinician as having spent more time with them and demonstrated more compassion (Strasser et al., 2005; Swayden et al., 2012). In Wysong and Driver (2009), nurses with positive interpersonal skills were rated by their patients as more highly competent than nurses with fewer interpersonal exchanges with the patient. In other words, kindness, compassion, honest communication (narrative), and

a smile that engages the patient as an integral part of their own care can help the patient to feel safe and comforted.

A neuroanatomist, and researcher–turned stroke patient, who was unable to verbalize for many months, later wrote that she perceived members of her healthcare team with either a positive or negative aura around them depending on their approach and interaction with her (Bolte–Taylor, 2006). Bolte–Taylor explains how she felt unsafe in the presence of staff that entered her room and did not attempt to communicate or interact with her and just went about their work, even if that work was competently performed. And physician–turned patient Deborah Cohen went viral on YouTube™ when she asked her surgical team to dance with her in the operating room prior to her surgery. After the surgery, Cohen explained she wanted to connect on a human level with her surgical team prior to being seen as the patient (Leibovich, 2013). Cohen shared an experience with her surgical team to create a personal, positive, healing, human connection.

Surgeon Atul Gawande speaks of the lack of shared human connection towards the end of life when he states, "how we treat our old and frail–leaving them to a life alone or isolating them in a series of anonymous facilities, their last conscious moments spent with nurses and doctors who barely knew their names" (Gawande, 2014, p. 14). Burger (2018) restates what his mentor and friend, Elie Wiesel, once told him; our stories define ourselves. In an interview, Wiesel remarked "Because people who meet us, who listen to us, we make them into witnesses, and to listen to a witness is to become one" (Morrison, 2013). Wiesel brilliantly provides the narratives of his experiences throughout his writings. While these are not medical narratives they are narratives nonetheless, and are powerful reminders of the strength of story–telling in preserving others' experiences as

contributions to knowledge, history, and identity; as in a story of a prisoner of war so consumed by hopelessness, hunger, and desperation that he drank from an unattended soup kettle knowing that death was the certain consequence (Wiesel, 1958).

Gawande (2007) discusses the inadequacies of his training in medical school as he navigates his way through his first patient examinations. He explains that the patient–provider relationship begins with human interaction which he and his peers were not taught in medical school (*Ibid.*). As he fumbled through his first patient examinations, he came to realize that the proficiency with which the physician develops the skill of human interaction and communication determines the extent to which the patient is heard by the physician, and can influence the level of trust between each (*Ibid.*).

Lamas (2018), writes of a patient she attended while she was a medical resident. Lamas followed her medical training, ran lab tests and procedures and, yet, could not discover the cause of the 90–year–old patient's anemia. Day after day the patient asked to go home and day after day Lamas explained to him why he must stay (*Ibid.*). At this point in her medical career, Resident Lamas had not learned to interact with the human being in the bed and admits feeling offended at the patient's continual requests to go home, which she perceived as her own failure as his physician (*Ibid*.). Lamas even went so far as to order a psychiatric consultation to determine the competency of the patient (*Ibid.*). Eventually, the patient got his way and many months later the patient's son visited and thanked Lamas for letting his father leave the hospital and go home, explaining how, after a life well–lived, his father was much happier being home and dying in his own bed (*Ibid*.). It was at that moment of understanding the patient's

narrative, through the son, that Lamas realized survival was not all that mattered, and medicine's complexities can obscure the desires and priorities of the patient (*Ibid.*).

Yet medical narrative and narrative in general, has its critics, such as Strawson (2004) who opposes narrative on the basis that it is a misconception of a self–obsessed world which builds present and future identity on past experiences. Strawson prefers episodic life, which he defines as one in which an individual is free from the constraints of an identity mired in memory by living in the moment and accepting the future however it presents itself (*Ibid.*). Strawson believes that narrative life is too limiting, and that episodic life is liberating (*Ibid.*). His existential, almost nihilistic, view of narrative further explains that emotion has no place in autobiographical memory, story–telling is not essential to feeling like a whole human being, nor is it necessary for a good life (*Ibid.*). Strawson makes an interesting point, explaining that autobiographical memory is not reliable, because every telling of a story slightly changes the version and moves farther from the original truth (*Ibid.*).

Like Strawson, Woods (2011) expresses many concerns regarding the use of narrative in medicine, stating that narrative as a linear story line may unnecessarily disturb those that do not fit the narrative model, such as Strawson's "episodic" individuals. In this context, both Strawson and Woods argue that there are many episodic people that are distressed when asked to conform to the more popular narrative way of viewing life. Atkinson (2009) states that, while narrative helps to gain perspective on various aspects of illness, methodical approaches are still needed to evaluate treatments for the larger population. Atkinson and Delamont (2007) explain that narrative needs to

be subjected to systematic analysis. Sartwell (2007) applauds individual narrative but believes it is self–limiting in its generalization.

However, Bruner (1991) explains that narrative helps to construct reality, whether that reality is an individual's life, a society or culture, or a business or government system. While Strawson (2004) criticizes narrative because the version of a story may change with each telling, Bruner (1991) points out narrative is often more important for the reason the story is being told, rather than its verifiability. Grace (1987) believes language is the fundamental tool in the social construction of reality, which he refers to as the linguistic construction of reality. Grace states we can only experience reality through our limited senses, so "all we can do is theorize about reality, to construct models of it. These models are our constructed realities, and they are reflected in the languages we speak" (*Ibid. p. 6*). Language allows us to perceive and respond to our environment and form our reality in terms of ourselves and our surroundings (*Ibid.*). We then preserve our version of reality by relaying it through story–telling to others (*Ibid.*). And, while stories may change over time, it is the story–telling, itself, which is the framework upon which social reality is constructed (*Ibid.*). In other words, an individual's narrative, including their illness narrative, is a part of that individual's experience and, therefore, a part of their personally–constructed reality.

1.9.1 Narrative and Motivational Interviewing.

In this research, the potential influence of narrative is the foundation of bedside counseling for addiction recovery. It is a way to understand what the patient and the provider are experiencing or experienced. In today's world of Internet–based medical

applications and technology–based diagnosis, treatment, and research, narrative struggles to remain a practical component in the development of a patient–provider therapeutic relationship. The behavioral therapies seem to be the last stronghold of narrative.

The bedside counselors in this research study were specifically trained in Screening, Brief Intervention, and Referral to Treatment[1] (SBIRT), which is based on Miller's 1983 landmark work on motivational interviewing. Motivational interviewing is a key concept in SBIRT and after each of the counselors received SBIRT training they were also given a copy of Miller's 1983 article. The counselors' primary goal when approaching a conversation with an informant was to build a therapeutic relationship, even if only for a brief intervention, in which the informant felt secure enough to express their true feelings about their alcohol or drug misuse, which, in turn, would help the counselors to make appropriate suggestions as to the best treatment services for the informant. The counselor's ability to listen to narrative and use it to motivate the informant also helped the informant to gain self–awareness through the insight provided by talking about their addiction.

For purposes of this research, narrative is viewed from the perspective of both patient and clinician. While narrative can enrich and enhance the experience for the patient, it can also maximize the clinician's investigative process through the procurement of vital illness-related information. In the current economic environment of the American healthcare system, demonstrating cost-effectiveness is a necessity. All healthcare workers are under time–constraints, so an understanding of optimizing a brief

[1] The Screening, Brief Intervention, and Referral to Treatment (SBIRT) tool was designed by the US Substance Abuse and Mental Health Services Administration (SAMHSA). All counselors were trained in SBIRT (Appendix G). SBIRT is based on Miller (1983) motivational interviewing, a technique also used by the counselors.

alcohol intervention for both the patient and clinician is imperative. In order to fully understand the benefit of narrative in this research, and ultimately, apply the knowledge in a pragmatic way, the benefits to both the patient and the clinician need to be studied.

To give some background on the importance of motivational interviewing in the narrative process, Miller (1983) describes the traditional model of alcoholism counseling as placing the success of the patient's recovery in the hands of the counselor and the blame of failure in the hands of the alcoholic. This imbalance of power leads to the alcoholic's learned helplessness. Learned helplessness is a situation in which the alcoholic feels powerless over their addiction and feels they must rely on the counselor to make decisions for them. This, in the mind of the alcoholic, then alleviates some of their ultimate responsibility for recovery by placing it back on the counselor, a set–up for recovery failure. In this learned helplessness model, the counselor benefits psychologically by his or her sense of omnipotence and this, in turn, can lead to a less–than therapeutic relationship between counselor and patient. Not unlike Singer's (2004) and Frankenburg's (1980) viewpoints discussing medicalization causing a shift in the power over illness control from patient to physician.

Maintaining equality within the informant–counselor relationship is an important aspect of motivational interviewing and the use of narrative. According to Miller (1983), social psychologists have long believed that "direct argumentation is absolutely the worst way to change the opinion of another person" (*Ibid. p. 151*) because as the person verbally defends themselves they actually become more committed to their position. In other words, the traditional method of putting an informant in the position of defending their addiction or negative consequences from alcohol misuse will only strengthen the

informant's position as the informant tries to retain power in the relationship and the counselor attempts to usurp it. Miller theorizes, and provides much support, that the concept of a client's denial of having an addiction is more a product of the way counselors relate to their addicted clients rather than a specific personality trait linked with addicts as a group. Miller describes affirmation by counselor to client as an active process. As Miller (1983) explains:

> The motivational interviewing approach expresses overt as well as implicit respect for the individual, and seeks attributions which elevate self–esteem…The motivational interviewing approach heavily emphasizes personal efficacy, internal attribution, and choice. The person is seen not as helpless over alcohol or dependent on others for judgment and direction, but as capable of redirection and responsible choice…In the presence of an affirmative atmosphere that encourages self–esteem and self–efficacy. (Miller, p. 158)

In this research, the bedside counselors, through SBIRT training and motivational interviewing, worked to avoid the traditional power shift from informant to counselor. Miller's motivational interviewing technique works to minimize use of the traditional labels of *alcoholic* and place responsibility of awareness of the addiction solely on the addict. The addicted are also motivated to accept responsibility, which includes the ability to change their addictive behavior. The counselor's primary responsibility is to offer positive motivational tools as a response to narrative, such as emotional support or reaffirmation of positive statements, and be a source of reference as to non–addictive behavioral choices and treatment guidance. The ultimate goals of motivational interviewing are to: increase an addict's self–esteem and self–efficacy, increase their comfort level towards positive change, and decrease their comfort level towards complacency. Narrative is essential to Miller's technique as the strength of the

therapeutic relationship rests on the counselor's ability to pull positivity from the patient's story and use it to reinforce a therapeutic self–assessment within the patient.

CHAPTER 2

METHODOLOGY

This chapter focuses on the methods used to conduct the current study. It includes an overview of the study design, sample population, informant recruitment, data collection and process, data analysis, bias, and ethics.

2.1 Study Design

This was a descriptive, comparative interventional mixed methods study examining outcomes of readmissions and lengths of stay for individuals admitted as medical inpatients to a suburban acute care medical center with a current, or history of, alcohol or drug misuse. This study also examined the methods used to identify the inpatients at the medical center that were admitted with current, or history of, alcohol misuse, and how that identification process impacts treatment for alcohol withdrawal symptoms.

2.2 Sample

2.2.1 Site Selection.

The medical center where this research took place is a large suburban 650-bed level I regional trauma hospital. The seven units of the hospital were chosen to participate in the study period because they had been identified as receiving roughly 30% of the

non–trauma alcohol and substance misuse inpatient admissions during the retrospective chart review. These hospital units included in the study were: two general medical units, one cardiac telemetry unit, one medical step–down unit, one medical respiratory unit, one medical neurology unit, and one orthopedic unit.

2.2.2 Sample Selection.

All individuals admitted as inpatients with alcohol or substance misuse diagnoses, or past medical history related to chronic or acute alcohol or substance misuse to these seven units formed a potential sample of informants for the study period. The potential study group of informants was further refined by limiting inclusion to patients 18 years of age or older that were conscious, alert, not cognitively–impaired[1], not physically aggressive[2], and English–speaking[3]. Informants with a diagnosis requiring medical isolation were excluded, as the counselors were not permitted by the medical center to enter isolation rooms[4]. There was a presumed reduction in bias in the first stage of informant recruitment, since the Principal Investigator, the Co–Investigator, or any of the bedside addiction counselors, involved in this study had no control or knowledge concerning which informants would be admitted to which units.

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[1] In order to give verbal consent, an informant must be of legal adult age (18 years or older) and capable of understanding the consent process and their right to refuse participation in the study.

[2] Physical aggression can occur during alcohol withdrawal. To protect the safety of the counselors, physically aggressive individuals were excluded from the study.

[3] Counselors were English–speaking.

[4] As volunteers, and for their own safety, the counselors were not trained or permitted to enter medical isolation rooms.

The population from which the potential study group was selected included individuals admitted as medical inpatients to the hospital with alcohol or substance diagnoses (Appendix D), or past medical history[5] related to chronic, or acute, alcohol or substance misuse, a PAWSS[6] score of two or greater (≥2), or a positive blood alcohol content[7] level.

2.2.3 Informant Recruitment.

All informants admitted as inpatients to the seven participating units of the medical center were included in the study sample for potentially receiving the intervention of bedside counseling. To reduce counselor bias, the Principal Investigator randomly assigned the counselors to units each day of the study based on which counselors were working on a particular day and how many informants needed to be seen. Just prior to going to their assigned unit, a counselor was given informant name, room number, medical record number, and Prediction of Alcohol Withdrawal Severity Scale (PAWSS) score as initial information.

Counselors proceeded to their assigned unit and first contacted the informant's primary nurse to determine if the informant was available for counseling[8] and if the

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[5] Past medical history as found in: physician records, consultations, assessments, and patient self–report.

[6] The Prediction of Alcohol Withdrawal Severity Scale (PAWSS) has a score range of 0–10. Study inclusion criteria was set at a score of 2 or greater (Appendix I).

[7] Blood alcohol content is a simple blood test to determine intoxication.

[8] Occasionally, the informant was off the unit at a test or procedure and not available to the counselor at that time. If this happened, additional attempts were made to speak with the informant.

informant's current nursing assessment demonstrated the informant's current ability[9] to have a conversation with the counselor. After speaking with the informant's primary nurse, the counselor then spoke with the unit's social worker to derive any additional information[10] about the informant.

Once the counselor determined that an informant was eligible for the intervention of bedside addiction counseling, the counselor knocked on the door of the informants' room, introduced him or herself, and asked for verbal consent from the informant for a brief conversation which included a questionnaire. If verbal consent was given, the informant was then determined to have been recruited as a participant in the study. If the informant did not consent or initially consented and then changed their mind at any point during the conversation or administration of the questionnaire, the counselor thanked the informant for their time, left the room, and the informant was removed from the study.

At the successful conclusion of a completed intervention, the informant was asked if he or she would like another visit from a counselor during the next study day. If the informant was not interested in a second counselor visit, the informant was still included in the study and a note was made by the counselor on their assessment sheet (Appendix E) that no follow–up visit was requested.

A total of 267 informants were recruited for this study, with 125 of those informants receiving the intervention of bedside addiction counseling. All informant

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[9] As can occur during alcohol or substance withdrawal, a patient's health or mental status may temporarily decline.

[10] The Social Worker may have valuable information from the family that can help guide the counselor in how to approach or guide the conversation with the informant.

information was kept in a locked cabinet in the locked office of the Principal Investigator (PI) with only the PI holding the key.

2.3 Data Collection

Data were collected in two ways. First, demographic information, readmission rates, and length of stay were obtained from medical chart review and used to confidentially determine any demographic trends in the alcohol misuse population coming to this medical center for treatment. Second, to understand if bedside addiction counseling had any effect on readmission rates or lengths of stay, the counselors collected information from each informant through counseling sessions. All data collected were de–identified by the Principal Investigator (PI), kept secured in a locked cabinet or encrypted, locked computer, and only aggregated comparative and statistical de–identified results were to be disseminated.

Data collected by the PI included demographics, admissions, length of stay, the informant's Prediction of Alcohol Withdrawal Severity Scale (PAWSS) score, whether or not the informant received a psychiatric consultation, and whether or not the informant was placed on the Clinical Institute Withdrawal Assessment–revised (CIWA–Ar). The data collected by the counselors consisted of the informant's Alcohol Use Disorders Identification Test (AUDIT) score and counselor notes of the informant's narrative that occurred during counseling.

Narrative took place in the form of informant-counselor conversation and administration of the AUDIT tool. Bedside addiction counseling took place over a six–

month period, from December 2016 through May 2017. The relationship between the identification process for the patients with alcohol misuse and their withdrawal symptom treatment, their readmissions and length of stay was examined. The impact of narrative through counselor–patient relationship and communication, about alcohol misuse, on the individual was examined by case study to summarize its potential therapeutic value to both the clinician and the informant. Informants with substance misuse were included in the data since counselors did counsel them and there was potential for them to discharge to recovery treatment and reduce their future admissions and length of stay (LOS). However, the two screening tools used at the medical center focused on alcohol misuse only. There were informants who stated a problem with substance misuse, and not alcohol, that were admitted to the medical center and met study inclusion criteria, such as a positive blood alcohol level. These informants were administered the alcohol misuse screening tools and were included in the data regardless of the results of the screening tools, since many of these informants were admitted for substance withdrawal but also had misused alcohol.

2.3.1 Instruments Used for Data Collection

2.3.1.1 Prediction of Alcohol Withdrawal Severity Scale.

The Prediction of Alcohol Withdrawal Severity Scale (PAWSS) is a ten–question assessment tool administered by the Registered Nurse (RN) to every patient admitted to an inpatient unit at the medical center (Appendix I). Each of the ten questions has a score of one point, for a maximum score of ten. This medical center uses the PAWSS tool as a means to identify alcohol misuse patients and their potential for experiencing alcohol

withdrawal symptoms. The process includes the RN administering the tool by asking the patient the ten PAWSS questions as part of the inpatient admission assessment. If the patient scores a two or greater (≥2) on the PAWSS scale, the RN is expected to notify the physician for further assessment of alcohol misuse and the potential for alcohol withdrawal symptoms. Currently, this is the only screening for alcohol misuse used by RNs at this medical center. Other than the PAWSS screening tool, the medical center relies on patient self–reports, blood alcohol content results and overt signs of intoxication or withdrawal to identify alcohol misuse patients.

PAWSS consists of three sections and was created after an extensive literature search and systematic review of current tools used to assess alcohol withdrawal syndrome (AWS) in medical patients (Maldonado et al., 2014). According to Maldonado et al., (2015), by determining a threshold alcohol misuse score of four or greater (≥4), the PAWSS tool demonstrated 93.1% sensitivity with a 95% confidence interval when administered by multiple individuals to a sample of 403 patients. It is important to note that the medical center involved in this research designates a PAWSS score of two or greater (≥2) as identification of potential AWS and alcohol misuse.

Section One of PAWSS is the threshold criteria and asks if the subject has consumed alcohol in the last 30 days. If the answer to Section One is "No", then the PAWSS scale is considered completed and no further questions are asked. A patient answering "No" is considered not at risk for AWS. If the answer in Section One is "Yes", then Section Two of PAWSS is administered. Section Two of PAWSS is the patient questionnaire section, and the patient is asked to answer seven questions about their alcohol consumption.

Section Three of PAWSS must be answered by the RN, and includes any documented blood alcohol level of the patient and the RNs evaluation of the patient's autonomic activity. Some examples of autonomic activity seen in patients going through alcohol withdrawal can include sweating, shaking, pressured speech, and the inability to concentrate. The RNs evaluation of the patient's autonomic activity is a customary part of the RNs admission assessment.

2.3.1.2 The Clinical Institute Withdrawal Assessment.

The Clinical Institute Withdrawal Assessment–revised (CIWA–Ar) is a set of physician order options used to treat alcohol withdrawal symptoms (AWS). Physicians use their assessment skills, patient test results, and the RN's PAWSS score of the patient to determine if there is potential for the patient to experience alcohol withdrawal symptoms (AWS). If the physician believes there is potential for AWS, then the physician checks off the orders they want the Registered Nurse (RN) to follow for that particular patient. The CIWA–Ar order set (Appendix F) includes requests for psychiatric or social work consultations, vitamin supplementation, fixed–dose and symptom–triggered medication administration for AWS. In order for the RN to administer symptom–triggered medications, the RN must complete the CIWA–Ar evaluation associated with the order set, which includes evaluation of the patient's level of: nausea or vomiting, tremors, sweating, anxiety, agitation, tactile disturbance, auditory disturbance, visual hallucinations, headache, and confusion.

Withdrawal from alcohol is more life–threatening than withdrawal from other drugs, such as opiates, inhalants, benzodiazepines, amphetamines, and cannabis (WHO,

2009). It is important to this research to determine if the patients identified as potentially experiencing AWS through PAWSS scores, who became study participants and were also identified by counselors as potentially misusing alcohol through administering the Alcohol Use Disorders Test (AUDIT), were appropriately placed on the CIWA–Ar order set protocol.

2.3.1.3 Alcohol Use Disorders Identification Test.

The medical center where this research took place does not administer the Alcohol Use Disorders Identification Test (AUDIT) to the patients that score a two or greater on the RN–administered Prediction of Alcohol Withdrawal Severity Scale (PAWSS). Currently at the medical center, the AUDIT tool (Appendix C) is administered exclusively by psychiatrists and psychiatric nurse practitioners and only during a psychiatric consult. The bedside addiction counselors providing the intervention during this research administered the AUDIT tool to every informant they counseled.

AUDIT was created by the World Health Organization and is a reliable, valid tool with high internal consistency (Cremonte, Ledesma, Cherpitel, & Borges, 2010; Meneses–Gaya, Zuardi, Loureiro, & Crippa, 2009). The AUDIT tool is a series of 10 questions regarding alcohol consumption, and consequences, with each question scored from 0–4 with a possible total score of 40, and scoring is broken down as follows:

0–3 = no issue with alcohol
4–7 = no further action required
8–15 = at risk; conduct brief intervention
16–24 = moderate alcohol use disorder; conduct brief intervention
25–40 = severe alcohol use disorder; referral to treatment

For purposes of this research, and in accordance with the AUDIT scoring recommendations, only informants with an AUDIT score of eight or greater (≥8) were considered to be at–risk for alcohol use disorder. The bedside counselors, through their Screening, Brief Intervention, and Referral to Treatment, known as SBIRT, training (Appendix G) followed the AUDIT recommendations accordingly, as shown above, from conducting a brief intervention to a referral to treatment.

2.3.2 Counselor Training

Although the medical center's Institutional Review Board (IRB) determined this study to be a quality improvement project and not human subject research, it still involved human subjects, so the Principal Investigator required that all counselors be trained in the human subject and ethics sections of the Collaborative Institutional Training Initiative (CITI). Also, because the counselors were instrumental in data collection, as they were the individuals having the addiction recovery conversations with the informants and were also administering the Alcohol Use Disorders Identification Test (AUDIT), counselors were trained in Screening, Brief Intervention, and Referral to Treatment (SBIRT)[11] and followed a scripted opening[12] to each conversation with each informant.

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[11] The Screening, Brief Intervention, and Referral to Treatment (SBIRT) tool was designed by the US Substance Abuse and Mental Health Services Administration (SAMHSA). All counselors were trained in SBIRT (Appendix G). SBIRT is based on Miller (1983) motivational interviewing, a technique also used by the counselors.

[12] The scripted conversational opening (Appendix H) is based on SBIRT and Miller (1983).

The study utilized seven counselors who were doctoral candidates in either clinical psychology (PsyD) or general psychology (PhD). For all of these counselors, this study met one of the requirements towards earning their doctorate. Some counselors had already successfully defended their dissertations and needed to complete this internship to complete their requirements for graduation while others were still in the dissertation writing process.

Counseling occurred between 12:30pm and 3pm, Tuesday through Thursday, each week during the study period. Because these counselors had other obligations they did not participate every day of every week; counselors were divided up and the same groups repeatedly came the same day each week. In other words, counselor groups consisted of the same three counselors every Tuesday, another two every Wednesday, and the last two every Thursday. A portion of the risk of counselor bias for informants may have been reduced if the informant wanted additional counselor visits, since it would most likely be a different counselor making narrative notations in the study records.

A scripted opening (Appendix H) was initiated by the counselor with the informant, during which verbal consent from the informant was requested. If verbal consent was obtained, once the conversation between the counselor and informant was under way the counselor made brief notes on a standardized data collection form, which included the informant's AUDIT score, and any important information gained through informant narrative. Counselors familiarized themselves with the standardized data collection form prior to the study.

After the counseling session with the informant, the counselors were trained to return the completed form to the Principal Investigator (PI), who kept the forms in a

binder in a locked cabinet in a locked office. If the informant requested a follow–up counselor visit, the next counselor was randomly assigned by the PI and provided the current counselor with access to the last counselor's notes to help guide the counselor's conversation with the informant. Since each subsequent visit to an informant was made by a different counselor, all counselors were trained to begin every informant contact with the scripted introduction and request for verbal consent from the informant to begin the counseling session.

Prior to the initiation of the study, the PI held a meeting and explained to all study personnel: the study plan, background, rationale, inclusion and exclusion criteria, the processes of informant recruitment, counseling, and documentation, and reporting of adverse events. A protocol binder defining every step of the study and all coding of information was kept in a locked cabinet with only the PI and Co–Investigator holding the keys; this allowed the study to continue if the PI was not available. All collected and de–identified data was transcribed into an encrypted Excel® spreadsheet and kept on a locked computer in a locked office with only the PI and Co–Investigator holding the passcode.

2.3.2.1 Counselor Training for Adverse Study Events.

Because withdrawal from alcohol or substances can have emotional components, adverse events did not include the informant becoming sad, angry, mildly belligerent, expressing denial, or any demonstrations of emotion unless it involved aggression or marked agitation where either the counselor was told to leave the room by the informant or the counselor felt unsafe due to the informant's words or actions.

If, at any time, the informant expressed suicidal or homicidal thoughts or plans, the counselor followed a process created by the Chair of the Psychiatric Department and the Crisis Counselor of the medical center, who were advisors on this study. This process required immediate face–to–face notification of the thought or plan expressed by the informant to the informant's primary nurse and unit social worker, and direct verbal communication with both the hospital Crisis Counselor and the informant's physician. After ensuring all parties were notified, and the patient and surrounding environment was safe per the medical center's established protocols, the counselor would not revisit the informant and the informant was removed from the study.

2.3.3 Data Collection Periods

This research consists of three data collection periods. The time frame of all three of these periods is the same and was chosen for its significance. Within the timeframe of December through May there are several holidays that may contribute to an increase in alcohol consumption in some individuals. These holidays include Christmas, New Year's, Valentine's Day, and St. Patrick's Day.

The first data collection period was a retrospective chart review of patients that would have met study inclusion criteria, had the study been underway at that time, from December 2015 through May 2016. The findings of this retrospective chart review helped determine if the patients admitted during the study period were a group consistent with the typical patient seeking treatment at this medical center that had underlying, or overt, alcohol misuse issue.

The second data collection period was the study period in which the intervention of bedside addiction counseling took place, and occurred from December 2016 through May 2017.

The third data collection period, the one year–post period, occurred from December 2017 through May 2018. This third data period allowed identification and comparison of readmission rates and length of stay of the patients that were counseled during the study period.

For ease of reference, the three periods are provided in the table below.

Table 1. Three Data Collection Periods and the Purpose of Each Period.

Data Collection Period	Timeframe	Purpose
Retrospective Chart Review	December 2015 through May 2016	To compare demographics with study group
Study Period	December 2016 through May 2017	To provide the intervention of bedside addiction counseling.
1 Year–Post Period	December 2017 through May 2018	To assess readmissions and length of stay one year after the study intervention.

2.3.4 Study Variables

Demographic variables, such as: race, age, sex, hometown, primary language, primary contact, employment status, and insurance status were collected to help identify patient trends, better understand this patient group, and plan community outreach programs. The manager of the medical center's Community Health Department was an advisor on this study. In this dissertation, only the demographics reflecting a significant majority of the sample will be discussed. All de–identified demographics have been reported to the medical center.

Other variables identified include whether or not the patient was evaluated using the medical center's Prediction of Alcohol Withdrawal Severity Scale (PAWSS) evaluation tool (Appendix I), if the patient was appropriately placed on the Clinical Institute Withdrawal Assessment–revised (CIWA–Ar) physician order set to treat alcohol withdrawal symptoms (Appendix F), and the patient's score on the Alcohol Use Disorders Identification Test (AUDIT) (Appendix C) and how the patient's AUDIT score correlates to the patient's PAWSS score. These variables are important to determine the extent that hospital staff utilized available and appropriate alcohol misuse screening tools, alcohol withdrawal assessment forms, and alcohol withdrawal treatment protocols.

2.4 Data Analysis

2.4.1 Outcome Measures.

A primary positive outcome of bedside counseling was defined as a decrease in rate of admissions and length of stay (LOS) of counseled informants during the one year–post period as compared to the study period. It was determined that many factors play a role in addiction recovery and the most effective way to determine a positive effect from bedside addiction counseling and informants' motivation to change addictive behavior is to measure subsequent admission rates and LOS. Due to limitations in the IRB approval, informants were not contacted after discharge; therefore, the proxy of informant readmissions and LOS was used to suggest correlation between bedside counseling and its potential impact on seeking recovery after discharge.

The secondary outcome measure was the comparison of each informant's scores on the Prediction of Alcohol Withdrawal Severity Scale (PAWSS) and the Alcohol Use Disorders Identification Test (AUDIT). The medical center where the study took place uses only the PAWSS on a regular basis to identify alcohol withdrawal symptoms (AWS) and also to help identify patients with potential alcohol use disorders (AUD). Comparing these scores helped determine if the medical center's use of PAWSS was accurately identifying all patients at risk for AUD.

2.4.2 Data Management.

Prior to the data analysis, the data (100%) were reviewed by the Principal Investigator (PI) for missing data and outliers. De–identified data were transmitted via a secure computer link to a statistician for confirmational statistics. At the end of the study, all data, previously de–identified, were kept in a locked cabinet in a locked office with the PI holding the key and is marked for shredding with a date equal to seven years after the completion of the study.

2.4.3 Data Analytic Methods.

Descriptive statistics and proportional analysis were used to describe demographic characteristics of the group of potential informants. Proportional analysis was also used to determine a correlation with scores on the Prediction of Alcohol Withdrawal Severity Scale (PAWSS) and the Alcohol Use Disorders Identification Test (AUDIT).

The nonparametric Wilcoxon Sign Rank test was used in a paired analysis comparing total number of counseled informants' admissions during the study period and the one year–post period. The nonparametric Mann Whitney test was used to analyze the difference in length of stay (LOS) for counseled informants from the study period to the one year–post period. The *a priori* setting of $p \leq 0.05$ was used for both the Wilcoxon Sign Rank and Mann–Whitney tests, which demonstrates that the statistical significance has a 95% probability that the observed difference between the two groups is not due to chance. Minitab® Version 17 was used for statistical analysis.

2.5 Bias

While this study was not a randomized controlled trial, the Principal Investigator (PI) attempted to randomize informant and counselor pairings to reduce potential bias. Each counselor worked the same day each week, which helped to randomize visits and achieve inter–rating reliability of counselors. If an informant was admitted on a Monday and not discharged until Friday, the informant could potentially see three different counselors, and would not see the same counselor twice because of the counselor's schedules.

Informants that were admitted to the hospital as medical inpatients were assigned to units by an independent department not aware of the ongoing study, limiting sample selection bias. Counselors completed a pre–designed counseling notation form and were trained to give their professional assessment of the informant's narrative and no personal comments or opinions of the informant. In this way, the next counselor performing a

subsequent visit was reading professional psychological notations to guide a conversation, and not a potentially biased counselor report of the informant or his or her narrative.

Bias is also a concern for the counselors towards the counseling process and towards the informant as an individual, and on the part of the informant towards the counseling process and towards the counselor as an individual. There is also concern for any unspoken yet conveyed coercion sensed by the informants, whether it is in the dress, mannerisms, word choice, tone of voice, or visual cues used the counselors. Counselors may unknowingly bias results by allowing personal interpretations to shape their written assessments. Something seemingly as subtle as the verbal delivery of the AUDIT tool could affect an informant's answer. An informant's state of withdrawal at the time of the counseling may also bias results. An informant experiencing anxiety may give shorter responses and narratives than when the anxiety diminishes. To try and reduce this bias, the counselors offered to re–visit all informants to give them an opportunity to talk more when they felt more comfortable.

Reducing the Hawthorne effect must also be considered; for some informants may answer in a manner that they believe the counselor wants to hear. Yet others may give false stories because they just want the counselor to leave and they don't want to appear uncooperative. Other informants may appear willing to speak with a counselor because they fear retribution if they refuse.

2.6 Ethics

There are several ethical concerns regarding this study. Informant privacy of health information and narrative statements must be considered. Also to be considered is the informant's right to refuse to participate before, at any time during, and even after, the study.

2.6.1 Informant Confidentiality.

To maintain confidentiality, the Principal Investigator (PI) assigned code numbers to the data. Coded patient identifiers and medical record numbers were stored in one locked cabinet; these records are necessary to follow the readmission trends of informants. All collected data were coded and de–identified and stored on a password protected, locked computer. Only two Collaborative Institutional Training Initiative (CITI)–trained study team members, the PI and Co–Investigator, were allowed supervised access to the coded data set for purposes of data input.

Verbal permission to have a discussion at the bedside was requested for the bedside addiction counseling and administration of the Alcohol Use Disorders Identification Test. During the verbal permission process, confidentiality of informant information was discussed by the counselor and an understanding of confidentiality was confirmed with the informant.

2.6.2 Informant Autonomy.

If the informant initially refused to speak with a counselor or changed their mind at any time during the conversation and refused to continue, the counselor was trained to politely thank them for their time and leave the room. The informant was then removed from the study.

Occasionally, an informant would initially refuse or change their mind once the conversation began due to fatigue or feeling ill. If this informant at any time changed their mind and requested to be seen by a counselor, they were added back into the study and seen. When an informant demonstrated or verbalized interest in pursuing recovery options after discharge, the counselor would give them a list of referrals (Appendix J). The decision and initiation of contact with an addiction recovery program after discharge was left to the informant.

If the informant verbalized a desire to discharge directly from the hospital to an inpatient addiction treatment program, the social worker was informed and followed up with the informant, physician, and insurance carrier to try and make that happen. Once the informant chose an inpatient addiction treatment program of interest to him or her, then the social worker worked with the informant's insurance carrier to get approval for admission. If, at any time during this process, the informant decided against discharging directly to addiction treatment, the social worker would notify the informant that if he or she changed their mind and wanted to go to the facility to just let the social worker know and they would continue the planning process. At no time was the informant coerced to pursue any form of addiction recovery services or a conversation with the counselor, as

the hospital is not a confinement institution, and the Patient Bill of Rights"[13] is displayed in each room.

Counselors were trained in Screening, Brief Intervention, and Referral to Treatment (SBIRT), which includes Miller's (1983) motivational interviewing techniques. By following the scripted conversational opening and the motivational interviewing techniques of SBIRT, the counselors were aware that the informant was to guide the conversation, with the counselor picking up on clues and reinforcing positive motivational statements made by the informant (Agerwala & McCance–Katz, 2012).

Every effort was made to ensure counselors were trained and aware that addiction recovery is a decision to be made by the informant, and their role in counseling was to listen, reinforce, and motivate the informant towards the goal of seeking addiction recovery at discharge, leaving the informant's autonomy intact.

2.6.3 Institutional Review Board.

The medical center's Institutional Review Board (IRB) approved this study (Appendix K) and Drew University accepted (Appendix L) the medical center's IRB approval. The study period which included the IRB approved intervention started on December 6, 2016 and ended May 25, 2017.

[13] The Patient's Bill of Rights is a part of the Affordable Care Act of 2010 and is a set of protections that guarantees patients the right to: receive care, refuse care, privacy, know the identity of all healthcare personnel, an explanation of care, informed consent, refuse to participate in research projects, and respectful treatment.

CHAPTER 3

RESULTS

I conducted this study to understand if bedside addiction counseling utilizing narrative would motivate counseled informants to seek addiction recovery after discharge from the medical center. The primary research question being explored is: 1) how does bedside addiction counseling reduce the patient's number of readmissions and length of stay? The secondary research questions are: 2) in what way can the medical center improve the process of identifying and treating patients with addiction? 3) What steps can be taken to improve awareness, and lessen stigma, of alcoholism in America?

3.1 Demographic Comparison of Retrospective and Study Groups

As identified in Table 2, the retrospective chart review group was made up of 975 individuals, and the study group was made up of 878 individuals. The majority of both groups lived within a 20–mile radius of the medical center, 95.5% in the retrospective group and 94.8% in the study group. The majority of individuals were admitted for alcohol misuse diagnoses that indicate alcohol intoxication, dependence, or withdrawal, 85.5% in the retrospective group and 85.7% in the study group. The age ranges for the retrospective and study groups were 18–93 (with a median of 44) and 23–86 (with a median of 41), respectively. In both groups, retrospective group and study group, respectively, most individuals were white (69.8% and 67.5%), English–speaking (84% and 81.3%) males (71.4% and 76.6%). The number of each group that was admitted to

the seven units participating in the study was similar, 30.3% for the retrospective group and 30.4% for the study group.

Through comparing the retrospective chart review group and the study group, it was determined that the sample of potential informants in the study group was characteristic of a group admitted to this medical center for alcohol misuse.

Table 2. Comparison of Demographics between Retrospective Group and Study Group

		Retrospective Group Dec 2015–May 2016	Study Group Dec 2016–May 2017
Total Individuals		100% (975)	100% (878)
Living within 20–mile radius of medical center		95.5% (931)	94.8% (832)
Have ICD–10 codes for alcohol misuse		85.5% (834)	85.7% (753)
Median age (min–max)		44 (18–93)	41 (23–86)
Race	White	69.8% (680)	67.5% (593)
Sex	Male	71.4% (696)	76.6% (646)
Language	English	84.0% (819)	81.3% (740)
Total patients admitted to units participating in the study		**30.3% (295)**	**30.4% (267)**

3.2 Total Potential Study Group and PAWSS administration

Referring to Table 2 above, I felt it was important to discuss the total group of potential informants, which equaled 878 patients, of which 30.4% were admitted to inpatient units participating in the study and 69.6% were admitted to non–participating inpatient units. After removing the 125 counseled informants from the total of 878, I had a subset of 753 patients that did not receive bedside addiction counseling for a variety of reasons, including their admitting unit, or not meeting the study's inclusion criteria.

As reported in Table 3 below, of that subset of 753 patients admitted to an inpatient unit of the medical center, which would trigger the required administration of PAWSS as part of the Registered Nurse's (RN) admission assessment, 584, or 79%, did not have a PAWSS score. Because bedside counselors did not see any of these 584 patients, only patients that received a psychiatric consultation may have had AUDIT administered; and, of those 584 patients, 440, or 75%, did not receive a psychiatric consult, so would not have an opportunity to complete an AUDIT tool. Coincidentally, only 31% of these 440 patients were placed on the Clinical Institute Withdrawal Assessment–revised (CIWA–Ar) physician order set for alcohol withdrawal symptoms (AWS). It is very possible that many of the 69% of the 440 patients may not have needed either a psychiatric consult or medications for AWS, and it is the medical physician's responsibility to place a patient on CIWA–Ar when they feel it is appropriate, rather than being the psychiatrist's responsibility.

In summary, Table 3, below, illustrates the underlined and bolded table contents indicating a positive correlation between patients being administered the PAWSS screening tool and being placed on the CIWA–Ar protocol for alcohol withdrawal.

Table 3. Total Study Group – Comparison between Potential Relationship of Psychiatric Consult, PAWSS Administration, and Initiation of CIWA–Ar

Did the patient get a psychiatric consult?	**Did the patient have the PAWSS administered?**	**% of patients placed on CIWA–Ar**	**% of patient NOT placed on CIWA–Ar**
No	**No**	21%	**79%**
No	**Yes**	**84%**	16%
Yes	No	53%	47%
Yes	**Yes**	**80%**	20%

3.3 Counseled and Non–Counseled Group Findings

As demonstrated in Table 2 in Section 3.1 above, of the 878 individuals admitted to the medical center during the study period, 267 were admitted to the seven units that participated in the study. The study period had two groups of informants on the participating units, counseled and non–counseled informants, as determined by inclusion criteria, counselor availability, and the informant's verbal consent to participate in counseling.

As reported in Table 4 below, there were 125 informants in the counseled group and 142 informants in the non–counseled group. These final totals were determined at the end of the study since informants identified as belonging to the non–counseled group were based on exclusion criteria such as aggressive behavior or refusal to speak with a

counselor. No potential informants were determined to be placed in either category before the counselor spoke to the healthcare staff on the unit and then the informant themselves, if appropriate.

A comparison of demographic data in Table 4 indicates that the groups of counseled informants and non–counseled informants were similar to each other. The majority of all potential informants lived within a 20–mile radius of the medical center, 96.8% of the counseled group and 97.9% of the non–counseled group. The majority of informants identified were admitted for alcohol misuse diagnoses that indicate alcohol intoxication, dependence, or withdrawal, 81.6% of counseled and 76.8% of non–counseled informants. The median age, and age range, of each group was 52 (age range 20–84) for counseled informants and 54 (age range 19–82) for non–counseled informants. In both the counseled and non–counseled groups, respectively, most individuals were white (84.8% and 83.8%), English–speaking (96% and 95.8%) males (76.8% and 60.6%).

Table 4. Comparison of Demographics between Counseled and Non–Counseled Informants on Participating Units

	Counseled	**Non–Counseled**
Total Potential Informants 100% (n=267)	**46.8% (125)**	**53.2% (142)**
Living within 20–mile radius of the medical center	96.8% (121)	97.9% (139)
Have ICD–10 codes for alcohol misuse	81.6% (102)	76.8% (109)
Median age (min–max)	52 (20–84)	54 (19–82)

Race	White	84.8% (106)	83.8% (119)
Sex	Male	76.8% (96)	60.6% (86)
Language	English	96.0% (120)	95.8% (136)

3.4 Narrative Themes, Screening Tools, Admissions, and Length of Stay

Table 5, below, provides a synopsis of narrative trends and corresponding AUDIT score ranges. This table has also been broken down, into Tables 5a, 5b, 5c, and 5d, and presented in each of the sections below, accordingly. Because the full data set is very large, it has been de–identified, abridged, and included as Appendix M. Only some of the informants are discussed at length in the following sections.

Table 5. Informant Narrative Trends and Related AUDIT Score Ranges

	Counseled	# Completed	# Low Risk Score	# Mod Risk Score	# Severe Risk Score
Total individuals	**% of 125 (n)**	**AUDITs**	**AUDIT (8-15)**	**AUDIT (16-24)**	**AUDIT (25-40)**
Intent to Seek Recovery	39% (49)	42	7	13	20
Motivated to Stop Drinking	30% (37)	37	10	11	16
Tried Treatment In the Past	49% (61)	55	7	13	19
Denial of Alcohol Misuse	27% (34)	30	9	3	9

3.4.1 Informant Narrative.

The informants' narratives are discussed in relation to the three at–risk categories for the Alcohol Use Disorders Identification Test (AUDIT), low risk, moderate risk, and severe risk for an alcohol use disorder (AUD). I have also included some informant narrative with the informant's score on the Prediction of Alcohol Withdrawal Severity Scale (PAWSS), whether or not they were placed on the Clinical Institute Withdrawal Assessment–revised (CIWA–Ar), their AUDIT score, whether or not they received a psychiatric consult, and the number of admissions with length of stay during the study period and the one year–post period.

3.4.1.1 Intent to Seek Recovery.

As reported in Table 5a, of the 49 informants in the "intent to seek recovery" category, 42 completed the AUDIT questionnaire. Of the 42 that did complete the AUDIT, two scored in the no–risk category for alcohol use disorder (AUD), seven scored in the low risk category for AUD, 13 scored in the moderate risk category for AUD, and 20 scored in the severe risk for AUD category.

Table 5a. Informants Stating Intent to Seek Recovery and Related AUDIT Scores

			# Low Risk Score	# Mod Risk Score	# Severe Risk Score
Total individuals	**Counseled % (n)**	**# Completed AUDITs**	**AUDIT (8-15)**	**AUDIT (16-24)**	**AUDIT (25-40)**
Intent to Seek Recovery	39% (49)	42	7	13	20

Informants that were actively seeking recovery options after their discharge based on statements made to the counselors were characterized as “intent to seek recovery” by the Principal Investigator. I have included blinded examples of some of the cases below. Informants in the “intent to seek recovery” category made statements to the counselors such as “will go to xxxx Medical Center for alcohol rehab”, “using employee assistance program (EAP) to get into xxxx alcohol rehab”, “wants to go to xxxx outpatient drug rehab”, and “will go to xxxx for alcohol rehab.”

A 26–year–old female informant wanting to go to xxxx Medical Center for alcohol rehab scored a one on the Prediction of Alcohol Withdrawal Severity Scale (PAWSS), did not complete the Alcohol Use Disorders Identification Test (AUDIT), received a psychiatric consultation, and had been admitted twice during the study period for alcohol misuse with a total of 15 days of inpatient stay. This informant was placed on the Clinical Institute Withdrawal Assessment–revised (CIWA–Ar) protocol. This informant had one admission, for a length of stay (LOS) of four days, during the one year–post period.

A 50–year–old female informant using the employee assistance program from her employer to get into xxxx alcohol rehab scored a two on PAWSS, did not complete the AUDIT, did not see a psychiatrist during her admission, and had been admitted once for one day. The informant was placed on the CIWA–Ar protocol, but discharged to her home the day after being seen by the study’s bedside addiction counselor. This informant had no admissions during the one year–post period.

Surprisingly, a 24–year–old female informant wanting to go to xxxx for outpatient drug rehab scored a two on PAWSS, which indicates a low risk for alcohol withdrawal

symptoms (AWS), but did complete the AUDIT with a score of 24, placing this informant in the severe risk category for an alcohol use disorder (AUD), suggesting alcohol dependence. This AUDIT score is surprising since most of the informants with an admitted drug problem did not want to complete the AUDIT, stating their problem was drugs and not alcohol. This informant was placed on the CIWA–Ar protocol and was seen by a psychiatrist during her admission and had been admitted to the medical center twice during the study period for a total LOS of 11 days. This informant had no admissions during the one year–post period.

A 55–year–old male informant, wanting to go to xxxx for alcohol rehab after discharge, scored a three on PAWSS, which placed him at potential risk for AWS, and scored a 32 on AUDIT, the severe risk category that suggests alcohol dependence. This informant saw a psychiatrist during admission and was admitted once for 10 days during the study period. He also told the counselor that his alcoholism caused his separation from his wife and was the motivating factor to seek recovery. This informant had no admissions during the one year–post period.

In an unfortunate case, a 33–year–old female informant was admitted with positive blood alcohol content, was placed on the CIWA–Ar protocol to help with physical withdrawal symptoms, and went through alcohol withdrawal during her inpatient admission. She spoke with the bedside counselors and had strong family support to get help for her alcoholism. Her PAWSS score was four, placing her in an at–risk category for AWS, and her AUDIT score was 30, placing her in the AUDIT severe risk for AUD category, suggesting alcohol dependence. She was not seen by a psychiatrist during her admission. She had been admitted three times during the study period for a

total LOS of 19 days. The counselor informed the social worker of this informant's intent to seek recovery and the social worker secured a bed for her at an inpatient alcohol treatment facility. After several days at the medical center, the woman's insurance carrier denied coverage for inpatient addiction treatment stating the informant was no longer withdrawing from alcohol. Understandably, she was angry and disappointed, making the statement to the counselor "What do I have to do to get help? I guess I have to go out and get drunk again for my insurance to pay for it!" The informant discharged home with her parents and stated she would attend an intensive outpatient rehab program (IOP) once she got home. This informant had no admissions during the one year–post period.

Informants that were categorized as "intent to seek recovery" were anticipated to take a more serious and active approach at planning post–discharge recovery options than informants categorized as "motivated to stop drinking." Curiously, none of the 49 informants that stated intent to seek recovery after discharge actually discharged directly from the medical center to either an inpatient or outpatient addiction treatment program.

3.4.1.2 Motivated to Stop Drinking.

As indicated in Table 5b, 30% of informants stated they were currently motivated to stop their drinking, but are not included in the "intent to seek recovery" category because they made no statements indicating any planning for addiction treatment after discharge.

Table 5b. Informants Stating Motivated to Stop Drinking and Related AUDIT Scores

	Counseled	# Completed	# Low Risk Score	# Mod Risk Score	# Severe Risk Score
Total individuals	**% (n)**	**AUDITs**	**AUDIT (8-15)**	**AUDIT (16-24)**	**AUDIT (25-40)**
Motivated to Stop Drinking	30% (37)	37	10	11	16

A 43–year–old female informant stated she "drinks four to five beers during the week and more on weekends, smokes marijuana two to three times weekly, but wants to cut down on drinking." She was not placed on the Clinical Institute Withdrawal Assessment–revised (CIWA–Ar) protocol, which the physician orders if there is concern for alcohol withdrawal symptoms (AWS). This informant scored one, a no–risk category on the Prediction of Alcohol Withdrawal Severity Scale (PAWSS) and scored a 13, a low risk for alcohol use disorder (AUD) on the Alcohol Use Disorders Identification Test (AUDIT), and had one admission during the study period for a length of stay (LOS) of 10 days. She had no admissions during the one year–post period.

A 67–year–old male informant told the counselor that "he has not worked since November, drinks nightly to relieve anxiety, and is motivated to discontinue drinking." This informant scored a two on PAWSS and a 10 on AUDIT, both scores are in a low risk category. This informant was placed on the CIWA–Ar order protocol for AWS. He did not see a psychiatrist during admission and was admitted just once during the study period for a LOS of three days, with no admissions during the one year–post period.

A 46–year–old male informant told the counselor he "will address my drinking but I won't give up the Vicodin for my chronic leg pain." This informant scored a five on PAWSS, placing him in an at–risk for AWS category, and a 24 on AUDIT, placing him in a moderate risk for AUD category. He was placed on the CIWA–Ar protocol. He had one admission during the study period for a LOS of three days and did not see a psychiatrist at that time. He had no admissions during the one year–post period.

A 72–year–old male informant told the counselor that "I had an alcohol problem from 1990 to 2005. I drink less now because my wife fights with me about it, and I guess I want to be drinking even less." This informant had a PAWSS score of two and an AUDIT score of 10, placing him at low risk for both AWS and AUD. He was placed on the CIWA–Ar protocol and stated he "drinks at least five drinks a day." He did not see a psychiatrist during his admission and was admitted once during the study period for a LOS of three days and was not admitted during the one year–post period.

A 33–year–old male informant told the counselor "this is not my first hospitalization for my drinking but I'm motivated to stop." This informant told the counselor he started drinking at the age of 15 and drinks five to ten drinks a day. The informant scored a six on PAWSS and a 19 on AUDIT, placing him at moderate risk for both AWS and AUD. At a later session, the informant told the counselor he drinks "two handles of vodka a day", a "handle" refers to a 1.75 liter bottle. This informant was placed on CIWA–Ar, saw a psychiatrist, and had one admission for a LOS of four days during the study period. He was not admitted during the one year–post

period.

A 71–year–old female informant told the counselor "I came here for detox and I need help." This informant scored a seven on PAWSS and a 30 on AUDIT, placing her at severe risk for AUD, suggesting alcohol dependence. She was placed on the CIWA–Ar protocol and saw a psychiatrist during the admission. She was admitted four times during the study period for a total LOS of 11 days and was not admitted during the one year–post period.

Interestingly, all of these informants answered the AUDIT questionnaire. Of the 37 responses, 10 scored in the low risk category for AUD, 11 scored in the moderate risk category for AUD, and 16 scored in the severe risk category for AUD. None of these informants scored in the no–risk category for AUD. These informants were very cooperative with the counselors and answered all questions, stated that they were motivated to stop drinking, but stopped short of working with the counselor, physician, or social worker, to arrange for addiction treatment.

3.4.1.3 Tried Treatment in the Past.

As expressed in Table 5c, almost half of the informants, 49%, stated they had tried addiction recovery treatments in the past.

Table 5c. Informants Stating Tried Treatment in Past and Related AUDIT Scores

			# Low Risk Score	# Mod Risk Score	# Severe Risk Score
Total individuals	**Counseled % (n)**	**# Completed AUDITs**	**AUDIT (8-15)**	**AUDIT (16-24)**	**AUDIT (25-40)**
Tried Treatment In the Past	49% (61)	55	7	13	19

"I went to AA [Alcoholics Anonymous] two years ago and found it helpful, I'm not sure if AA or counseling is the best options but I need to slow down, and I would like a list of recovery resources." This 52–year–old male informant scored a six on the Prediction of Alcohol Withdrawal Severity Scale (PAWSS), placing him at risk for alcohol withdrawal symptoms (AWS). He also scored a 16 on the Alcohol Use Disorders Identification Test (AUDIT), placing him at moderate risk for an alcohol use disorder (AUD). He was placed on the Clinical Institute Withdrawal Assessment–revised (CIWA–Ar) protocol and saw a psychiatrist during his admission. He was admitted once during the study period for a total length of stay (LOS) of 37 days, discharged to an addiction treatment program, and was not admitted during the one year–post period. It is interesting that this informant showed little interest in recovery when speaking with the bedside counselor, yet discharged from the medical center directly into an inpatient addiction treatment program.

A 56–year–old male informant stated, "I was in rehab just a year ago, but lost my coping skills." This informant scored in a low risk category on PAWSS with a score of three, and in a moderate risk category for AUD on the AUDIT tool, with a score of 22. The informant was placed on the CIWA–Ar protocol and saw a psychiatrist during admission. The informant was admitted twice during the study period for a total LOS of eight days, and admitted once during the one year–post period, also for a total LOS of eight days.

A 26–year–old male informant told the counselor that he "was sober for three months after a drinking–related arrest, went to alcohol rehab, I don't like AA [Alcoholics Anonymous] or NA [Narcotics Anonymous] and will continue to be sober through

willpower but I was drinking up to two liters of whiskey a day." This informant scored a five on PAWSS, placing him at risk for AWS. The AUDIT score for this informant was 35, placing him at severe risk for AUD, suggesting alcohol dependence. The informant's history includes alcohol–induced seizures, a very dangerous, and potentially fatal, occurrence. This informant told the counselor he was recently sober; he was not placed on the CIWA–Ar protocol and did not see a psychiatrist. He was admitted once during the study period for a LOS of three days and not admitted during the one year–post period.

Two other informants mentioned relapsing on alcohol as the result of fighting chronic pain. The first informant, a 49–year–old male, told the counselor "The pain makes stopping drinking difficult; when I stopped the pain meds, I drank more." This informant was not given the PAWSS screening tool, but scored 27 on the AUDIT, placing him at a severe risk for AUD. He was placed on the CIWA–Ar protocol and did not see a psychiatrist during his admission. He was admitted once during the study period for a LOS of two days and not admitted during the one year–post period.

The other chronic pain informant, a 36–year–old female, told the counselor "I was treated for alcoholism 17 years ago, but I started drinking again 10 years ago because I've been dealing with fibromyalgia pain." This informant also told the counselor that she "had a significant daily drinking problem for the past 10 years, then I quit, but I started drinking again two months ago and now I drink about five liters of white wine a week." This informant scored a four on PAWSS and 15 on AUDIT, placing her at a low risk for AUD. She did not see a psychiatrist but was placed on the CIWA–Ar protocol. She had

one admission during the study period for a LOS of two days and had no admission during the one year–post period.

Six of these informants refused to answer the AUDIT questions. Of the remaining 55, seven scored in the low risk category for AUD, 13 scored in the moderate risk category, and 19 scored in the severe risk category. Interestingly, 16 of these informants had AUDIT scores below eight, the no–risk category for AUD.

3.4.1.4 Denial of Alcohol Misuse.

As identified in Table 5d, below, of the 125 counseled informants, only 27% outwardly expressed a denial of alcohol misuse.

Table 5d. Informants Expressing Denial of AUD and Related AUDIT Scores

	Counseled	# Completed	# Low Risk Score	# Mod Risk Score	# Severe Risk Score
Total individuals	**% (n)**	**AUDITs**	**AUDIT (8-15)**	**AUDIT (16-24)**	**AUDIT (25-40)**
Denial of Alcohol Misuse	27% (34)	30	9	3	9

A 47–year–old male informant stated “I know I drink a lot, but I see no problem with it.” This informant scored a three on the Prediction of Alcohol Withdrawal Severity Scale (PAWSS), indicating a low risk for alcohol withdrawal symptoms (AWS). The informant’s score was nine on the Alcohol Use Disorders Identification Test (AUDIT), also indicting a low risk for an alcohol use disorder (AUD). The informant was not seen by a psychiatrist but was placed on the Clinical Institute Withdrawal Assessment–revised

(CIWA–Ar) protocol. This informant was admitted three times during the study period for a total length of stay (LOS) of 12 days, and was not admitted during the one year–post period.

A 59–year–old male informant told the counselor "I only drink two or three drinks a day and have no intention to stop." This informant scored a two on PAWSS, indicating low risk for AWS, and a 12 on AUDIT, also indicating a low risk for AUD. The informant did not see a psychiatrist during the admission but was placed on the CIWA–Ar protocol. This informant was admitted twice during the study period for a total LOS of 63 days and was not admitted during the one year–post period.

A 61–year–old male informant told the counselor "I'm here because I got in a bar fight, I know I have to change my drinking habits but I can do it on my own." He scored a two on PAWSS, a low risk category, and an 11 on AUDIT, also a low risk category. He did not see a psychiatrist and was not placed on the CIWA–Ar protocol. He had one admission during the study period for a LOS of three days and no admissions during the one year–post period.

A 60–year–old male informant told the counselor "I'm not interested in changing anything; I drink about 16 drinks a day and more on Sundays." He scored a three on PAWSS, a low risk category for AWS, but a 34 on AUDIT, a severe risk for AUD category, suggesting alcohol dependence. He was admitted once during the study period for a LOS of seven days, and not admitted during the one year–post period.

A 46–year–old female informant told the counselor "I had three years sober but I want to drink one more time and have no interest right now in any help." This informant was not given the PAWSS screening tool, but scored a 24 on the AUDIT, indicating a

moderate risk for AUD. The informant was placed on the CIWA–Ar protocol and did not see a psychiatrist during the admission. She was admitted three times during the study period for a total LOS of 18 days but was not admitted during the one year–post period.

A 45–year–old male informant stated to the counselor "I have no intention to stop drinking." This informant scored a five on PAWSS and a 21 on AUDIT, scores that indicate moderate risk for AWS and AUD, respectively. He did not see a psychiatrist but was placed on the CIWA–Ar protocol. He was admitted once during the study period for a LOS of nine days and was not admitted during the one year–post period.

Four of these informants refused to complete the AUDIT questionnaire. Of the remaining 30, nine scored in the low risk category for AUD, three scored in the moderate risk category, and nine scored in the severe risk category. Interestingly, four of these informants had AUDIT scores, ranging from two to seven, which is a no–risk category for AUD.

3.4.1.5 Comparisons of PAWSS and AUDIT Results.

The Prediction of Alcohol Withdrawal Severity Scale (PAWSS) is a screening tool that measures the potential level of alcohol withdrawal symptoms a patient may experience. At the research site, this tool is currently administered by the Registered Nurse (RN) at time of admission to an inpatient unit for two reasons. First, the tool is used to identify patients with the potential for alcohol withdrawal symptoms (AWS). Second, the tool is used, along with other medical information by the patient's physician to determine whether or not the patient needs to be place on the Clinical Institute Withdrawal Assessment–revised (CIWA–Ar) protocol. The CIWA–Ar protocol is a set of

physician orders that the RN follows in order to provide intravenous vitamins, anti–anxiety or anti–seizure medications to the patient to curtail AWS.

The Alcohol Use Disorders Identification Test (AUDIT) is a screening tool used to determine a patient's risk for an alcohol use disorder (AUD). The AUDIT tool is currently administered at the medical center by a psychiatrist during a psychiatric consult, if the psychiatrist feels it is appropriate. Because PAWSS administration by a Registered Nurse (RN) is required for all inpatient admissions, yet AUDIT is administered at the discrimination of the psychiatrist, it appears that the medical center may be using PAWSS as a surrogate for AUDIT. In this research, the bedside addiction counselors administered the AUDIT tool to every informant they counseled. Some informants chose not to answer all of the questions; and some informants scored in the no–risk for AUD category.

I have compared the RNs PAWSS score for each counseled informant with the corresponding AUDIT score from the counselors. Of the 125 counseled informants, 81 informants, (65%), had an AUDIT score that placed them in an at–risk for alcohol use disorder (AUD) category. The PAWSS screening tool identified 79% of the informants that also had an AUDIT score indicating they were at risk for AUD. The PAWSS screening tool did not identify 21% of the informants that did score as at risk for AUD through the AUDIT tool. At the medical center, a PAWSS score below two is defined as no–risk for AWS. AUDIT at–risk categories begin at a score of eight or higher. PAWSS and AUDIT use separate scoring scales adapted during their independent developments.

In the low risk AUDIT category, 32% of the informants scored below a two on the PAWSS, meaning these informants were not identified as being at risk for AWS. In

the moderate risk AUDIT category, 25% scored below a two on PAWSS, and in the severe risk AUDIT category 11% scored below a two on PAWSS; those percentages demonstrate a potential deficiency in the medical center's process of AUD identification.

Figures 1, 2, and 3, below, illustrate the discrepancies between PAWSS and AUDIT scores for counseled informants based on the at–risk categories for AUDIT: low, moderate, and severe risk for AUD. The bold, black vertical line with left–facing arrows in each figure indicates the informants who scored below two on PAWSS, meaning the medical center would consider that informant not at risk for AWS. This also indicates there is no identification for any potential underlying AUD. However, these same informants scored in an at–risk category on AUDIT, the screening tool specifically for AUD that is not currently in general use at the medical center. If a counseled informant had an AUDIT score but was not asked the PAWSS questions, or could not respond, a score of negative one (–1) was assigned in order to graph the data.

By far, most counseled informants found to be at risk for AWS were also found to be at risk for AUD, with the percentage rising proportional to the AUDIT risk level at 53% for low risk, 67% for moderate risk, and 87% for severe risk for AUD also scoring in an at–risk category on PAWSS. While this supports the validity of PAWSS in determining potential AWS, it does not address identification of AUD. Beyond a psychiatrist administering the AUDIT tool, there is no overarching process in place at the medical center to identify AUD patients other than to treat potential AWS symptoms.

Figure 1. PAWSS versus AUDIT Scores for Counseled Informants in the Low Risk AUDIT Category

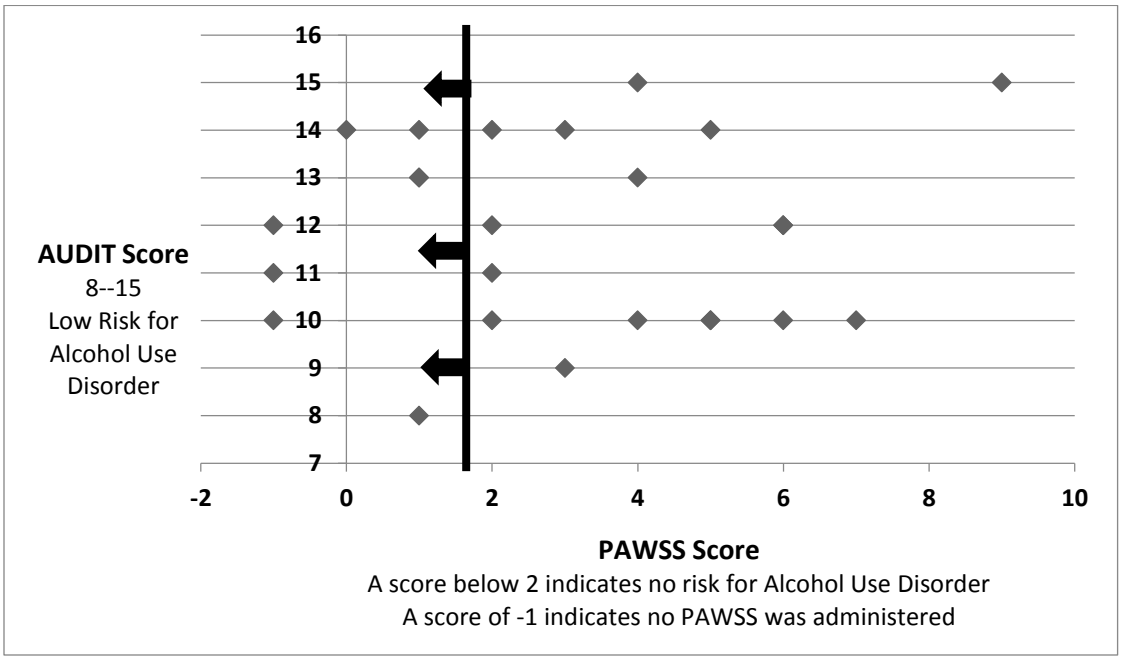


Figure 2. PAWSS versus AUDIT Scores for Counseled Informants in the Moderate Risk AUDIT Category

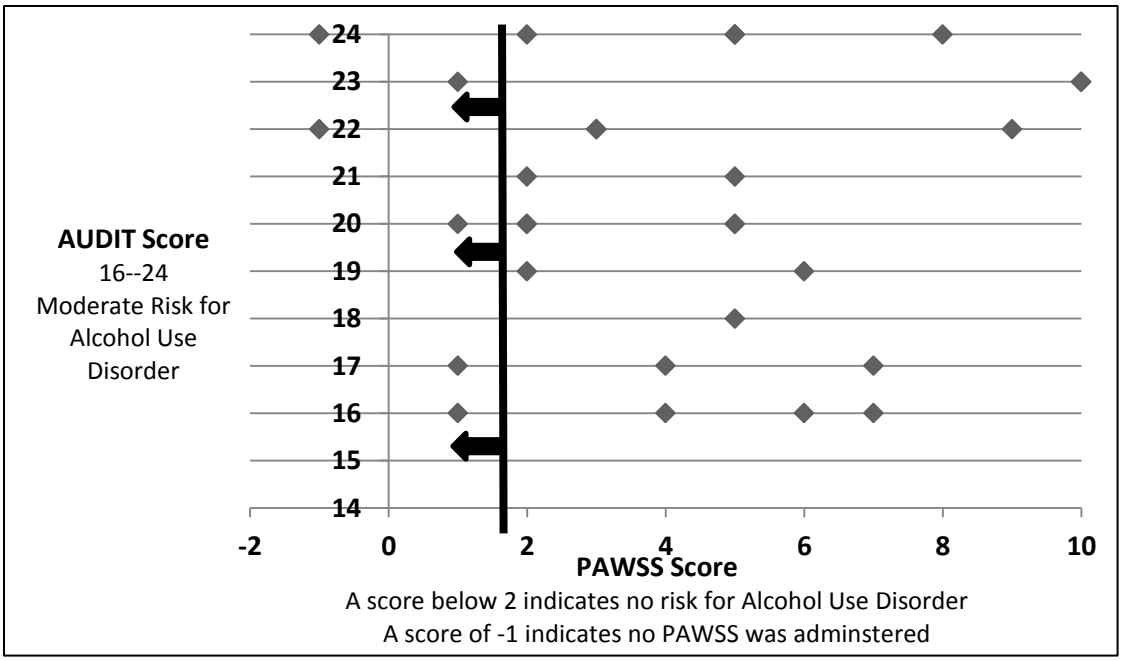
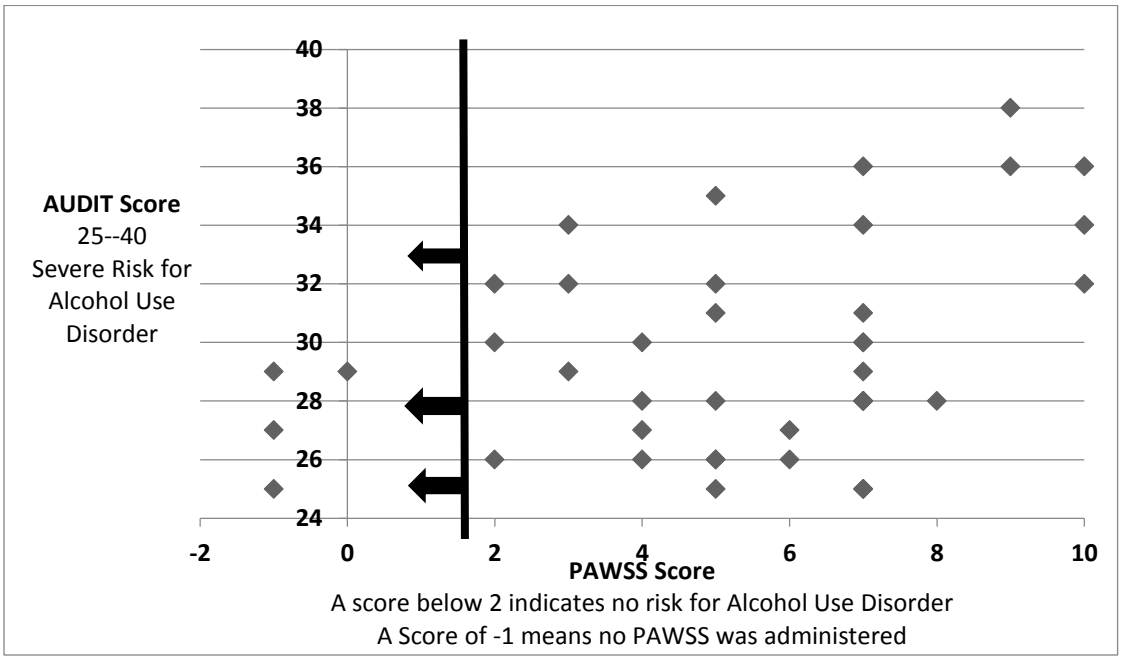


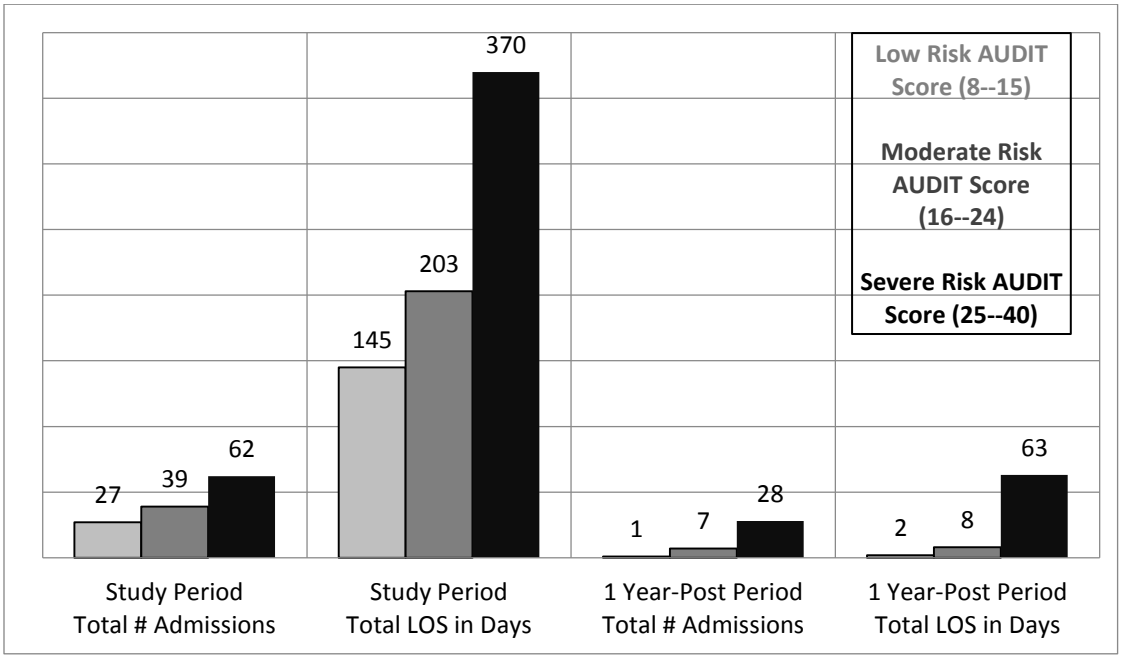
Figure 3. PAWSS versus AUDIT Scores for Counseled Informants in the Severe Risk AUDIT Category



3.4.1.6 Counseled Informants Readmitted in the One Year–Post Period.

As seen in Figure 4, below, the total number of admissions and length of stay (LOS) for the counseled informants, based on AUDIT score risk category, is compared between the study period and the one year–post period. There is a clear reduction in admissions and LOS from the study period to the one year–post period for all AUDIT categories. However, the severe risk for alcohol use disorder (AUD), which is the AUDIT score range of 25–40, indicates a higher number of readmissions and total LOS than the low or moderate risk categories.

Figure 4. Counseled Informants Total Number of Admissions and Total Length of Stay (in days) for the Study Period and the One Year–Post Period Grouped by AUDIT At–Risk Score Range Categories



As described in Table 6 below, 11 counseled informants, or nine percent, of the 125 total counseled informants, were readmitted during the one year–post period. Based on the narratives as told to the counselors, six of those informants had been sober previously and relapsed. One relapsed after his fiancé died, one relapsed after he retired, and one stated he "slowly stop using coping skills." All 11 counseled informants had been placed on the Clinical Institute Withdrawal Assessment–revised (CIWA–Ar) protocol to minimize alcohol withdrawal symptoms (AWS). Seven of the 11 received a psychiatric consultation. Only one of these informants scored in the low risk for AUD category on AUDIT, six scored in the moderate risk AUDIT category, and four in the severe risk AUDIT category.

Table 6. Counseled Informants Readmitted during the One Year–Post Period

AUDIT Score	PAWSS Score	Got a Psych Eval?	Placed on CIWA?	Narrative Notes by Counselor
10	6	Yes	Yes	Recently graduated from an inpatient addiction program
17	4	Yes	Yes	Wanted to talk but not about alcoholism
20	1	Yes	Yes	Wants to go to xxxx Medical Center for rehab
20	2	Yes	Yes	Plans on going to outpatient rehab after discharge
21	2	No	Yes	Was sober for 10 years, started drinking again in 1998 after retiring
22	3	Yes	Yes	In rehab 1 year ago and slowly stopped using coping skills
22	3	No	Yes	Was willing to listen and converse but not interested in talking about alcohol intake
25	5	No	Yes	Will go back to AA
28	7	Yes	Yes	Was sober for 2 years, started drinking after fiancé died
36	7	No	Yes	Relapsed 3 weeks after last medical discharge, was attending an intensive outpatient rehab program and was sent here for confusion
36	10	Yes	Yes	Going to AA right after discharge

3.4.1.7 Counseled Informants Discharging Directly to Treatment.

As outlined in Table 7 below, during the study period, five of the counseled informants did discharge from the medical center directly to inpatient addiction treatment programs. Four of the five counseled informants were seen by a psychiatrist while they were admitted at the medical center. Curiously, only one of these five informants that discharged directly to inpatient addiction treatment programs stated an "intent to seek recovery" as noted by the study's bedside addiction counselors.

One counseled informant scored below the at–risk categories in both the Prediction of Alcohol Withdrawal Severity Scale (PAWSS) and the Alcohol Use Disorders Identification Test (AUDIT), but told the counselor he wanted to go to xxxx for alcohol treatment and discharged directly from the medical center to that facility. Two of these informants scored within the moderate risk for AUD, at 16 and 22, and had at–risk PAWSS scores. Two others scored within the severe risk for alcohol use disorder (AUD) category, at 28 and 34, and were also identified as at–risk through PAWSS assessment.

Table 7. Five Counseled Informants that Discharged Directly to In–Patient Addiction Rehabilitation Programs

AUDIT Score	PAWSS Score	Intervention Period Total Admissions (total LOS)	One Year–Post Period Total Admissions (total LOS)	Seen by Bedside Counselor?	Seen by Psychiatrist?	Did Informant state "Intent to Seek Recovery After Discharge"?	Informant Narrative as stated to Bedside Counselor
4	6	1 (24)	0 (0)	Yes	Yes	Yes	Wants xxxx alcohol rehab, SW made aware
16	6	1 (37)	0 (0)	Yes	Yes	No	Went to Alcoholics Anonymous (AA) 2 years ago, found helpful, not sure

							now if AA or counseling the best option, needs to "slow down", would like a list of resources.
22	3	1 (6)	1 (4)	Yes	No	No	Open to help but has tried rehab
28	7	2 (8)	0 (0)	Yes	Yes	No	Does not want to stop drinking, will cut down to only weekends
34	10	3 (7)	0 (0)	Yes	Yes	No	Has tried all types of rehabs

3.4.1.8 Intent to Seek Recovery Findings as a Proxy.

The findings that these five counseled informants discharged directly to inpatient addiction treatment programs, without stating intent to seek recovery to the bedside counselors, indicates that the results in Table 8, below, are being used as a proxy for the positive influence of bedside addiction counseling. The counseled informants were not contacted after discharge, so some of those that stated their intent to seek recovery may have done so after discharge from the medical center, but that information is unknown.

Table 8. Comparison of Intent to Seek Recovery After Discharge for Counseled and Non–Counseled Informants				
	Seen by counselor n=125	Not seen by counselor n=142	p–value	test
Intent to Seek Recovery	49/125 (39.2%)	4/142 (2.8%)	<0.001	2–proportions

These results were derived by using a 2–proportion t–test, in Minitab® Version 17, in order to compare the counseled and non–counseled informants.

3.4.1.9 Statistical Significance Found in Readmission Rates.

As reported in Table 9 below, there was statistical significance found in a reduction in the number of admissions for the counseled informant group from the study period to the one year–post period. The result was highly statistically significant, demonstrating a reduction in the number of inpatient hospital admissions of counseled informants when comparing the study period to the one year–post period. This result was derived using the Wilcoxon Sign Rank test, a nonparametric test, in Minitab® Version 17. *A priori* statistical significance was set at less than 0.05 ($p<0.05$), meaning there is a 95% or greater confidence in the accuracy of these results.

Table 9. Counseled Informants' Number of Admissions – Comparison of Study Period to the One Year–Post Period			
Wilcoxon Sign Rank	**During Study Period**	**One Year–Post Period**	**p–value**
Total Number of Admissions	167	19	$p<0.001$

3.4.1.10 No Statistical Significance Found in Median Length of Stay.

As indicated in Table 10 below, no statistical significance was found in the median length of stay (LOS) of admissions for counseled informants when comparing the study period to the one year–post period. The Mann–Whitney test, a nonparametric test used in Minitab® Version 17, was used, and an *a priori* statistical significance was set at the standard of less than 0.05 ($p<0.05$).

Table 10. Counseled Informants' *Median* Length of Stay (LOS) in Days for Individual Admissions – Comparison of Study Period to the One Year–Post Period

Mann–Whitney	During Study Period	One Year–Post Period	p–value
Total LOS, *LOS median* (LOS range)	1247, 5 (0–54)	112, 6 (2–14)	p=0.7986

Although there is no significance in the median LOS, in the next chapter I will discuss the significance of the dramatic reduction in total LOS between the study period and the one year–post period. Bedside addiction counseling was a positive influence on the counseled informants and seems to have contributed to motivating informants to seek recovery as witnessed through a reduction in admissions after the counseling.

CHAPTER 4

DISCUSSION

4.1 Research Questions and Findings

The primary research question explored was: 1) how does bedside addiction counseling reduce the patient's number of readmissions and length of stay? The findings of this research suggest an association between bedside addiction counseling and a reduction in readmissions and length of stay of the informants during the follow–up period. However, it is important to note the suggestion is one of association; no causality or correlational relationship can be established due to multiple confounding variables. Because contacting informants after discharge from the medical center was not included in the study protocol, I can only suggest an association between bedside addiction counseling and a reduction in informant readmissions. The statistical surrogate, or proxy, of informants receiving bedside counseling who stated they intended to seek recovery, and the significant reduction in informant readmissions, may suggest a potential connection between bedside counseling and its effect as a positive motivator to seek addiction recovery after discharge.

There were two secondary research questions. The first secondary research question was: in what way can the medical center improve the process of identifying and treating patients with addiction? During this research, it was identified that the time constraints of the Registered Nurse's (RN) administration of the Prediction of Alcohol Withdrawal Severity Scale (PAWSS) does not promote narrative or contribute to a

therapeutic relationship between patient and RN. The bedside addiction counselors spent more time with the informants, and informants commented on their appreciation of the counselor's time and their lack of appreciation of the seemingly rushed time that RNs and physicians spent at the bedside. Counselors engaging in narrative with informants helped to more effectively identify informants with an alcohol use disorder (AUD) and began the first steps towards an understanding what may be lacking in the identification and treatment process for AUD patients.

The second secondary research question was: what steps can be taken to improve awareness, and lessen stigma, of alcoholism in America? The positive response by informants, towards bedside counseling, suggests that clinicians can interact at a deeper narrative level with patients, even if only for a brief time. This information can contribute to developing training programs focusing on maximizing narrative engagement with patients, for multiple reasons. Patients can be heard and appreciated for their individual experience, while clinicians can grasp a better understanding of the illness experience. For this research, utilizing narrative can help clinicians better understand and treat alcoholism and begin to reduce the stigma that exists among clinicians towards alcoholics in general. Yet, narrative can also be an enriching human experience for the clinician. Narrative can give clinicians the experiences for which they purportedly entered the field of medicine in the first place, by looking beyond the lab values and focusing on the soul-enriching value of connecting to another human being on a divine level and simply helping them to heal.

4.2 The Theories and Realities of Narrative Use.

The bedside addiction counselors were doctoral candidates in psychology, which is based in talk therapy. The bedside addiction counselors' main task was to visit with an informant and engage in narrative while administering the Alcohol Use Disorders Identification Test (AUDIT). The time constraints of healthcare professionals make narrative a difficult option to successfully initiate or maintain, making the use of volunteer bedside addiction counselors, as done in this research, an intriguing option for this medical center.

The bedside addiction counselors' lack of time constraints, the intent to utilize narrative, and lack of workload concerns was beneficial to the informant, counselor, and the medical center. This bedside addiction counseling program continued after the research concluded, and indicates the medical center's interest in promoting better identification and treatment options for alcohol misuse patients. It is the hope of this researcher that, as the program progresses, the importance of narrative and narrative development as part of the counseling program will be recognized and valued as part of routine clinician practice.

The ability to see the difference in the value of subjective information received from narrative versus from the objective results of the screening tools helped to initiate productive conversations about alcohol misuse patients. The philosopher Martin Buber (1923) identifies two methods of human interaction, referring to two separate contextual human experiences, I–Thou, the person as subject, and I–It, the person as object. Narrative is an effective method to foster the I-Thou experience. In Buber's I–Thou

encounter, an individual experiences another individual subjectively, within the framework of the other's experiences, while respecting the humanity of the individual and treating that other with empathy (Buber, 1923). Narrative naturally exists within the I-Thou realm, where patients are viewed as whole human beings, valued for their individual experiences that helps to define their identity and enrich their encounter with the clinician. In the healthcare realm, a focus on narrative can also enrich the clinician's experience, allowing the clinician to engage with others on a human level that is deeper than modern medical advances suggest; thus enhancing the clinicians experience as well.

Yet, it is Buber's I–It experience that seems to be the way clinicians currently encounter their patients. Within the I–It experience, one disengages with the other on an empathic and divine human level, seeing that other as an object (Buber, 1923). The I–It encounter is more of an observation of another, rather than an experience; in healthcare, the clinician remains empathically distant from the patient and avoids human familiarity (*Ibid*.). In the current healthcare environment, this distance placed by the clinician may be a consequence of time constraints, fear of human intimacy, fear of the appearance of professional weakness, or simply a lack of training. The I–It experience interprets the patient as a conglomeration of test results and procedural evaluations, or, as demonstrated in this research, the numeric results of screening tools. By keeping humanity at arm's length, the objective experience of I–It is predictable and safe, and modern biomedicine and technology provides the basis for this interaction. As medicine moves towards technology and away from subjective I–Thou encounters, patients have become objects in the I–It realm.

In this research, even limited use of narrative identified issues of alcohol misuse informants that were significant factors behind their drinking. Many informants discussed reasons they either drank, or relapsed after a period of sobriety, which helped to guide treatment. Singer, Singer, and Berry (2013) discuss narrative identity as a means by which individuals find coherence and continuity in their lives by forming a self–identity that relates to the world around them, providing them with a context of a given set of circumstances. Addiction occurs when this identity narrative becomes rigid and self-damaging, leading to negativity and anxiety, where negative self-perceptions become a significant obstacle to achieving a sense of meaning and purpose (*Ibid*.). In this research, reduction of the individual to a number, whether it was the score on an alcohol screening tool or a lab value, objectified that individual and devalued their human experience. In order to break the negative self–narratives, therapeutic narrative can enlighten the individual about their negative self-identity and how it contributes to the repetitive cycle of alcohol misuse. Through narrative, negative self–perceptions can be gradually replaced with positive ones and the individual can realign to a more realistic self–identity (*Ibid*.). In this research, the bedside addiction counselors worked to promote this positive informant change.

In many ways, this is how Alcoholics Anonymous (AA) works. Individuals come to AA with self–identities skewed by alcohol misuse, and over time, many of these individuals begin to replace negative self–perceptions with positive ones, and achieve, and maintain, sobriety through the trust and community of AA. The 12–step program of AA continues to claim success for over 80 years. The first, and most important principle in AA, incorporates narrative by way of the alcoholic being present and part of the

conversation at AA meetings, where a group of recovering alcoholics talk about personal issues that may be affecting their sobriety while others listen, identify with those issues in their own lives, and offer verbal support. AA embodies Buber's I-Thou encounter, where each individual encounters another as a subject, in terms of their struggles with alcoholism and recovery. The divine humanity of each individual that Buber suggests as part of the I-Thou encounter is present in AA's depiction of the alcoholic's relationship with God and humanity. The AA symbol is an equilateral triangle, the top point represents God, the bottom two base points each represent an "A" from AA; in the center is a small circle, which represents the recovering alcoholic and their need for humility in acceptance of others and their relationship to those around them, to God, and to the fellowship of AA. In order to maintain sobriety, AA members advise each other to "stay centered between God and AA."

AA also promotes responsibility and accountability to not only oneself, but, also, to the rest of the AA fellowship and anyone seeking recovery. In a small way, the principles of the AA program echo Frankenburg's assertion, as discussed by Singer (2004), that "the importance of making social of disease entails both the revelation of the structure of social relationships that shape the making of disease and the social roles, behaviors, locations, and messages involved in the making individual of disease" (*Ibid. p. 15*). In other words, the 12–step AA program guides individuals towards achieving and maintaining sobriety based on three core principles: the importance of joining the supportive social AA fellowship with other recovering alcoholics, Frankenburg's "the making social of disease" (*Ibid. p. 15*), a personal connection with a *Higher Power* to promote self–forgiveness, maintain hope, and form an appropriate behavioral compass,

Frankenburg's "social roles, behaviors" (*Ibid*.), and a rigorously honest self–exploration of character defects that may have contributed to one's alcoholism, Frankenburg's "the making individual of disease" (*Ibid. p. 14*). The beauty of the AA program is its consideration of alcoholics as whole human beings, hence subjects in Buber's I-Thou realm, who acknowledge, through narrative, that the entirety of the person needs to be considered if they are to maintain sobriety.

When narrative is used properly in healthcare, its purpose is to focus on patient stories to promote empathy, strengthen human connection, and create a mindset in the healthcare staff which demonstrates respect for the patient. Glimpses of potential beginnings of this healthcare paradigm shift were seen in this research. Bedside addiction counselors talked with clinicians on a daily basis, and healthcare staff began to demonstrate more compassion for their alcoholic patients in morning rounding. Social workers spent more time and effort to connect informants with addiction treatment programs. And nurses felt more comfortable speaking with their patient after the bedside counselor had been in the room. While these changes were not measured in this research, conversations between the Principal Investigator, the informants, the bedside counselors, and the healthcare staff confirmed these positive consequences.

4.3 The Value of AUDIT versus PAWSS Screening Tools

Currently, the medical center involved in the study requires that every patient aged 18 or older be asked the ten–question Prediction of Alcohol Withdrawal Severity Scale (PAWSS) as part of the Registered Nurse's (RN) inpatient admission assessment.

The PAWSS score is then used as part of the physician's decision making process to determine if the patient is at risk for alcohol withdrawal symptoms (AWS). If the physician believes there is a chance for AWS, then medications are ordered to treat AWS via the physician completion of the Clinical Institute for Withdrawal Symptoms-revised (CIWA-Ar) protocol. The RN then follows the CIWA-Ar protocol to treat the patient's AWS. The PAWSS screening tool is valid and reliable as a means to identify the potential for AWS, not for the identification of alcohol use disorders (AUD).

A large number of the total study group did not have the PAWSS administered to them by an RN during the inpatient admission process. This may have been due to several reasons. Some patients may not have been cognitively able to answer the PAWSS questions during the admission process. However, I frequently found that the RN would ask the PAWSS questions once the patient was able to respond, even several days after the patient's admission. In the way that the medical center currently utilizes PAWSS, a screening score of two or greater not only indicates the potential for AWS but seems to circuitously imply the potential for an AUD. The medical center reserves use of the Alcohol Use Disorders Identification Test (AUDIT), a valid and reliable screening tool to identify AUD, for psychiatrist–administration only.

The administration of the AUDIT screening tool performed by this research's bedside addiction counselors often identified informant scores indicating a risk for AUD when the RN–administered PAWSS screening tool did not indicate potential AWS. The RNs are trained in administration of the PAWSS tool and the bedside addiction counselors were trained in administration of the AUDIT tool. The difference between administering each tool, PAWSS by the RN or AUDIT by the bedside addiction

counselor, was the amount of time the RN or bedside counselor was able to commit to asking the screening tool questions. Many RNs disclosed to the Principal Investigator that, unless the patient is specifically admitted for alcohol withdrawal, the administration of the PAWSS tool is not a priority during the admission process. The bedside counselors were able to incorporate conversation into the administration of the AUDIT tool with the informant, which allowed the counselors to spend as much time as they felt was appropriate. Admittedly, narrative was evoked in relation to the administration of the AUDIT tool. Consequently, while administration of either screening tool was not timed, both the RNs and the counselors agreed, in discussions with the Principal Investigator, that the counselors were able to spend more time with the informants during counseling than the RN can during the admission process. The additional time the counselors could spend with the informant offered more opportunities for the counselor to establish therapeutic conversation with the informant and understand the informant on an empathic level.

4.4 Objectification as a Consequence of AUD Screening Tools

Utilizing the Prediction of Alcohol Withdrawal Severity Scale (PAWSS) and the Alcohol Use Disorders Identification Test (AUDIT) screening tools as a way to identify alcohol misuse patients, acts as a reductive means of addressing the patient and their individual human experience. Use of these screening tools as the primary means of identifying alcohol use disorders seems antithetical to narrative's potential in this research in that it reduces the multi-faceted experience of being human to a number, to be

quantified and analyzed instead of heard and understood. The conversation between the RN and the patient exists simply to obtain the PAWSS score and complete the required admission assessment. After discussion with the psychiatrists, it appears their administration of the AUDIT tool is performed with similar time constraints as the RNs administration of PAWSS. Therefore, it was discovered through this research that narrative seems to be lacking in the standard patient-clinician interaction at this medical center. Unfortunately, with the state of healthcare reimbursement driven by data, it seems unlikely that this, or any medical center, will relax time constraints through reduced workloads simply to allow for a greater use of narrative in the patient-clinician interaction. This research demonstrated that the addition of brief narrative produced a cost savings benefit to the medical center, which may encourage greater use of narrative in the patient-clinician encounter.

While the PAWSS and the AUDIT screening tools are necessary and useful, they do not necessarily explain the illness experience of the patient. Narrative can give more information and guide a more thorough treatment plan for alcohol use disorders (AUD) that goes beyond the physician simply checking off boxes on the order protocol for alcohol withdrawal symptoms (AWS), the Clinical Institute Withdrawal Assessment–revised (CIWA-Ar). Reducing an individual to a number objectifies and devalues the unique human experience of that individual, which negates the individual's illness experience. Contrary to this is narrative. Effective narrative can uncover factors that may have contributed to an individual's illness experience that can help the individual to feel heard and help the clinician to understand factors outside of the individual's hospitalization that may be exacerbating the illness. Therefore, narrative can enrich the

individual's experience with the clinician, and can help the clinician to better understand the individual.

In the following case studies from this research, Buber's I–Thou encounter through narrative was an effective means of viewing patients as whole human beings and understanding the patient's illness experience. Even during a brief intervention, the bedside counselors experienced informants in the I–Thou realm, where informants opened up about the personal issues underlying their current alcohol misuse.

One such case study identifies a 56–year–old male informant, who was determined to have an at–risk PAWSS score of 7 and a severe risk for AUD score of 28 on AUDIT. He was placed on the CIWA–Ar protocol for potential AWS. This information does not explain this mans' experience with alcohol, his history of addiction, or the causes of his current drinking; it simply provides an opportunity to label him as alcoholic. Through narrative, the bedside counselors learned that this informant recognized his problems with alcohol, had been sober for two years, until his fiancé suddenly died, thrusting him back into drinking as the only way he knew to cope with his loss. If the clinician encountered the informant from an I-Thou perspective, this additional information resulting from brief narrative may have indicated a need for grief counseling as well as addiction treatment, enriching the informant's encounter and providing him with a greater potential for recovery (Furr, Johnson, & Goodall, 2015).

Regrettably, beyond a positive alcohol blood test, these screening tools are currently the only way in which patients at the medical center who misuse alcohol are being identified for potential treatment. This reductionist view of AUD does not necessarily parallel other chronic diseases in the healthcare setting: the literature

describes multiple supportive program types for heart disease (Dale et al., 2015; Frederix et al., 2015; Sidebottom, Jorgenson, Richards, Kirvan, & Sillah, 2015) and for cancers (Agboola, Ju, Elfiky, Kvedar, & Jethwani, 2015; Hui & Bruera, 2016; Williams et al., 2017). The medical center where this research took place has branches that specialize in heart disease and cancers. Each of these branches have special patient education departments, with social workers who offer talk therapy, nurse navigators to help patients understand their disease and treatment options, as well as follow–up contact to continue support after discharge. Interestingly, the medical center also has outpatient departments to continue treating these patients after discharge from the medical center. However, there is no affiliated outpatient department or services to continue treating AUD patients.

Every hospital has financial obligations to meet in order to remain in business. These obligations have been increased through changes in Medicare that withhold reimbursement to hospitals based on their performance for certain value indicators (IOM, 2014). These value indicators currently include readmission rates for certain chronic conditions, but not for readmissions related to addiction relapse. Also, many of the patients identified in my research were either uninsured or insured through government programs, both of which strictly limit reimbursement for hospital admissions. Consequently, for a business, even if that business is a hospital with a mission of benevolence, decisions whether or not to expand services can be financially motivated. Also, most of the patients identified in this research were admitted to the hospital as medical inpatients for chronic illnesses with primary diagnoses other than alcohol misuse.

In addition, with outpatient treatment being preferred under the Affordable Care Act as a less expensive option to inpatient admission (IOM, 2014), patients admitted to

the hospital are more acutely ill than in the past (Brimmer, 2012). However, the current practice of 12–hour nursing shifts and overtime, the shift to electronic health records, and utilizing physicians as employees of the hospital, rather than independent contractors, is adding to the stress and fatigue of physicians and nurses already caring for more complex patients (Hobbs and Wightman, 2018; Scott, Orav, Cutler,& Jha, 2017; Zadvinskis, Garvey–Smith, & Yen, 2018).

Physicians are also under the pressures of reimbursement restrictions and profitability from both the hospital and their private practice, compelling them to rely on biomedicine's empirical and authoritative results, with the consequence of limited personal engagement with the patient (Young, Burge, Kumar, Wilson, & Ortiz, 2018). Young et al., (2018), identified that 54% of the time a physician spent with a patient was dedicated to inputting information into the electronic health record and not face–to–face time with the patient. A minimal time–encounter with a patient allows for the physician to see more patients during the day and increase profitability, yet also adds to their stress and job dissatisfaction (*Ibid*). Nurses are also expected to meet quality standards through charting and reporting, which takes away from patient time and contributes to their job dissatisfaction (Zadvinskis, Garvey–Smith, & Yen, 2018).

CHAPTER 5

CONCLUSION

5.1 Overall Findings and the Impact of this Study

I identified a statistically significant reduction in admissions for counseled informants during the one year–post period that suggests a positive influence of bedside counseling. However, the reduction in admissions is limited in any correlational value between the performance of bedside addiction counseling and counseled informants seeking recovery after discharge. And, while the median length of stay (LOS) for individual admissions did not vary to any measurable degree, the total LOS for the counseled informant group dropped significantly, by 1,135 days, from the study period to the one year–post period. Rappleye (2015) indicates the cost of a day of inpatient medical stay at a United States hospital is $2,520. These 1,135 fewer inpatient admission days is estimated to have produced a cost savings of over $2.86 million to the medical center. By using this potential future cost savings as the foundation for the initial expenditure, the medical center may be able to establish a bedside addiction counseling program.

I also found that narrative is lacking in clinician-patient encounters at the medical center. Admittedly, bedside counselors engaged in brief narrative during this research. They also administered a screening tool. The screening tool is a necessary part of any hospital evaluation process to justify treatment to the regulatory agencies and insurance companies. Ultimately, this research began a process of understanding the benefit of narrative to enhancing and improving the patient experience. The reduction in

readmissions is an optimistic interpretation of the benefit of even a brief narrative encounter. It is a very limited view to believe that any reduction in admissions related to bedside addiction counseling is only beneficial to the medical center. If there is a true correlation between bedside addiction counseling and a subsequent reduction in readmissions it also suggests that bedside counseling positively affected the health of the informant. Also of importance, the only difference that occurred between a typical day of an inpatient's hospital experience at this medical center and a day during my study's intervention period was that a counselor walked into the patient room and initiated a conversation about alcohol misuse. A screening tool was administered, as it should be in order to justify treatment to the regulatory agencies and insurance companies, but the screening tool would have been done anyway. The real difference was the conversation; a narrative encounter between two individuals for therapeutic value.

These research findings also suggest opportunities for the medical center, through physician and nurse training and community education, to initiate a more comprehensive and compassionate approach to addressing individuals with alcohol use disorders. Through this research, the medical center was given the opportunity to investigate whether a bedside addiction counseling program had a positive impact on patient care. Based on this research, the bedside addiction counseling program was continued at this medical center and currently employs one part-time counselor and one part-time volunteer to provide bedside addiction counseling. Administration of the AUDIT screening tool for alcohol misuse is still incorporated into the counseling conversation.

5.2 Study Limitations

A noteworthy limitation regarding the impact of narrative in this study is the medical center's inadvertent objectification of individuals through assessment tools, such as PAWSS and AUDIT used in this research, which quantifies disease and limits the overall value of the patient by negating narrative. Alcoholism has physical, psychological, social, and spiritual dimensions that need to be addressed on an individual basis for recovery to occur. Screening tools serve an important purpose, but there must be a process for treatment in place if identification of the disorder is to serve any purpose beyond data collection. Alcohol use disorder screening tools, such as PAWSS and AUDIT, as well as other well-known tools such as CAGE and MAST, have all demonstrated validity and reliability. However, these tools are valid and reliable based on large sample data which is generalized to a population experiencing alcohol use disorders; the intent of the screening tools is not to describe or understand why or how each individual experiences an alcohol use disorder.

The findings of this research suggest an association between bedside addiction counseling and a reduction in readmissions and length of stay of the informants during the follow–up period. However, it is important to note the suggestion is of association; no causality or correlational relationship can be established due to multiple confounding variables, such as objectification through screening tools and a limited use of narrative. When discussing limitations of this study, consideration must be given to factors beyond developing a brief therapeutic relationship between counselor and informant as an association between a reduction in admissions and length of stay. Narrative was a

consequence of the informant-counselor conversation and administration of the AUDIT tool; therefore, a correlating reduction in readmissions to the use of narrative cannot be established.

Another limitation is the possibility that informants chose to utilize other medical centers in the area to avoid bedside counseling if it initially made them uncomfortable. Some informants may have moved out of the area or been incarcerated. Several informants were known to have passed away. Counseled informants may have wanted to discharge to an addiction treatment program and been denied by their insurance carrier, such as the 33–year–old female informant who was disappointed when her insurance carrier denied her access to an inpatient treatment program. Informants may have discharged from the medical center to their home and then sought addiction treatment, such as the 52–year–old male informant who told the counselor he "will go back to AA."

It appears many informants told the bedside counselor what they thought the counselor wanted to hear, i.e.; the Hawthorne effect; which may account for a portion of the difference in informants stating their intention to seek recovery and those that actually discharged to treatment. Some of these informants may have been placating the counselor by saying whatever it took to end the conversation without forthrightly refusing to speak with the counselor. An example of placating the counselor is suggested in the following case study from this research. A 59-year-old female informant with a positive drug screening for opiates, and alcoholic pancreatitis, spoke with a bedside addiction counselor. This informant stated to the counselor that she "wanted to stop drinking because of all the problems it had caused in [her] life." However, she minimized her drinking history, even in light of her pancreatitis, and did not mention her use of opiates.

Informants that felt ill from withdrawal at the time of counseling may change their minds about seeking recovery as they began to feel better (Ibrahim, Kwoh, & Krishnan, 2007; Jeremiah, O'Sullivan, & Stein, 1995). Many patients going through withdrawal in a hospital setting do not crave alcohol because they are receiving withdrawal medications, which is the optimal time to provide addiction counseling to the patient. Because they feel ill, do not want to go through withdrawal again, appreciate the lack of addiction cravings that medications are providing, and are more willing to contemplate recovery, they are more willing to talk about their addiction. Unfortunately, as withdrawal symptoms subside and the patient receives fewer medications for withdrawal, the patient begins to feel healthier, the addictive cravings return, and they begin to feel they can successfully practice self–control over alcohol; this is the time that patients are most likely to discharge against medical advice[1] (*Ibid, 2007; Ibid. 1995*). As an example, a 45–year–old male informant going through alcohol withdrawal and admitted twice during the study period told the counselor he "was going to Alcoholics Anonymous (AA) right after discharge." This informant was admitted three times for alcohol withdrawal during the one year–post period, so if he did attend any AA meetings, it doesn't appear, at least in his case, that it was successful.

An interesting case in point demonstrates the positive effect therapeutic conversation, narrative, can have for a patient. A 28–year–old informant who was withdrawing from alcohol and was also a heroin user, had just been visited by a friend. As the friend was walking away down the hall, the nurse witnessed the informant in his hospital bed injecting heroin into his arm. We were to later find out that the friend was

[1] Discharging against medical advice is defined as when a patient leaves the hospital before treatment has ended and the physician formally discharges the patient.

actually his heroin dealer who delivered heroin to the informant's hospital bed. The heroin was confiscated, a visitor restriction was instituted, and as the informant withdrew from the heroin he told the counselor "I feel so bad from the drugs and alcohol that I shot up in here, I need help." Because this informant was surprised by the nurse while injecting the heroin, he missed his vein and caused a painful infiltration of heroin in his arm. He needed to stay in the hospital for over a month until he was medically healthy enough to leave, which gave the counselors and psychiatrists time to repeatedly engage him in therapeutic conversation. By the time the hospital physicians medically cleared him for discharge, he had agreed to be admitted directly to a long–term inpatient treatment facility for addiction. The length of this informant's stay and the additional counseling time it provided, suggest that more opportunities for narrative can create a more robust therapeutic relationship and, ultimately, be more beneficial to the patient. Unfortunately, current insurance reimbursements and governmental restrictions based on diagnostic criteria are limiting lengths of stay rather than extending them.

5.2.1 Bias.

Lack of consistent bedside counseling and potential counselor or informant bias, may also constitute barriers to determining the true value of bedside counseling and narrative in the medical center's inpatient alcohol misuse population. The possibility of bias existed among both the informants and the counselors. Every precaution was taken to limit bias among the counselors but it must still be considered. While all counselors were trained in Screening, Brief Intervention, and Referral to Treatment (SBIRT), motivational interviewing, and followed a script, personal bias on the part of the

counselor cannot be excluded as a concern. Counselors were doctoral candidates in psychology but that does not mean their preferred patient groups are individuals with an addiction, so concealed bias could have existed. Informants may also have held bias, possibly through shame, guilt, or perceived stigma, and reacted to counselors in a less than therapeutic manner. The fact that an informant was a patient in a hospital, and not feeling well, could also contribute to a desire to minimally contribute narrative to the counseling session. Informants may also have reacted to the counselor by telling the counselor what he or she thought the counselor wanted to hear.

Also, the counselors were aware that the narrative they were engaging in with the informant was to be recorded for review as one of the intentions of the study; in other words, there was no blinding of the study aim. This potentially limits the actual value of the narrative itself. Additionally, the counselors were participating in the study to complete one of their doctoral degree requirements, which does not ensure that any of them had any interest in fully participating, or that they had any interest in the common welfare of the alcohol misuse informants. It is possible that informants may have wanted to supply more narrative but were stopped by the counselor if the counselor felt they got enough information to satisfy the minimal requirements for the task. And, while it is believed that each counselor initiated an informant conversation following the scripted opening, there was no oversight within the informant's hospital room to confirm the script was followed or assess the quality of the conversation after the script.

Subsequently, at the end of this research I received a grant to continue the bedside addiction counseling study for six months in a new format which included direct contact by the counselors for follow–up after discharge. None of the new study's informants

contacted the counselors after discharge from the medical center, even though contact times were set up in advance. These findings suggest that the practicality of a longitudinal study may be difficult in measuring anything beyond readmissions and length of stay. As mentioned earlier, the bedside addiction counseling program is still proceeding at this medical center. In light of the disappointing findings from the grant-funded extension of the study, the original design of the program as outlined in this research is being used, and patients are not contacted after discharge.

5.3 Recommendations for the Medical Center

5.3.1 Formal Development of a Bedside Addiction Counseling Program.

My recommendation for the medical center is to develop and implement a sustainable bedside addiction counseling program. This program would utilize SBIRT-trained recovering alcoholics with at least two years of continuous sobriety as the bedside addiction counselors. Recovering alcoholics have already been in similar situations to the struggling alcoholic in the hospital bed. As they say in Alcoholics Anonymous (AA) meetings, “you can’t bullshit a bullshitter”, meaning a recovering alcoholic remembers their own deceptions and manipulations so they know what to expect from an active alcoholic. Volunteer recovering alcoholics as counselors can see both alcohol and substance misuse patients, since many individuals with alcoholism have also had issues with substance misuse. The cost of the program would be minimal, since the volunteer counselors would not be receiving financial compensation for their time or efforts. Many recovering alcoholics with strong sobriety may appreciate the opportunity to help another

alcoholic. The twelfth step of the 12–step AA program suggests that a recovering alcoholic carry the message of recovery to other still–struggling alcoholics. It is possible that a struggling alcoholic may be more open and honest when speaking with someone who has experienced that same struggle. In turn, and according to AA's twelfth step, helping a struggling alcoholic also helps to strengthen personal recovery for the recovering alcoholic.

5.4 Recommendations beyond the Medical Center

5.4.1 Considerations for Building a Public Awareness Campaign.

Current social expectations in the United States demand that the individual be held responsible for their alcoholism. Government and economic attentions towards a free market supply and demand economy, where increased alcohol consumption equals increased revenue dollars, leaves little room for a discussion on stricter industry regulations. The disease concept of alcoholism, medical consumerism, and a newly spawned Internet–based mistrust of medical professionals have reinforced the individual's sole responsibility for their disease of alcoholism, relaxed public policy and diverted attention from the social and economic costs of alcoholism as a chronic illness.

Alcoholism has deeper biopsychosocial roots than simple medicalization can explain or overcome. With alcohol use disorders (AUD) well-defined in the literature and government's own identification of AUD as a preventable disease with high mortality, it is time for the development of a national education campaign focusing on alcohol misuse.

A national education campaign focusing on alcohol misuse cannot be paternalistic or morality–based, such as the 1980s "Just Say No" anti–drug campaign (Goode & Ben–Yehuda, 1994). Morality, as a form of social deviance caused by poor personal choice, is paternalistic, punitive in nature, and counterproductive, rather than educational (Heather, 2017). Goode and Ben–Yehuda (1994) suggest public health campaigns should have foundations of "Just Say Know", where education and awareness are the tenets. A public health campaign should initiate a preventive view of alcohol misuse, rather than compound the social stigma.

5.4.2 Changing the Social Understanding of Alcoholism in America.

A national education, or public awareness, campaign with a strong impact that provokes an emotional reaction may make an inspiring difference in how American society views alcoholism. This alcohol misuse awareness campaign should be supported through government funding and include better access to treatment, much like the Centers for Disease Control's national antismoking campaign of 2012. Legislative steps should also be taken to limit social acceptability of public drinking, such as pub crawls being restricted or eliminated. Part of the success of the anti-smoking campaign included legislative actions that dramatically reduced public smoking. It is unfortunate that this recommendation seems drastic and unrealistic to expect, however, eliminating alcohol consumption in football stadium parking lots and at outdoor eating establishments may be a place to start legislative restrictions.

Smoking rates have significantly decreased in America by dramatically reducing public smoking opportunities while educating the public about the health consequences

of smoking (CDC, 2018b; Jamal et al., 2015). The successful anti–smoking campaigns of the last 20 years focused on legislative restrictions on smoking, along with the shock value of smoking's health consequences, to motivate individuals to quit, as well as prevent the creation of new smokers (Duke et al., 2015).

In 2012, the Centers for Disease Control (CDC) launched a three month national education campaign called *Tips from Former Smokers*. Duke et al., (2015) found that the use of graphic advertisements intended to elicit emotional responses were effective in reducing smoking rates. These advertisements featured, among others: a woman speaking with an electro larynx, a mechanical vocalizer, because she lost her voice box to smoking–related throat cancer, a woman showing her fingerless hands after amputations from smoking–related vascular disease, a woman with no jaw after smoking–related oral cancer, and a man having to cover his tracheostomy to shower, a hole for breathing placed in the throat, after losing his trachea to smoking–related cancer. While smoking and cancers have been directly linked through research, the public continues to have only a reactive stance against alcoholism. There is public outcry when a drunken motorist kills another in a fatal accident, but no public outcry over the disease of alcoholism that created the situation. One reason for this is that alcoholism is not commonly written as a cause of death. Chronic alcoholics typically die from liver, heart, and lung disease, and stroke. Alcohol's underlying contribution to these US death rates needs to be illuminated in both research and a public awareness campaign.

The *Tips from Former Smokers* advertisements are graphic and difficult to watch, but they invoke a fear of smoking while portraying the smokers as victims rather than deviants or social outcasts. Like alcoholism, smoking is an addiction. Each anti-smoking

advertisement offered a toll free number and website that smokers could access for tips on how to quit smoking. While some critics considered the campaign scaremongering, these advertisements motivated many smokers to quit, and prevented many young adults from ever beginning to smoke (Jamal et al., 2015). Augustson et al., (2012) reported that within this three month antismoking campaign, calls to the toll free number increased by 132% and visits to the website increased by 428%, with an estimated 566,000 smokers reporting their intentions to quit smoking in the next six months. Duke et al., (2015) suggests that implementing the awareness campaign along with increasing access to smoking cessation aids and services was the key. In a three month follow–up, McAfee, Davis, Alexander, Pechacek, and Bunnell, (2013), found that an estimated 1.6 million smokers were motivated by the campaign to quit smoking and 220,000 were still smoke–free. It is important to note that both the 566,000 smokers reporting intentions to quit and the estimated 1.6 million that were motivated are both proxies, similar to this research's proxy of readmissions and length of stay. These proxies suggest an association but do not predict a cause-and-effect relationship; however, smoking rates in the US have lowered.

The success of the past national anti–smoking campaigns is in sharp contrast to the current state of alcoholism awareness in America. In the New York tri–state area smoking is no longer allowed in bars, yet many cities, like New York City and Hoboken, New Jersey, allow "Santa pub crawls" and "Leprechaun pub crawls" where large groups of people walk around the city from bar to bar drinking alcohol. There is even an Internet site named *pubcrawls.com*. Apparently, it is acceptable to spend the day publicly drunk, just don't smoke in the bar. A national education campaign about alcoholism can mirror

the CDCs anti–smoking campaign and illustrate the physical consequences of alcohol misuse, just as the anti–smoking campaign did for cigarette smoking.

Examples of alcoholism awareness campaign advertisements can include some of the stories associated with this research. One advertisement could show an individual in a long–term care facility, on a ventilator, which is a mechanical breathing apparatus, after he drove drunk into a tree. Another advertisement might feature a yellow–skinned, jaundiced, man suffering liver failure and waiting on the liver transplant list due to cirrhosis. While he has been in recovery for years he is not a priority for the transplant because of his drinking history; a tragic example of how the label of alcoholic, even after recovery, continues to act as a barrier to treatment. Another advertisement can portray a man with 12 years of sobriety who relapses, takes a bath while drunk, passes out in the warm water of the tub and drowns, while his family innocently watches television downstairs.

The reality of the consequences of alcoholism used in a national public awareness campaign have the ability to increase awareness for younger generations, who may think twice about their alcohol consumption when they become adults, or may seek help for alcohol misuse earlier. This type of campaign may also start a national conversation about alcohol misuse and the need for early identification and treatment. The advertisements should also be accompanied by access to help and services. The United States Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) already has a 24 hour toll-free help hotline, called *The National Helpline*. This helpline offers free, confidential treatment referral and information services for both mental health and addiction.

5.5 Future Research in this Area

It is unfortunate that social interpretation, lack of public health initiatives, healthcare system and professional bias, social stigma, and the individual shame and guilt of the alcoholic, all contribute to the insidious nature and pervasiveness of the disease of alcoholism. Further research needs to be conducted into the social understanding of alcoholism to formulate public awareness campaigns that focus on prevention, early identification, and access to treatment. Only through defeating the negative social perceptions of alcoholism can this disease be treated as the chronic illness that it is, which, left untreated, can be progressive and fatal.

Additional research into the effectiveness of narrative in the identification and treatment process of alcohol use disorders (AUD) is also needed. This research suggests that the numeric result of a screening tool does not adequately serve this group. Alcohol use disorders have complex physical and emotional components, and a more in–depth investigation into how narrative can be used to understand the disease of alcoholism and, ultimately, best treat each individual, is needed.

Research into the benefits of elevating narrative in the curricula of medical and nursing education, as well as in the training process of healthcare institutions, can illuminate the potential benefit of understanding the patient on a human level. The ability for healthcare professionals to understand the alcoholic's experience and offer supportive services can enrich the lived experience of both alcoholic and clinician. Healthcare professionals, especially physicians, psychiatrists, and nurses, need to be able to engage with their patients and understand more than the lab results in order to promote a trusting

therapeutic relationship. Narrative is essential to meet these challenges. If I were to re–design this research concept I would focus more on narrative and less on the screening tools used to identify alcohol use disorder (AUD) patients. Narrative would be investigated as both a therapeutic interaction for the AUD patient and a way to enhance compassionate awareness in the healthcare staff. This research design would be twofold.

The first portion of my re–designed study would be longitudinal and utilize specially trained recovering alcoholics as bedside counselors, with the emphasis on therapeutic conversation followed by a more robust attempt at matching the patient to an appropriate treatment program, with follow–up support provided. I can only hope that the informants would be more willing to follow–up with recovering alcoholics than they were with the bedside counselors during this study.

The second portion of my re–designed study would be cross-sectional and would begin with the medical center where the first portion of the study would also take place. Pre-study, I would establish a baseline of healthcare staffs' perceptions of AUD patients and the perceptions of recovery success that the healthcare staff attributes to AUD patients as a group. Interaction would occur between the recovering alcoholic counselors and the healthcare staff, to promote empathy towards patients with AUD, and healthcare staff perceptions towards patients with AUD would be re-evaluated both qualitatively and quantitatively at 6 or 12 month intervals. My hypothesis would be that interaction with recovering alcoholic counselors positively modifies healthcare staff perceptions of alcoholism and enables the healthcare staff to more effectively care for those who misuse alcohol.

5.6 Final Thoughts

This research involving bedside addiction counseling was an educational experience. The medical center was given the opportunity to see whether this type of program had a positive impact on patient care, and I was able to identify some shortcomings in their identification process of patients with alcohol use disorders. According to the main advisor on this research, the Chair of the medical center's Psychiatry Department, this is a unique study in utilizing bedside addiction counseling for patients with addiction, preceded by only two other studies of its kind, which have been mentioned in this dissertation. The success of this research motivated the medical center to continue the bedside addiction counseling program using both compensated and volunteer counselors. I have recommended a national public education and awareness campaign modeled after the CDC's 2012 anti–smoking campaign. I believe this type of national campaign can reduce stigma towards the individual with alcoholism while at the same time increasing the antipathy towards the substance causing the addiction. Drinking alcohol is seen as socially acceptable in American society until it becomes an addiction; alcoholism, on the other hand, is seen as moral failing and deviant behavior. It is time to change the American social interpretation of alcoholism and direct stigma towards the product and not the individual. The anti–smoking campaign was successful in creating sympathy for the portrayed victims of cigarette use while curtailing the desire to smoke among the public; it is time that the same is done for victims of alcohol use.

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Appendices

Appendix A

The *Grapevine* Questionnaire used by Jellinek (1946)

Text of the Grapevine *Questionnaire*

The purpose of this questionnaire is to ascertain at what age the incidents or experiences listed below first happened. The order in which they are set down may not accord with your own experience, but please fill in the year after the item anyway. If you never had a particular experience, leave the space blank. The samples are intended to be suggestive only and are in no way definitive.

At What Age Did You First:

1. Get drunk? (No example or illustration is attempted or necessary. If you were ever drunk you will know what we mean) ....
2. Experience a blackout? (Example: Wake up in the morning after a party with no idea where you had been or what you had done after a certain point) ....
3. Start sneaking drinks? (Example: Take a quick one in the kitchen without anyone seeing you when you were pouring drinks for guests) ....
4. Begin to lose control of drinking? (Example: Intend to have only a couple and wind up cockeyed) ....
5. Rationalize or justify your abnormal drinking? (Example: Excuse your drinking on the ground that you were sad, or happy, or neither) ....
6. Attempt to control your drinking by changing its pattern? (Example: Deciding to drink only before dinner) ....
7. Attempt to control your drinking by going on the wagon? ....
8. Act in a financially extravagant manner while drinking? (Example: Cashing a check for more than you need and spending all of it without getting anything for it except a hangover) ....
9. Start going on week-end drunks? ....
10. Start going on middle-of-the-week drunks? ....
11. Start going on day-time drunks? ....
12. Take a morning drink? (Example: Feel the need of and take a drink the first thing in the morning in order to get yourself going, or "for medicinal purposes only") ....
13. Start going on benders? (Example: Staying drunk for more than a day without regard for your work or your family or anything else) ....
14. Develop indefinable fears? ....
15. Experience acute and persistent remorse? (Example: Realizing that you have made a fool of yourself while drinking without being able to shake the realization off) ....
16. Develop abnormal and unreasonable resentments? (Example: Going into a rage because dinner wasn't ready the minute you got home) ....
17. Commit antisocial acts while drinking? (Example: Pick a fight with a stranger in a saloon for no justifiable reason) ....
18. Realize that your friends or family were trying to prevent or discourage your drinking? ....
19. Become indifferent to the kind or quality of the liquor you drank so long as it did the business? ....
20. Experience uncontrollable tremors (i.e., the jitters, the shakes, or whatever your pet name is) after drinking? ....

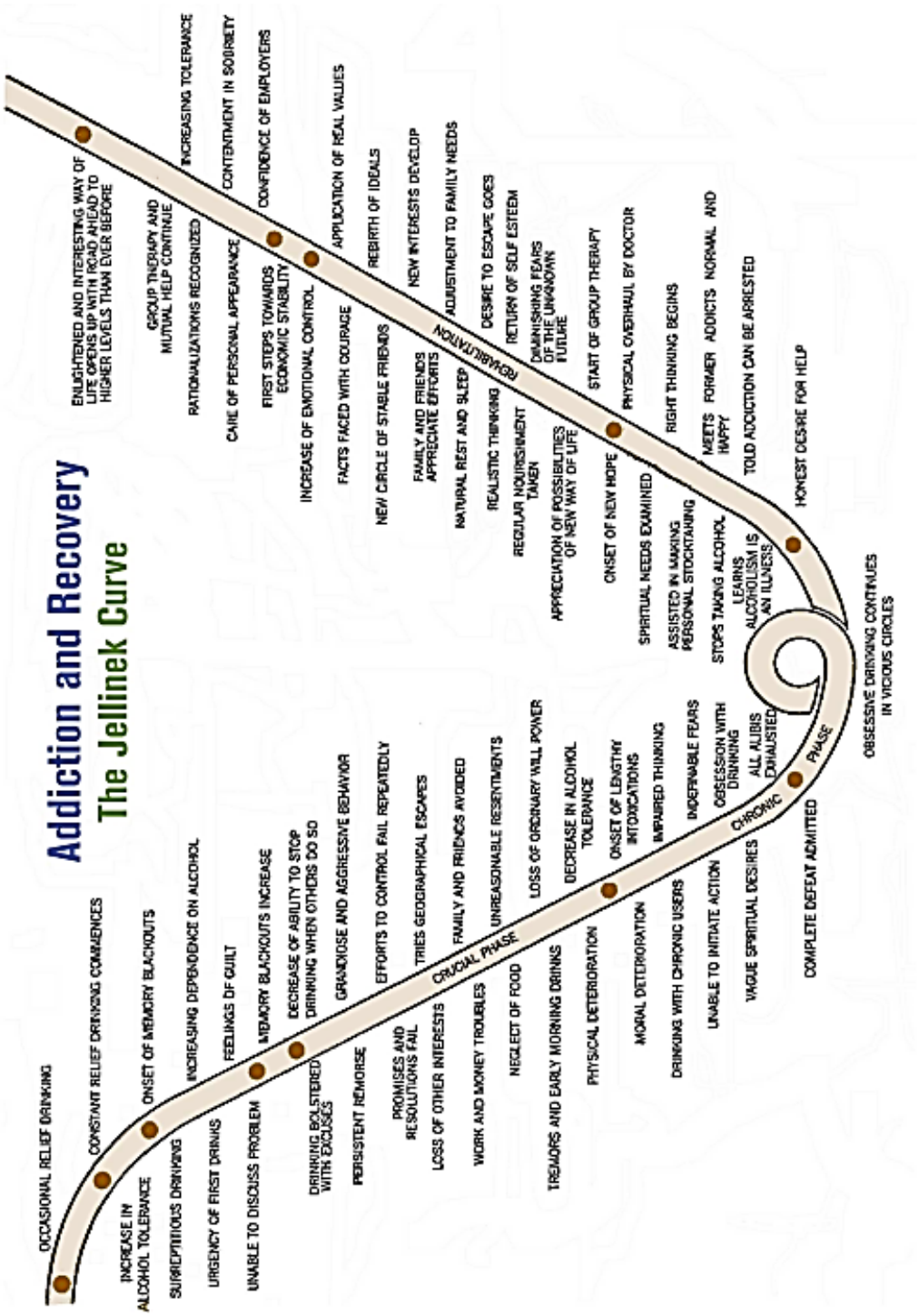
21. Resort to taking sedatives to quiet yourself after drinking? ....
22. Seek medical advice or aid? ....
23. Seek psychiatric advice or aid? (This includes advice or aid from any adviser, such as a minister, a priest or a lawyer, as well as from a psychiatrist) ....
24. Have to be hospitalized as a result of drinking? ....
25. Lose a friend as the result of drinking? ....
26. Lose working time as the result of drinking? ....
27. Lose a job as the result of drinking? ....
28. Lose advancement in a job as the result of drinking? ....
29. Use alcohol to lessen self-consciousness concerning sex? ....
30. Attempt to find comfort in religion? ....
31. Desire to escape from your environment as a solution for the drinking problem? (Example: Deciding that all would be well if only you could get a job in Chicago instead of having to go on working in New York) ....
32. Start solitary drinking? ....
33. Start to protect your supply? (Example: Buying a quart on the way home so you would be sure to have a drink in the morning) ....
34. Admit to yourself that your drinking was beyond control? ....
35. Admit to anyone else that your drinking was beyond control? ....
36. Reach what you regard as your lowest point? ....

Please state the following: (a) Present age .... (b) Sex ....

From: Jellinek, E. M. (1946). [Image]. Phases in the drinking history of alcoholics: Analysis of a survey conducted by the official organ of Alcoholics Anonymous. *Quarterly Journal of Studies on Alcohol, 7*, 1–88.

Appendix B

E. M. Jellinek's Phases of Alcoholism, known as "The Jellinek Curve"



From: The Hazelden Betty Ford Foundation.[Image]. Retrieved December 28, 2018 from https://www.hazeldenbettyford.org/articles/jellinek–curve

Appendix C

Alcohol Use Disorders Identification Test

ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

1. **How often do you have a drink containing alcohol?**
   (0) Never (Skip to Questions 9-10)
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 3 times a week
   (4) 4 or more times a week
2. **How many drinks containing alcohol do you have on a typical day when you are drinking?**
   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7, 8, or 9
   (4) 10 or more
3. **How often do you have six or more drinks on one occasion?**
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
4. **How often during the last year have you found that you were not able to stop drinking once you had started?**
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
5. **How often during the last year have you failed to do what was normally expected from you because of drinking?**
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
6. **How often during the last year have you been unable to remember what happened the night before because you had been drinking?**
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
7. **How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?**
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

8. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

Add up the points associated with answers. A total score of 8 or more indicates harmful drinking behavior.

Total Score: _____

Patient Signature: _____ Date: _____ Time: _____

Brief interventions provided based on above risk assessment:

☐ Not applicable
☐ Patient refused interventions
☐ Handouts/written materials provided: _____
☐ Dangerous situations: _____
☐ Ways of coping: _____
☐ How to remember your plan: _____
☐ Referrals (e.g. AA. etc.): _____
☐ Other: _____

Patient Response: _____

_____

_____

Clinician Signature: _____ Date: _____ Time: _____

From: Atlantic Health System. (2014a). Alcohol use disorders identification test form. [Image]. Morristown, NJ adapted from Babor, T. F., Higgins–Biddle, J. C., Saunders, J. B. & Montiero, M. G. (2001). *The alcohol use disorders test: Guidelines for use in primary care*. (2nd ed.). World Health Organization.

Appendix D

ICD–10 Diagnostic Codes used to Identify and Trigger Bedside Addiction Counseling

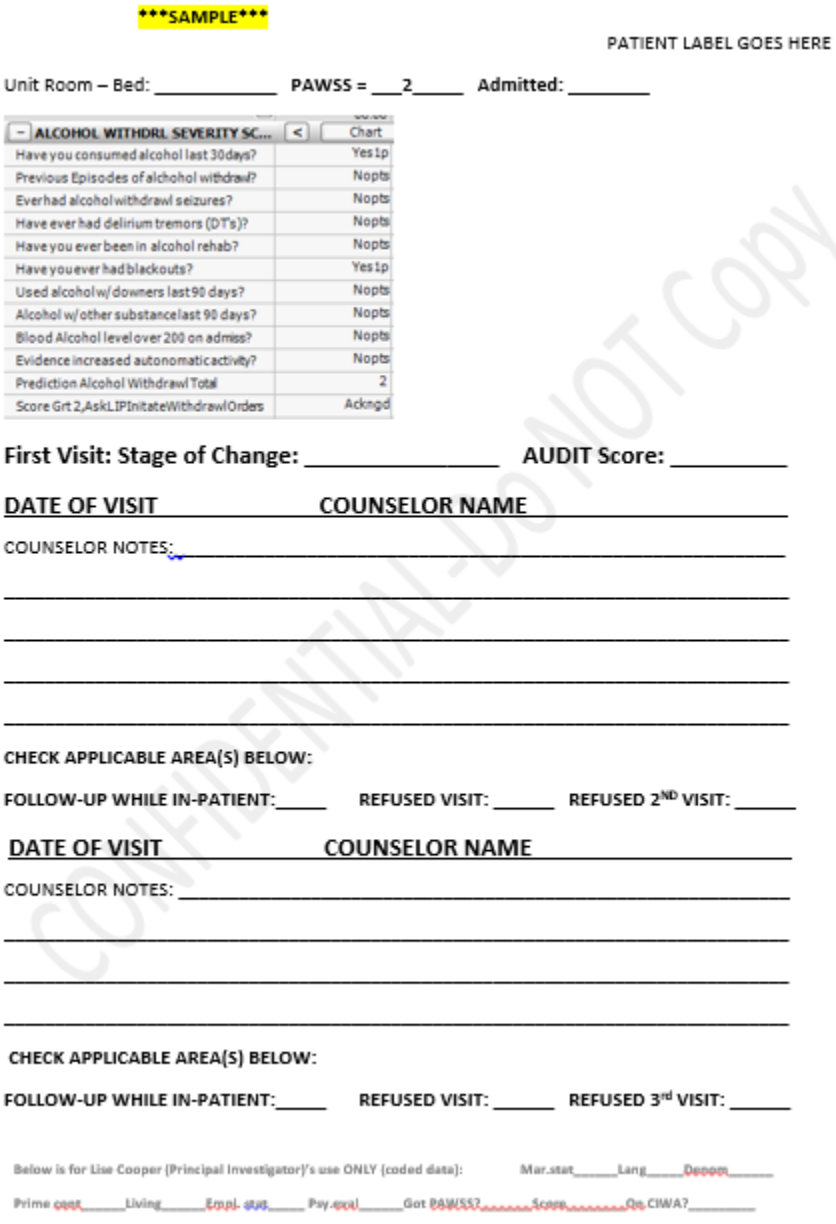
F10220	Alcohol dependence with intoxication, uncomplicated
F10221	Alcohol dependence with intoxication, delirium
F10229	Alcohol dependence with intoxication, unspecified
F10230	Alcohol dependence with withdrawal, uncomplicated
F10231	Alcohol dependence with withdrawal delirium
F10232	Alcohol dependence with withdrawal with perceptual disturbance
F10239	Alcohol dependence with withdrawal, unspecified
F10120	Alcohol abuse with intoxication, uncomplicated
F10121	Alcohol abuse with intoxication, delirium
F10129	Alcohol abuse with intoxication, unspecified
F11220	Opioid dependence with intoxication, uncomplicated
F11220	Opioid dependence with intoxication, uncomplicated
F11220	Opioid dependence with intoxication, uncomplicated
F11221	Opioid dependence with intoxication, delirium
F11229	Opioid dependence with intoxication, unspecified
F1123	Opioid dependence
F11230	Opioid dependence with withdrawal, uncomplicated
F11231	Opioid dependence with withdrawal delirium
F11232	Opioid dependence with withdrawal with perceptual disturbance
F11239	Opioid dependence with withdrawal, unspecified
F11120	Opioid abuse with intoxication, uncomplicated
F11121	Opioid abuse with intoxication, delirium
F11129	Opioid abuse with intoxication, unspecified
F13220	Sedatives, hypnotics, anxiolytics dependence with intoxication, uncomplicated
F13221	Sedatives, hypnotics, anxiolytics dependence with intoxication, delirium
F13229	Sedatives, hypnotics, anxiolytics dependence with intoxication, unspecified
F13230	Sedatives, hypnotics, anxiolytics dependence with withdrawal, uncomplicated
F13231	Sedatives, hypnotics, anxiolytics dependence with withdrawal delirium
F13232	Sedatives, hypnotics, anxiolytics dependence with withdrawal with perceptual disturbance
F13239	Sedatives, hypnotics, anxiolytics dependence with withdrawal, unspecified
F13120	Sedatives, hypnotics, anxiolytics abuse with intoxication, uncomplicated
F13121	Sedatives, hypnotics, anxiolytics abuse with intoxication, delirium
F13129	Sedatives, hypnotics, anxiolytics abuse with intoxication, unspecified
F14220	Cocaine dependence with intoxication, uncomplicated
F14221	Cocaine dependence with intoxication, delirium
F14229	Cocaine dependence with intoxication, unspecified
F1423	Cocaine dependence with withdrawal
F14230	Cocaine dependence with withdrawal, uncomplicated

F14231	Cocaine dependence with withdrawal delirium
F14232	Cocaine dependence with withdrawal with perceptual disturbance
F14239	Cocaine dependence with withdrawal, unspecified
F14120	Cocaine abuse with intoxication, uncomplicated
F14121	Cocaine abuse with intoxication, delirium
F14129	Cocaine abuse with intoxication, unspecified
F16220	Hallucinogens dependence with intoxication, uncomplicated
F16221	Hallucinogens dependence with intoxication, delirium
F16229	Hallucinogens dependence with intoxication, unspecified
F16230	Hallucinogens dependence with withdrawal, uncomplicated
F16231	Hallucinogens dependence with withdrawal delirium
F16232	Hallucinogens dependence with withdrawal with perceptual disturbance
F16239	Hallucinogens dependence with withdrawal, unspecified
F16120	Hallucinogens abuse with intoxication, uncomplicated
F16121	Hallucinogens abuse with intoxication, delirium
F16129	Hallucinogens abuse with intoxication, unspecified
F19220	Other psychoactive substance dependence with intoxication, uncomplicated
F19221	Other psychoactive substance dependence with intoxication, delirium
F19229	Other psychoactive substance dependence with intoxication, unspecified
F19230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19231	Other psychoactive substance dependence with withdrawal delirium
F19232	Other psychoactive substance dependence with withdrawal with perceptual disturbance
F19239	Other psychoactive substance dependence with withdrawal, unspecified
F19120	Other psychoactive substance abuse with intoxication, uncomplicated
F19121	Other psychoactive substance abuse with intoxication, delirium
F19129	Other psychoactive substance abuse with intoxication, unspecified

From: Centers for Disease Control and Prevention. (2016). [Image]. International Classification of Diseases, Clinical Modification (ICD–10–CM). Retrieved Nov 15, 2018 from https://www.cdc.gov/nchs/icd/icd10cm.htm

Appendix E

Counselor Assessment Note Form



SAMPLE

PATIENT LABEL GOES HERE

Unit Room – Bed: _____ PAWSS = ___2_____ Admitted: _____

ALCOHOL WITHDRL SEVERITY SC...	<	Chart
Have you consumed alcohol last 30days?		Yes1p
Previous Episodes of alchohol withdrawl?		Nopts
Ever had alcohol withdrawl seizures?		Nopts
Have ever had delirium tremors (DT's)?		Nopts
Have you ever been in alcohol rehab?		Nopts
Have you ever had blackouts?		Yes1p
Used alcohol w/ downers last 90 days?		Nopts
Alcohol w/other substance last 90 days?		Nopts
Blood Alcohol level over 200 on admiss?		Nopts
Evidence increased autonomatic activity?		Nopts
Prediction Alcohol Withdrawl Total		2
Score Grt 2,AskLIPInitateWithdrawlOrders		Acknqd

First Visit: Stage of Change: _____ AUDIT Score: _____

DATE OF VISIT COUNSELOR NAME

COUNSELOR NOTES: _____

_____

_____

_____

_____

CHECK APPLICABLE AREA(S) BELOW:

FOLLOW-UP WHILE IN-PATIENT:_____ REFUSED VISIT: _____ REFUSED 2ND VISIT: _____

DATE OF VISIT COUNSELOR NAME

COUNSELOR NOTES: _____

_____

_____

_____

CHECK APPLICABLE AREA(S) BELOW:

FOLLOW-UP WHILE IN-PATIENT:_____ REFUSED VISIT: _____ REFUSED 3rd VISIT: _____

Below is for Lise Cooper (Principal Investigator)'s use ONLY (coded data): Mar.stat_____Lang_____Depom_____

Prime cost_____Living_____Empl. stus_____ Pay.eval_____Got PAWSS?_____Score_____On CIWA?_____

Created by: Principal Investigator Lise Cooper, MSN, RN–BC (2014). [Image].

Appendix F

Clinical Institute Withdrawal Assessment–revised

Health System

PREVENTION AND INITIAL TREATMENT OF ALCOHOL WITHDRAWAL
PAGE 1 of 2

- DATE & TIME ALL ORDERS -

Patient Wt. _____ kg Allergies: _____

Consults:

☐ Social work ☐ Psychiatry ☐ Toxicology ☐ Speech therapy for dysphagia evaluation

MEDICATIONS

VITAMIN SUPPLEMENTATION *(Vitamin supplementation beyond Day 3 is not necessary)*

Day 1

☐ **IV:** 1000 mL 0.9% Sodium Chloride with Multivitamins 10 mL/Folic acid 1 mg/Thiamine 100 mg at 125 mL/hour x 8 hours and then _____ at _____ mL/hour

Day 2 and 3

☐ **IV:** 1000 mL 0.9% Sodium Chloride with Multivitamins 10 mL/Folic acid 1 mg/Thiamine 100 mg at 125 mL/hour x 8 hours and then _____ at _____ mL/hour

OR

☐ **PO**
Multivitamins 1 tablet PO daily
Folic acid 1 mg PO daily
Thiamine 100 mg PO daily

☐ **NGT/OGT**
Multivitamins 10 mL liquid NGT/OGT daily
Folic acid 1 mg NGT/OGT daily
Thiamine 100 mg NGT/OGT daily

ALCOHOL WITHDRAWAL TREATMENT OPTIONS *(Refer to Page 2)*

Define: Prediction of Alcohol Withdrawal Severity Scale (PAWSS): _____

Choose One:

☐ **Symptom-Triggered Assessment ONLY** (only for patients with PAWSS less than or equal to 3)

☐ **Fixed-Doses and Symptom-Triggered Assessment** (for patients with PAWSS greater or equal to 4, recommend to use the same agent for fixed-doses and symptom-triggered)

GENERAL INSTRUCTIONS FOR INITIATION, MAINTENANCE, AND TAPER

- Assess withdrawal severity (and benzodiazepine dose) based on class (revised Clinical Institute Withdrawal for Alcohol (CIWA-Ar) and presence of vital signs (see boxes below).
- If patient is placed on fixed-dose, the class (and benzodiazepine dose) is determined at the initial assessment.
- For patients on fixed-dose the frequency of symptom triggered reassessment should be based on the class as indicated by the symptom triggered assessment.
- **Give fixed-dose if both fixed and symptom-triggered doses are due at the same time.**
- Fixed-dose must be reassessed every 24 hours and accounting for the symptom-triggered doses from last 24 hours.
  1. Reassess every 24 hours, the new fixed dose is determined by adding the total fixed dose from the preceding 24 hours plus all symptom-triggered doses over past 24 hours.
  2. Begin taper (when **NO** symptom-triggered doses needed for 48 hours) decreasing total fixed dose by 25% daily. Initially, it is recommended to decrease the dosage and maintain dosing frequency. Towards the end of taper decrease frequency to every 8 or 12 hours. Taper may need to be slowed down if symptom-triggered doses are required.
  3. Fixed dose should be maintained for 48 hours beyond the last symptom-triggered dose.

MONITORING

- Hold doses for somnolence, respiratory rate 10 or less, SBP 100 or less.
- Call MD for any of the following:
  1. CIWA –Ar score greater than 15
  2. Respiratory Rate 10 or less
  3. Minimal or no response to physical stimulation

Physician Signature: Date: Time:

Contact Number: ID#:

DOCTOR'S ORDER SHEET

Health System

PREVENTION AND INITIAL TREATMENT OF ALCOHOLWITHDRAWAL
PAGE 2 of 2

- DATE & TIME ALL ORDERS -

Patient Wt. _____ kg Allergies: _____

Classes Based on CIWA-Ar Scores:
Class 1: CIWA-Ar score less than or equal to 7
Class 2: CIWA-Ar score between 8 and 15
Class 3: CIWA-Ar score between 16 and 20
Class 4: CIWA-Ar score greater than or equal 21

Vital Signs (VS)
*Must fulfill **all three** and be related to alcohol withdrawal rather than alternative illness (sepsis, pancreatitis, major trauma, etc.)*
Temperature greater or equal to 38.5°C
SBP greater than 160
HR greater than 120

SYMPTOM – TRIGGERED ASSESSMENT

Choose ONE (Benzodiazepine and Route of Administration; Nursing Assessment based on CIWA-Ar and VS will determine Class):

LORazepam is preferred in patients greater than 65 years of age, hepatic dysfunction (INR greater than 1.6), and/or renal dysfunction (CrCl less than 30 mL/min, SCr greater than 2 mg/dL)

Class			☐ DIAzepam ☐ IV ☐ PO/NGT/OGT	☐ LORazepam ☐ IV ☐ PO/NGT/OGT	☐ ChlordiazePOXIDE ☐ PO/NGT/OGT	Reassess
1			none	none	none	Every 4 hours
2	OR	1+VS	10 mg	2 mg	50 mg	Every 2 hours
3	OR	2+VS	15 mg	3 mg	75 mg	Every 1 hour
4	OR	3+VS	20 mg	4 mg	100 mg	Every 30 minutes
			If assessed as Class 4 twice consecutively, consider transfer to higher level of care			
		4+VS	30 mg	6 mg	150 mg	Every 30 minutes
			If assessed as Class 4 plus VS, consider transfer to higher level of care			

FIXED – DOSES

Choose ONE (Class, Benzodiazepine, and Route of Administration):

LORazepam is preferred in patients greater than 65 years of age, hepatic dysfunction (INR greater than 1.6), and/or renal dysfunction (CrCl less than 30 mL/min, SCr greater than 2 mg/dL)

Choose One Based on Initial Assessment	Class			☐ DIAzepam ☐ IV ☐ PO/NGT/OGT	☐ LORazepam ☐ IV ☐ PO/NGT/OGT	☐ ChlordiazePOXIDE ☐ PO/NGT/OGT
☐	1			none	none	none
☐	2	OR	1 + VS	10 mg every 6 hours	2 mg every 4 hours	50 mg every 6 hours
☐	3	OR	2 + VS	15 mg every 6 hours	3 mg every 4 hours	75 mg every 6 hours
☐	4	OR	3 + VS	20 mg every 6 hours	4 mg every 4 hours	100 mg every 6 hours
☐			4 + VS	____ mg every 6 hours	____ mg every 4 hours	____ mg every 6 hours

Benzodizepine Equivalence Chart Reference

Benzodiazepine	Comparative Dose (mg)	Time to Peak (hours)	Half-life (hours)
DIAzepam	5	1-2	30-200
LORazepam	1	2-4	8-24
ChlordiazePOXIDE	25	1-4	24-100

Physician Signature: Date: Time:

Contact Number: ID#:

DOCTOR'S ORDER SHEET

PREVENTION AND INITIAL TREATMENT OF ALCOHOL WITHDRAWAL NURSING DOCUMENTATION

NAUSEA & VOMITING
'Do you feel sick to your stomach? Have you vomited?'
Observations:
0 – No nausea and/or vomiting
1 – Mild nausea without vomiting
2
3
4 – Intermediate nausea with dry heaves
5
6
7 – Constant nausea. Frequent dry heaves & vomiting

TREMOR
Arms extended & fingers spread apart
Observations:
0 – No tremor
1 – Not visible, but can be felt fingertip to fingertip
2
3
4 – Moderate, with patient's arms extended
5
6
7 – Severe, even with arms not extended

PAROXYSMAL SWEATS
Observations:
0 – No sweat visible
1 – Barely perceptible sweating, palms moist
2
3
4 – Beads of sweat visible on forehead
5
6
7 – Drenching sweats

ANXIETY
Ask, 'Do you feel Nervous?' Observations:
0 – No Anxiety/at ease
1 – Mildly anxious
2
3
4 – Moderately anxious, or guarded, so anxiety inferred
5
6
7 – Equivalent to acute panic states, as seen in severe delirium or acute schizophrenic reactions

AGITATION
Observations:
0 – No activity
1 – Somewhat more than normal activity
2
3
4 – Moderately fidgety and restless
5
6
7 – Paces back and forth during most of the interview or constantly thrashes about

TACTILE DISTURBANCES
Ask, 'Have you any itching, pins & needles; any burning, any numbness or feel bugs crawling on or under your skin?'
Observations:
0 – None
1 – Very mild itching, pins & needles, burning, numbness etc.
2 – Mild itching, pins & needles, burning, numbness etc.
3 – Moderate itching, pins & needles, burning, numbness etc.
4 – Moderately severe hallucinations
5 – Severe hallucinations
6 – Extremely severe hallucinations
7 – Continuous hallucinations

AUDITORY DISTURBANCES
Ask, 'Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing things that are disturbing to you? Are you hearing things you know are not there?'
Observations:
0 – Not present
1 – Very mild harshness or ability to frighten
2 – Mild harshness or ability to frighten
3 – Moderate harshness or ability to frighten
4 – Moderately severe hallucinations
5 – Severe hallucinations
6 – Extremely severe hallucinations
7 – Continuous hallucinations

VISUAL HALLUCINATIONS
Ask, 'Does the light seem too bright, colors different? Does the light hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things that you know are not there? Observations:
0 – Not present
1 – Very mild sensitivity
2 – Mild sensitivity
3 – Moderate sensitivity
4 – Moderately severe hallucinations
5 – Severe hallucinations
6 – Extremely severe hallucinations
7 – Continuous hallucinations

HEADACHE, FULLNESS IN HEAD
Ask, 'Does your head feel different? Does it feel like there's a band around your head?' (Do not rate for dizziness or light-headedness) Otherwise, rate severity.
0 – Not present
1 – Very mild
2 – Mild
3 – Moderate
4 – Moderately severe
5 – Severe
6 – Very severe
7 – Extremely severe

ORIENTATION & CLOUDING OF SENSORIUM
Ask, 'What day is it? Where are you? Who am I?
0 – Oriented, and can do serial additions
1 – Can't do serial additions, or uncertain about date
2 – Disoriented for date by no more than two days
3 – Disoriented for date by more than two days
4 – Disoriented for place and person

From: Atlantic Health System, Morristown, NJ. (2014b). [Image].

Appendix G

Screening, Brief Intervention, and Referral to Treatment–Abridged

National Screening, Brief Intervention and Referral to Treatment (SBIRT)
ATTC

Substance Use Screening, Brief Intervention, and Referral to Treatment

Primary Goal

- The primary goal of SBIRT **is not** to identify those who are have a substance use disorder and need further assessment.
- The primary goal of SBIRT **is to** identify those who are at moderate or high risk for psycho-social or health care problems related to their substance use choices.

2

National Screening, Brief Intervention & Referral to Treatment
ATTC Addiction Technology Transfer Center Network

The SBIRT Concept

- SBIRT uses a public health approach to universal screening for substance use problems.
  - SBIRT provides:
    - Immediate rule out of non-problem users;
    - Identification of levels of risk;
    - Identification of patients who would benefit from brief advice;
    - Identification of patients who would benefit from further assessment, and;
    - Progressive levels of clinical interventions based on need and motivation for change.

4

National Screening, Brief Intervention & Referral to Treatment
ATTC Addiction Technology Transfer Center Network

Screening Does Not Provide

A Diagnosis

7

National Screening, Brief Intervention & Referral to Treatment
ATTC Addiction Technology Transfer Center Network

Screening Does Provide

- Immediate rule-out of low/no risk users.
- Immediate identification of level of risk.
- A context for a discussion of substance use.
- Information on the level of involvement in substance use.
- Insight into areas where substance use may be problematic.
- Identification of patients who are most likely to benefit from brief intervention.
- Identification of patients who are most likely in need of referral for further assessment.

8

National Screening, Brief Intervention & Referral to Treatment
ATTC Addiction Technology Transfer Center Network

Validated Screening Tools

- ***AUDIT*: Alcohol Use Disorder Identification Test.**
  World Health Organization. (1982). *The Alcohol Use Disorders Identification Test.*
- DAST: Drug Abuse Screening Test.
  The Addiction Research Foundation. (1982). *The Drug Abuse Screening Test.*
- POSIT: Problem Oriented Screening Instrument for Teenagers.
  National Institute on Drug Abuse. (1991). *The Problem Oriented Screening Instrument for Teenagers.*
- CRAFFT: Car, Relax, Alone, Forget, Family or Friends, Trouble (for adolescents).
  Knight, J. R., Sherritt, L., Shrier, L. A., Harris, S. K., & Chang, G. (2002). Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Archives of Pediatrics & Adolescent Medicine, 156*(6), 607-614.
- ASSIST: Alcohol, Smoking, and Substance Abuse Involvement Screening Test.
  World Health Organization. (2002). The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): development, reliability and feasibility. *Addiction, 97*(9), 1183-94.
- GAIN or GAIN-SS: Global Appraisal of Individual Needs.
  Dennis, M. L., & Rourke, K. M. (1998). Global appraisal of individual needs. *Bloomington, IL: Chestnut Health Systems.*

9

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What are the Goals of BI?

- The general goal of a BI is to:
  - Educate the patient on safe levels of substance use.
  - Increase the patients awareness of the consequences of substance use.
  - Motivate the patient towards changing substance use behavior.
  - Assist the patient in making choices that reduce their risk of substance use problems.
- The goals of a BI are fluid and are dependent on a variety of factors including:
  - The patients screening score.
  - The patients readiness to change.
  - The patients specific needs.

20

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What is Your Role?

- Provide feedback about the screening results.
- Offer information on low-risk substance use, the link between substance use and other lifestyle or healthcare related problems.
- Understand the client's viewpoint regarding their substance use.
- Explore a menu of options for change.
- Assist the patient in making new decisions regarding their substance use.
- Support the patient in making changes in their substance use behavior.
- Give advice if requested.

21

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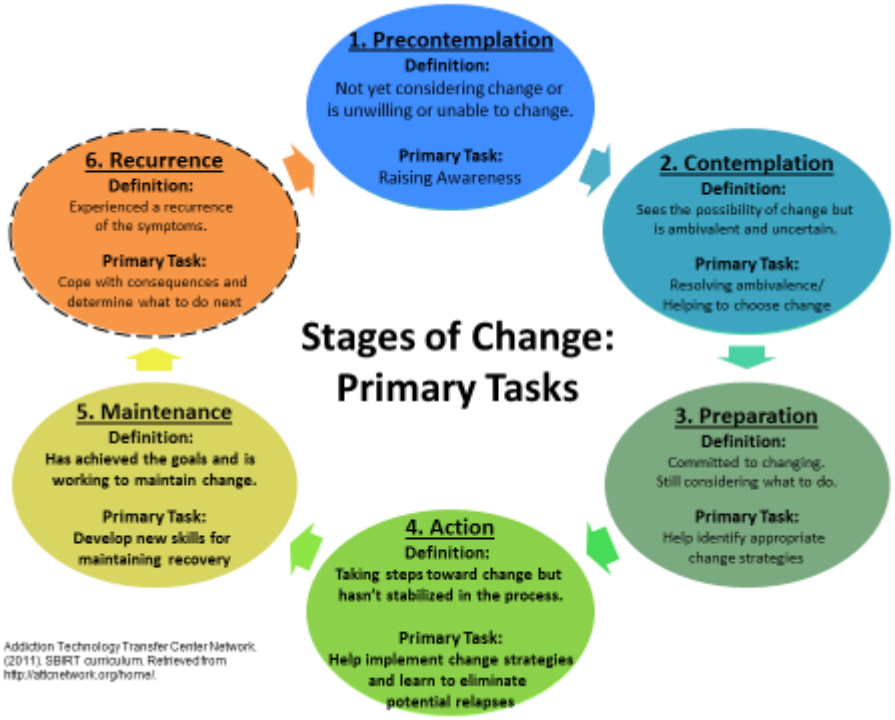
Where Do I Start?

What you **do** depends on where the patient **is** in the process of changing.

The first step is to be able to **identify where the patient is coming from.**



Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/.

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Motivational Interviewing

Motivational Interviewing is a person-centered, evidence-based, goal-oriented method for enhancing intrinsic motivation to change by exploring and resolving ambivalence with the individual.

26

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Why Motivation

- Research has shown that motivation-enhancing approaches are associated with greater participation in treatment and positive treatment outcomes.

(Landry, 1996)
(Miller, et al., 1995)

- A positive attitude and commitment to change are also associated with positive outcomes.

(Miller & Tonigan, 1996)
(Prochaska & DiClemente, 1992)

27

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Motivation

- Motivation is not something one has but is something one does.
- Motivation is a key to change.
- Motivation is dynamic and fluctuates.
- Motivation can be influenced.
- Motivation can be modified.
- The clinician can elicit and enhance motivation.

28

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The Spirit of MI

- MI is an adaptation and extension of Carl Roger's humanistic client-centered style.

- MI is as much a way of being with patients as it is a therapeutic approach to counseling.

29

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Motivational Interviewing

- Is focused on competency and strength:
  - Motivational Interviewing affirms the client, emphasizes free choice, supports self efficacy, and encourages optimism that changes can be made.
- Is individualized and client centered:
  - Research indicates that positive outcomes are associated with flexible program policies and focus on individual needs (Inciardi et al., 1993).
- Does not label:
  - Motivational Interviewing avoids using names, especially with those who may not agree with a diagnosis or don't see a specific behavior as problematic.

Inciardi, J., Horowitz, R., & Pottieger, A.E. (1993). *Street Kids, Street Drugs, Street Crime: An Examination of Drug Use and Serious Delinquency in America*. Belmont, TN: Wadsworth Publishing.

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Motivational Interviewing

- Creates therapeutic partnerships:
  - Motivational Interviewing encourages an active partnership where the client and counselor work together to establish treatment goals and develop strategies.
- Uses empathy not authority:
  - Research indicates that positive outcomes are related to empathy and warm and supportive listening.
- Focuses on less intensive treatment:
  - Motivational Interviewing places an emphasis on less intensive, but equally effective care, especially for those whose use is problematic or risky but not yet serious.

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Motivational Interviewing

- Assumes motivation is fluid and can be influenced.
- Motivation is influenced in the context of a relationship – developed in the context of a patient encounter.
- Principle tasks – to work with ambivalence and resistance.
- Goal – to influence change in the direction of health.

32

Types of Change Talk

- **Desire:** I want to.... I'd really like to....I wish....
- **Ability:** I would....I can....I am able to....I could....
- **Reason:** There are good reasons to....This is important....
- **Need:** I really need to....
- **Commitment:** I intend to....I will....I plan to....
- **Activation:** I'm doing this today....
- **Taking Steps:** I went to my first group....

36

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Four BI Model Options

- **FLO** (**F**eedback, **L**isten and understand, **O**ptions explored)
- **4 Steps of the BNI** (Raise the Subject; Provide Feedback; Enhance Motivation; Negotiate and Advise)
- **Brief Negotiated Interview (BNI) Algorithm** (Build Rapport; Pros and Cons; Information and Feedback; Readiness Ruler; Action Plan)
- **FRAMES** (**F**eedback; **R**esponsibility; **A**dvice; **M**enu of options; **E**mpathy; **S**elf efficacy)

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Option 2: the 4 Steps of a BNI

1) Raise The Subject
2) Provide Feedback
3) Enhance Motivation
4) Negotiate And Advise

D'Onofrio, G., Pantalon, M.V., Degutis, L.C., O'Connor, P.G., Fiellin, D., Owens, P., & Martel-Regan, S. (2008). Screening, brief intervention, and referral to treatment (SBIRT) training manual for alcohol and other drug problems. Retrieved from http://medicine.yale.edu/sbirt/curriculum/manuals/SBIRT%20training%20manual_2012_tcm608-100719_tcm608-284-32.pdf

Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/.

Step 1: Raise the Subject

Key Components

- Be respectful
- Ask permission to discuss use
- Avoid arguing or being confrontational

Key Objectives

- Establish rapport
- Raise the subject

Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/.

Step 2: Provide Feedback

What you need to cover.

1. Ask permission; explain how the screen is scored
2. Range of scores and context
3. Screening results
4. Interpretation of results (e.g., risk level)
5. Substance use norms in population
6. Patient feedback about results

Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/.

Feedback

What do you say?

- **Range of score and context** - Scores on the AUDIT range from 0-40. Most people who are social drinkers score less than 8.
- **Results** - Your score was 18 on the alcohol screen.
- **Interpretation of results** - 18 puts you in the high risk range. At this level, your use is putting you at risk for a variety of health issues and other negative consequences.
- **Norms** - A score of 18 means that your drinking is higher than 70% of the U.S. adult population.
- **Patient reaction/feedback** - What do you make of this?

Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/.

Feedback

Handling Resistance

- Look, I don't have a drug problem.
- My dad was an alcoholic; I'm not like him.
- I can quit using anytime I want to.
- I just like the taste.
- Everybody drinks.

What would you say?

Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/.

Feedback

Easy Ways to Let Go

- I'm not going to push you to change anything you don't want to change.
- I'm not here to convince you that you have a problem/are an alcoholic.
- I'd just like to give you some information.
- I'd really like to hear your thoughts about…
- What you decide to do is up to you.

Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/.

Feedback

Finding a Hook

- Ask the patient about their concerns
- Provide non-judgmental feedback/information
- Watch for signs of discomfort with status quo or interest or ability to change
- **Always ask this question: "What role, if any, do you think alcohol played in your (getting injured)?**
- Let the patient decide.
- Just asking the question is helpful.

Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/.

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Step 3: Enhancing Motivation

Critical components:

- Develop discrepancy
- Reflective listening
- Open-ended questions
- Assess readiness to change

Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/.

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Enhance Motivation

Importance/Confidence/Readiness

On a scale of 1–10…

- How important is it for you to change your drinking?
- How confident are you that you can change your drinking?
- How ready are you to change your drinking?

For each ask:

- Why didn't you give it a lower number?
- What would it take to raise that number?

	1	2	3	4	5	6	7	8	9	10

Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/.

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Enhance Motivation

- Strategies for Weighing the Pros and Cons
- What do you like about drinking?
- What do you see as the downside of drinking?
- What else?
- Summarize Both Pros and Cons
- "On the one hand you said..,
- and on the other you said…."

Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/.

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Dig for Change Talk

- I'd like to hear your opinions about…
- What might you enjoy about…
- If you decided to ____ how would you do it?
- What are some things that bother you about using?
- What role do you think ____ played in your _____?
- How would you like your drinking/using to be 5 years from now?
- What do you need to do in order to_____?

Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/.

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Listen to Understand Dilemma. Don't Give Advice.

- Ask:
- Why do you want to make this change?
- What abilities do you have that make it possible to make this change if you decided to do so?
- Why do you think you should make this change?
- What are the 3 best reasons for you to do it?
- Give short summary/reflection of speaker's motivation for change
- Then ask: "So what do you think you'll do?"

Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/.

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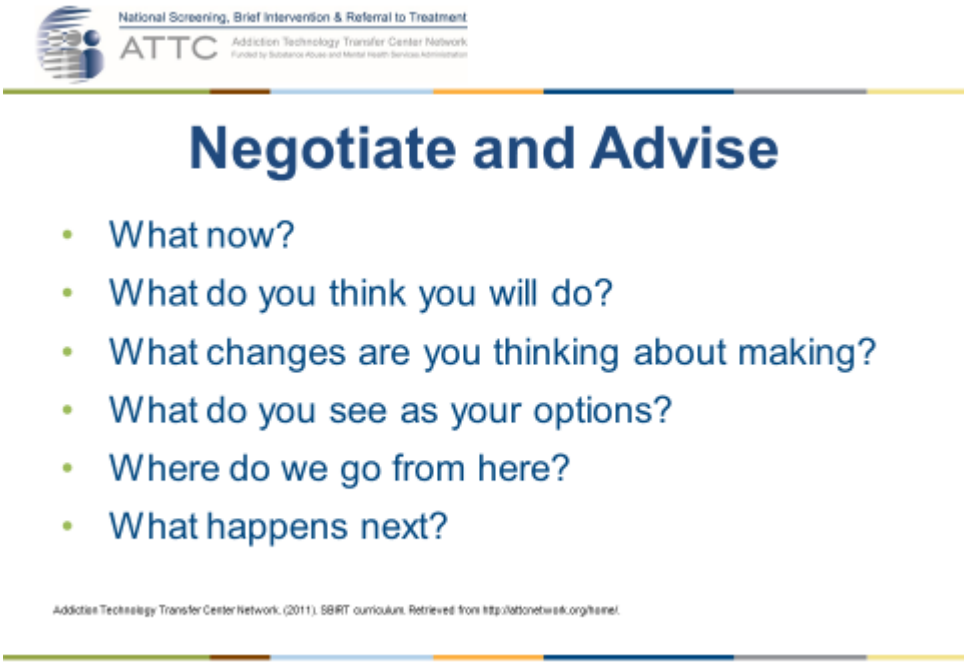
Step 4: Negotiate and Advise

- **Critical components:**
- Negotiate a plan on how to cut back and/or reduce harm
- Direct advice
- Provide patient health information
- Follow-up

Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/.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ATTC
Addiction Technology Transfer Center Network
Negotiate and Advise
What now?
What do you think you will do?
What changes are you thinking about making?
What do you see as your options?
Where do we go from here?
What happens next?
Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/.


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Negotiate and Advise
You can also explore previous strengths, resources, and successes
Have you stopped drinking/using drugs before?
What personal strengths allowed you to do it?
Who helped you and what did you do?
Have you made other kinds of changes successfully in the past?
How did you accomplish these things
Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/.


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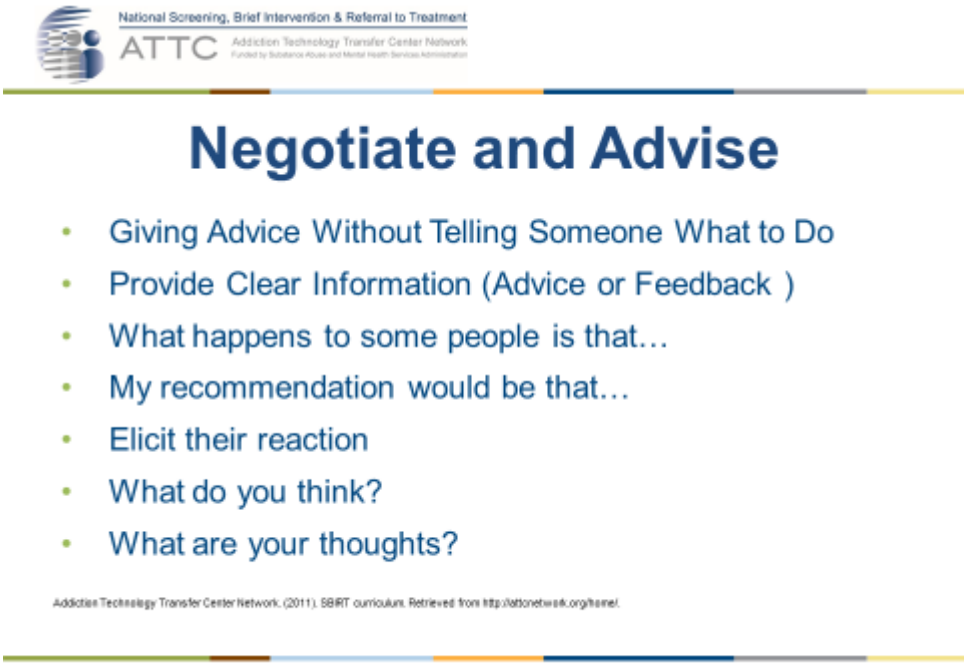
Negotiate and Advise
Offer a Menu of Options
Manage drinking/use (cut down to low-risk limits)
Eliminate your drinking/drug use (quit)
Never drink and drive (reduce harm)
Utterly nothing (no change)
Seek help (refer to treatment)
Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/.


National Screening, Brief Intervention & Referral to Treatment
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Negotiate and Advise
Giving Advice Without Telling Someone What to Do
Provide Clear Information (Advice or Feedback)
What happens to some people is that…
My recommendation would be that…
Elicit their reaction
What do you think?
What are your thoughts?
Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/.

Negotiate and Advise

- Closing the Conversation ("SEW")
- Summarize patients views (especially the pro)
- Encourage them to share their views
- What agreement was reached (repeat it)

Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/.

Role play: Putting It All Together

1. **Raise The Subject**
   - Establish rapport
   - Raise the subject
2. **Provide Feedback**
   - Provide screening results
   - Relate to norms
   - Get their reaction
3. **Enhance Motivation**
   - Assess readiness
   - Develop discrepancy
   - Dig for Change
4. **Negotiate and Advise**
   - Menu of Options
   - Offer advise

Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/.

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Referral to Treatment

- Approximately 5% of patients screened will require referral to substance use evaluation and treatment.
- A patient may be appropriate for referral when:
  - Assessment of the patient's responses to the screening reveals serious medical, social, legal, or interpersonal consequences associated with their substance use.

These high risk patients will receive a brief intervention followed by referral.

Addiction Technology Transfer Center Network. (2011). SBIRT curriculum. Retrieved from http://attcnetwork.org/home/

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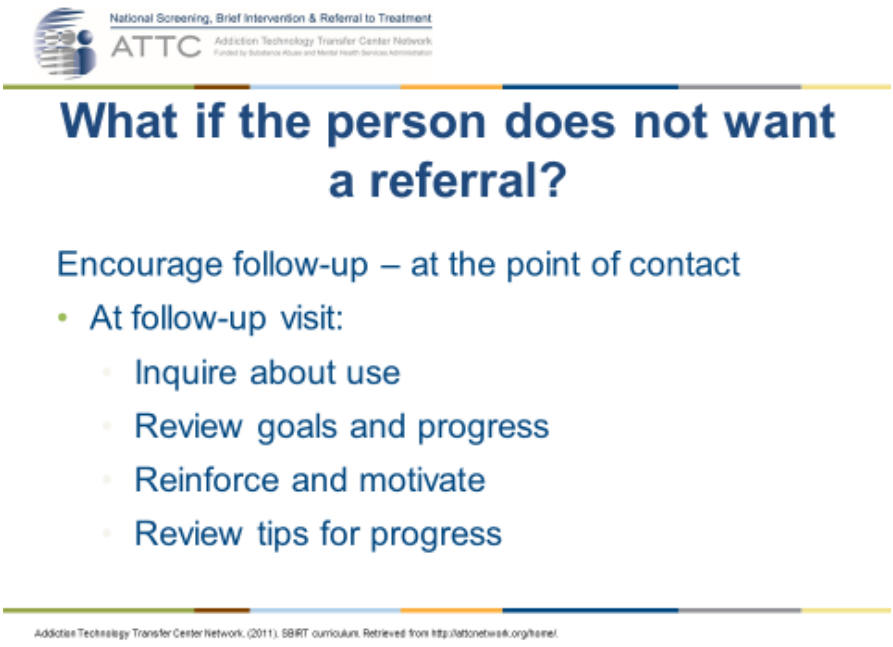
Referral to Treatment

- Always:
  - Follow appropriate confidentiality (42, CFR-Part 2) and HIPAA regulations when sharing information.
  - Establish a relationship with your community provider(s) and ensure you have a referral agreement.
  - Maintain a list of providers, support services, and other information that may be helpful to patients.
  - Reduce barriers and build bridges.



From: Substance Abuse and Mental Health Services Administration. (n.d.). *SBIRT Curriculum*. [Image]. Retrieved November 23, 2018 from https://www.samhsa.gov/

Appendix H

Scripted Steps to Initiate Motivational Interviewing and Establish a Therapeutic Relationship between the Bedside Addiction Counselor and the Informant

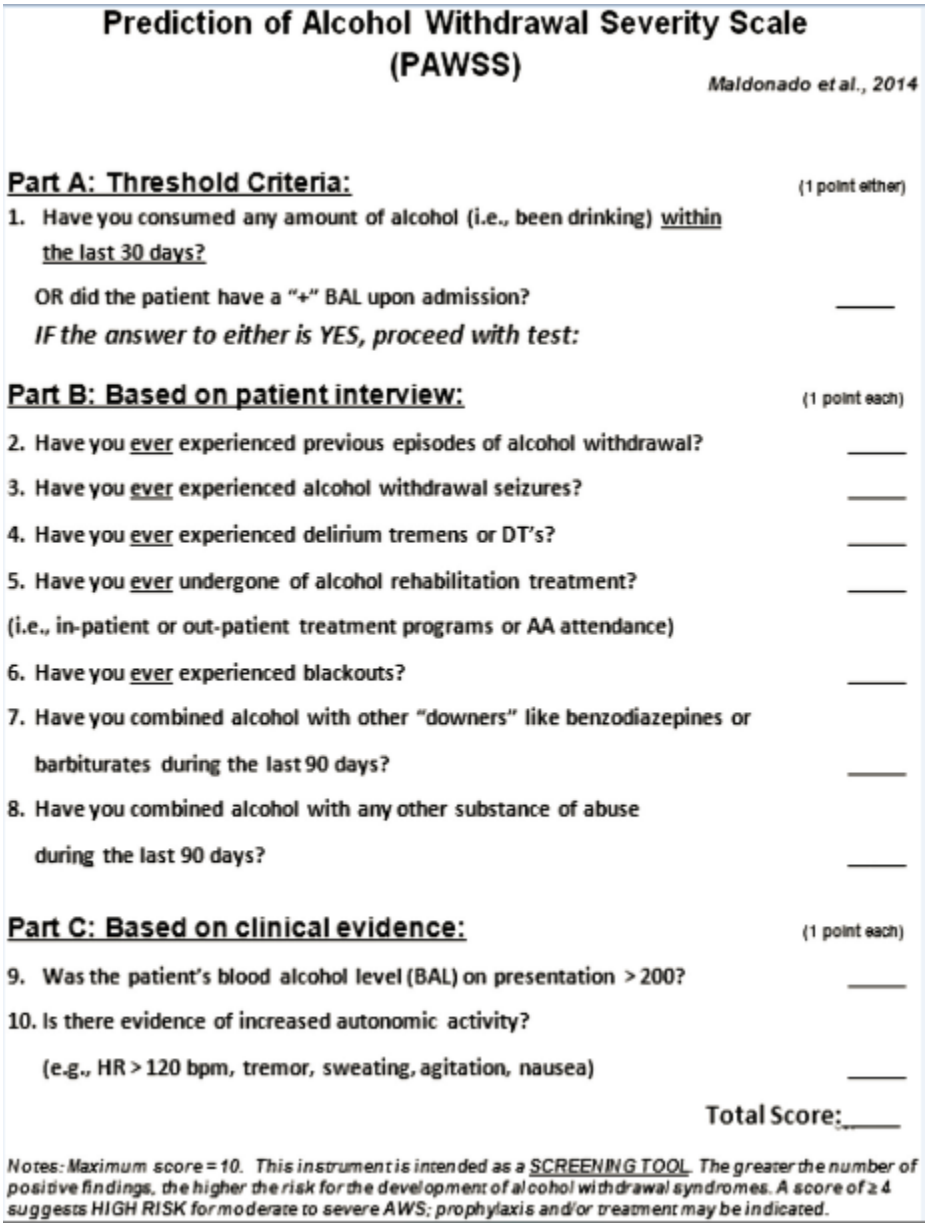
1. Prior to initializing contact with the patient:
    a. Find out any concerns regarding the patient from physician, nurse, social worker, or care manager to determine if the patient meets study inclusion criteria E, F, & G.
    b. If the patient meets these criteria, gather information from the healthcare team to better understand the patient situation and any potential therapeutic barriers.
2. Determine correct patient identity by checking the wrist band and asking the patient's name:
    a. "Can you please tell me your name?" (If patient name does not match the name on your counseling sheet, politely end the conversation and excuse yourself).
3. Initialize conversation with the patient through a scripted entrance:
    a. "Hi [patient first name], my name is _____, I'm a counselor at the hospital and I would like to spend some time talking to you about issues regarding your health, is that ok with you?"
        i. (If the patient is <u>not agreeable</u> you must politely accept their decision and leave the patient room)
4. If the patient is agreeable, continue:
    a. "I wanted to talk to you because your healthcare team is concerned about your alcohol [drug] use. Has anyone every talked to you about their concern for you regarding your alcohol [drug] use?"
5. IMPORTANT. If patient expresses suicidal ideation or intent you must immediately excuse yourself from the room and inform the crisis counselor, nurse, and social worker. Once you have spoken directly to the crisis counselor, nurse, and social worker you may return to the patient and continue with Step 6.
6. Continue the conversation with the patient about their alcohol or drug use. Do not allow for long gaps of silence; fill them in with motivational interviewing. At the end of the conversation:
    a. Ask the questions on the AUDIT (if not answered during the conversation).

7. If appropriate, illicit further patient narrative describing their history and causes of alcohol or drug use.
    a. Utilize motivational interviewing to promote patient awareness, acceptance, and responsibility for change of alcohol or drug use behaviors.
8. At the end of the conversation:
    a. “I would like to give you information regarding treatment options.”
9. Discuss referrals (If patient is interested in discharging to alcohol or drug in–patient rehab program inform the social worker for appropriate follow–up).
10. Ask the patient if he/she would like a return counseling visit.

Written by: Co–Investigator Brooke Donald, PsyD., and Principal Investigator Lise Cooper, MSN, RN–BC, DMH(c)., (2014). [Image].

Appendix I

Prediction of Alcohol Withdrawal Severity Scale



Prediction of Alcohol Withdrawal Severity Scale (PAWSS)

Maldonado et al., 2014

Part A: Threshold Criteria: (1 point either)

1. Have you consumed any amount of alcohol (i.e., been drinking) within the last 30 days?

   OR did the patient have a "+" BAL upon admission? _____

   IF the answer to either is YES, proceed with test:

Part B: Based on patient interview: (1 point each)

2. Have you ever experienced previous episodes of alcohol withdrawal? _____
3. Have you ever experienced alcohol withdrawal seizures? _____
4. Have you ever experienced delirium tremens or DT's? _____
5. Have you ever undergone of alcohol rehabilitation treatment? _____

   (i.e., in-patient or out-patient treatment programs or AA attendance)
6. Have you ever experienced blackouts? _____
7. Have you combined alcohol with other "downers" like benzodiazepines or barbiturates during the last 90 days? _____
8. Have you combined alcohol with any other substance of abuse during the last 90 days? _____

Part C: Based on clinical evidence: (1 point each)

9. Was the patient's blood alcohol level (BAL) on presentation > 200? _____
10. Is there evidence of increased autonomic activity?

    (e.g., HR > 120 bpm, tremor, sweating, agitation, nausea) _____

Total Score: _____

Notes: Maximum score = 10. This instrument is intended as a SCREENING TOOL. The greater the number of positive findings, the higher the risk for the development of alcohol withdrawal syndromes. A score of ≥ 4 suggests HIGH RISK for moderate to severe AWS; prophylaxis and/or treatment may be indicated.

From: Maldonado, J. R., Sher, Y., Ashouri, J. F., Hills–Evans, K., Swendsen, H., Lolak, S., & Miller, A. C. (2014). [Image]. The "Prediction of Alcohol Withdrawal Severity Scale" (PAWSS): Systematic literature review and pilot study of a new scale for the prediction of complicated alcohol withdrawal syndrome. *Alcohol*, *48*, 375–390.

Appendix J

Referral List Given to Counseled Informants

SUBSTANCE ABUSE TREATMENT IN MORRIS COUNTY:

AHS Substance Abuse IOP: 973-971-4635
Program runs Monday through Thursday 10am to 2pm

NJ Addictions Hotline	800-238-2333
High Focus Centers	800-877-3628
Gen Psych	855-436-7792
Market Street Mission (men)	973-538-0431
Seabrook House	800-761-7575
Turning Point	973-239-4600
NJ AA Information Hotline	800-245-1377
St. Clare's Hospital	973-316-1905

SUBSTANCE ABUSE TREATMENT OUTSIDE MORRIS COUNTY:

Summit Oaks Hospital	908-522-7000
Carrier Clinic	908-281-1000
Sunrise House	973-383-6300
Straight and Narrow	877-882-9347
Bergen Regional	800-730-2762
Poison Control Number	973-972-9280

From: Atlantic Health System, Morristown, NJ. (2015). [Image].

Appendix K

Atlantic Health System IRB Letter

Atlantic Health System

Morristown Medical Center
Overlook Medical Center
Newton Medical Center
Chilton Medical Center
Hackettstown Medical Center
Goryeb Children's Hospital
Atlantic Rehabilitation

INSTITUTIONAL REVIEW BOARD (IRB)

December 2, 2016

Lise Cooper, MSN, RN
Morristown Medical Center
100 Madison Avenue
Morristown, NJ 07960

Dear Ms. Cooper:

The project entitled "Bedside Counseling for Individuals with Hazardous Drinking Behavior" has been submitted to the Atlantic Health System Institutional Review Board (AHS IRB). The activities do not meet the definition of "Human Subject Research"; therefore the project does not require IRB oversight.

Any changes to this proposal that may alter this determination should be presented to the AHS IRB for approval prior to implementation of the changes.

Sincerely,

Anita Bond Richards, MAS, CIP
IRB Manager/ Administrative Chair

Appendix L

Drew University IRB Letter of Approval

December 12, 2016

Dear Lise Cooper:

The Institutional Review Board has conducted an expedited review and approved your research entitled "'Bedside Counseling for Indviduals with Hazardous Behavior" with the following conditions:

- This approval is based upon the approval of the Atlantic Health System IRB dated December 2, 2016.

The approval for your research protocol and the human participants' component of your work is valid through 12-December-17. If you plan to continue this research past this date, you will need to reapply for IRB approval. If you make any modifications to your research, you will need to obtain IRB approval for those changes as well.

Sincerely,

William B. Rogers

William B. Rogers, Ph.D.

Lise Cooper <lcooper@drew.edu> Fri, Aug 19, 2016, 1:20 PM

to Bill

My proposed dissertation is considered a quality improvement project at Atlantic Health's IRB, although I will submit for approval to them anyway in anticipation of eventual publication.
I am sure I must submit to Drew's IRB.
My question is: I am CITI certified in their basic course and investigator course as I have been a PI before (I have attached the reports).
Looking at Drew's IRB pages it looks like I may need to certify in a different program (OHRP?)
Please advise.
Thanks !!

lise.cooper@atlantichealth.org

Bill Rogers <wrogers@drew.edu> Fri, Aug 19, 2016, 7:32 PM

to me

Lise:

No, you are good to go with that certification. Also, once you have AH IRB's approval, all we need is a copy of that letter, and then you are fine. Good luck with the research!

Bill

Appendix M

Abridged De–Identified Informant Data Report

AUDIT score	Got Psych eval?	PAWSS Score	On CIWA?	Other inclusion criteria	States will D/C to addiction treatment?	States has tried rehab, AA, NA in past?	Currently motivated to stop drinking?	Counselor written comments	Study Period total # admissions (total LOS)	1 Year–Post Period total # admissions (total LOS)
Low Risk AUDIT Score Range (8–15)										
8		1	Yes	hx significant etoh abuse				has 1 glass wine nightly, doesn't feel drinking issue, trouble quitting smoking,her for vascular issues so motivated to stop smoking.	1(4)	
9		3	Yes					pt states no problem with etoh	3(12)	
10	Yes	6	Yes		Yes	Yes	Yes	graduated from IP program	3(14)	1(2)
10	Yes	7	Yes		Yes	Yes	Yes	will go back to AA	2(11)	
10	Yes	5	Yes					pt states he will probably do it on his own	1(5)	
10	Yes	4	Yes					pt denies problem	1(4)	
10		5	Yes				Yes	pt states etoh problem 1990–2005, drinks less now r/t increased fights with wife when drinking, wants to drink even less.	1(1)	
10		Not done						pt states he can stop drinking if he wants	1(2)	
10		2	Yes	drinks 5+ drinks daily				Patient not working since Nov, drinks nightly to relieve anxiety, motivated to discontinue drinking	1(3)	

11		Not done						no plans for rehab	1(13)	
11		2		admitted r/t bar fight				Pt realizes need to change drinking habits r/t bar fight, minimizes drinking, confident he can stop without help	1(3)	
12	Yes	6	Yes		Yes	Yes	Yes	waiting for bed at xxxx to open up	1(9)	
12		6	Yes			Yes		patients states no plans to seek tx	1(9)	
12		2	Yes	on CIWA				pt reports 2–3 drinks daily, no intention to change his behavior	2(63)	
12	Yes	Not done	Yes	drinks 5–6 24–oz cans of beer daily	Yes	Yes	Yes	interested in xxxx, concerned about insurance. Ambivalent about tx, feels badly about substance use	1(48)	
13	Yes	4	Yes			Yes	Yes	wants to understand medical issue first. States OP won't work.	2(7)	
13		Not done		drinks 5 drinks daily			Yes	Pt states he drinks 4–5 beers during week & more on weekends, smokes marijuana 2–3 times weekly, wants to cut down on his drinking	1(10)	
13		1	Yes					pt denies etoh issue	1(5)	
14	Yes	2	Yes				Yes		1(2)	
14	Yes	5	Yes					doesn't feel he has a problem	1(14)	
14		0		hx of etoh abuse	Yes	Yes	Yes	wants xxxx county for IP rehab, sons finding place for her to live, pt going to SAR first, then wants etoh rehab xxxx county.	1(39)	
14		1	Yes				Yes		1(9)	
14		3				Yes	Yes	was sober	1(3)	

								x25 years, drinking last year.		
15		9	Yes		Yes	Yes	Yes	insurance may be issue for rehab	1(3)	
15		4	Yes			Yes	Yes	Pt treated for etoh 17 yrs ago, quit for 10 years, started drinking again 10 yrs ago, dealing with fibromyalgia pain, now drinks 5 L white wine weekly.	1(2)	
Moderate Risk AUDIT Score Range (16–24)										
16	Yes	4	Yes		Yes		Yes	plans on going to xxxx after d/c	1(11)	
16	Yes	1	Yes					denies problem	1(1)	
16		7	Yes			Yes	Yes		1(4)	
16	Yes	6	Yes			Yes	Yes	pt went to AA 2 yrs ago, found helpful, not sure now if AA/counseling a good option, drinks 6–pack nightly, needs to "slow down", would like a list of resources.	1(37)	
17	Yes	7	Yes		Yes	Yes	Yes	pt states going to xxxx in FL upon d/c	1(6)	
17	Yes	4	Yes				Yes		2(8)	2(4)
17		1		On CIWA, drug screen (+) opiates, drinks 5–7 beers daily			Yes	pt state she wants to stop drinking r/t all the problems it has caused in her life	1(13)	
18		5	Yes			Yes	Yes		1(11)	
19	Yes	2	Yes		Yes		Yes	pt's father in AA, 1st time pt has etoh issue	1(12)	
19	Yes	6	Yes				Yes	started drinking at age 15, drinks 5–10 drinks daily, not first etoh	1(4)	

								hospitalization, motivated to stop drinking		
20	Yes	1	Yes		Yes	Yes	Yes	wants to go to xxxx rehab	3(23)	1(4)
20		2	Yes		Yes	Yes	Yes	using EAP to get to xxxx rehab	1(1)	
20	Yes	5	Yes			Yes	Yes		1(2)	
20		5	Yes			Yes			1(2)	
20	Yes	2	Yes	drinks between 6–8 drinks daily	Yes		Yes	plans on going to OP after d/c	1(4)	1(2)
21		2	Yes	On CIWA, drinks 2 martinis every night		Yes	Yes	PT reported having 2–3 martinis nightly, wants to stop drinking, was sober x 10 yrs and began drinking again after 1998 retirement.	1(1)	1(6)
21		5	Yes					pt states he has no intention to change drinking behavior	1(9)	
22		9	Yes		Yes	Yes	Yes	patient states will go to IOP at D/C	1(3)	
22	Yes	3	Yes		Yes	Yes		in tx 1 year ago and slowly stopped using coping skills	2(8)	1(8)
22		Not done	Yes			Yes	Yes	didn't like AA, concerned about insurance covering rehab, will talk to SW	1(4)	
22		3	Yes		Yes	Yes	Yes		1(6)	1(4)
23		10	Yes		Yes	Yes	Yes	going to rehab in TN from d/c	3(10)	
23	Yes	1	Yes			Yes	Yes	sober for years, started drinking after an assault	3(11)	
23	Yes	10	Yes		Yes	Yes	Yes	has appt with xxxx upon d/c		
24	Yes	2	Yes		Yes		Yes	wants to go to xxxx OP	2(11)	
24		5	Yes		Yes		Yes	will address etoh but won't give up Vicodin for chronic leg pain	1(3)	

24		5	Yes		Yes		Yes	started drinking after divorce	1(2)	
24		8	Yes			Yes			2(24)	
24		Not done	Yes			Yes	Yes	had 3 years clean. Wants to drink one more time. Last tx 5/2016. no desire to do OP tx.	3(18)	
Severe Risk AUDIT Score Range (25–40)										
25		5	Yes		Yes	Yes	Yes	will go back to AA	2(3)	2(5)
25	Yes	7	Yes			Yes	Yes	sober for 4 weeks since last admission	3(11)	
25		Not done	Yes	consult states etoh abuse, drinks 3 pints vodka daily			Yes		1(15)	
25	Yes	7	Yes			Yes		pt states started drinking after wife died, is stubborn and wants to stop on his own without help	1(2)	
26	Yes	6	Yes		Yes	Yes	Yes	wants to start attending AA	1(7)	
26		5	No		Yes		Yes	Pt stated she is going to OP rehab from here, says she is fully committed to stopping substance use.	2(5)	
26		4					Yes	has supportive family, been soberx8months, wants to go back to work and move out of NJ, in indv therapy now	1(2)	
26		5	Yes				Yes	getting married this weekend	1(5)	
26		2		On CIWA				pt sees no issue with his current lifestyle, etoh not problematic even though he drinks	2(7)	

								heavily.		
27		6	Yes		Yes	Yes	Yes	will contact xxxx at d/c	1(3)	
27	Yes	4	Yes		Yes		Yes	drinks 1/2 to 1 pint vodka 3–5 times a week, plans on attending AA	2(18)	
27		Not done	Yes			Yes	Yes	pt states pain makes stopping drinking difficult, stopped pain meds and drank more	1(2)	
28	Yes	7	Yes		Yes	Yes	Yes	sober 2 years,started to drink 3 days a week after fiance died	2(7)	1(12)
28	Yes	7	Yes			Yes	Yes	pt wants OP tx, SW aware	2(12)	
28	Yes	4	Yes				Yes		1(19)	
28	Yes	8	Yes			Yes		needs time to think about tx options	1(21)	
28	Yes	5	Yes					will look into help after med issues resolve	1(16)	
28	Yes	7	Yes				Yes	does not want to stop drinking, will cut down to only weekends	2(8)	
29	Yes	7	Yes		Yes	Yes	Yes	will go to AA with daughter	2(10)	
29		0	Yes	pt's husband states patient drank 4 days prior, hx etoh abuse and treatment	Yes	Yes	Yes	was sober x 10 years, wants help now but husband very intrusive	1(4)	
29		Not done	Yes	Positive blood alcohol content, on CIWA	Yes		Yes	going to SAR then will try AA	1(6)	
29		3	Yes			Yes	Yes	started drinking again after mother died & kids left home	3(11)	
30		4	Yes		Yes		Yes	pt going to IP then insurance denied so pt d/c home with family and go to IOP	2(19)	

30		7	Yes		Yes	Yes			1(3)	
30	Yes	7	Yes			Yes	Yes	came here to detox	2(11)	
30	Yes	2		H&P states former heroin user, but pt denies drug use.	Yes	Yes	Yes	will return to OP drug rehab after d/c but really only for food stamps	3(13)	1(7)
31	Yes	7	Yes		Yes	Yes	Yes	wants IOP	3(11)	
31	Yes	5	Yes		Yes		Yes	started drinking 5 months ago after incident in her life, ready to talk with psychologist about incident	1(14)	
32	Yes	10	Yes		Yes	Yes	Yes	pt states he plans on xxxx for rehab	1(3)	
32	Yes	2	Yes					pt unsure about desire to stop drinking	1(10)	
32	Yes	5	Yes					pt showed no motivation to stop drinking	1(4)	
32	Yes	3	Yes		Yes	Yes	Yes	separated from wife r/t etoh, will go to xxxx for rehab after d/c	1(10)	
34		3	Yes	H&P states etoh abuse			Yes	Pt states drinks 16 drinks daily with more on Sundays, not interested in changing behavior or getting help	1(7)	
34	Yes	7	Yes		Yes	Yes	Yes		1(9)	
34	Yes	10	Yes			Yes	Yes	tried all types of rehabs	2(7)	
35		5				Yes		Pt reports sober x 3 months after drinking–related arrest, went to rehab, doesn't like AA or NA, will continue to be sober through willpower, used to drink 2 liters of whiskey daily, has history of etoh–induced seizures	1(3)	
36	Yes	9	Yes		Yes	Yes	Yes	plans on	6(20)	

								going to IP after d/c		
36	Yes	10	Yes		Yes	Yes	Yes	going to AA right after d/c	2(11)	4(32)
36		7	Yes		Yes	Yes	Yes	relapsed 3 weeks after last d/c, was attending xxxx IOP	2(28)	1(14)
38	Yes	9	Yes				Yes	been binge drinking 2 weeks straight r/t incarceration	2(11)	
AUDIT NOT Completed										
		1	Yes	On CIWA	Yes	Yes	Yes	tried to stop cocaine & marijuana use many times, doesn't like group settings but will call IP & OP on referral list.	1(3)	
		0		Currently using heroin, no etoh, drug screen (+) opiates	Yes	Yes	Yes	Pt recently OD'd, went to xxxx facility in FL, plans to look at nj IP rehab.	1(3)	
		1		hx etoh abuse, drinks 5–6 drinks daily but stopped 5 weeks ago.				Pt states that he hasn't had drink in 5–6 weeks, will quit like he quit smoking 30 yrs ago, wife threw away all etoh in house, mortivated to change, doesn't want help or to talk.	1(15)	
	Yes	7	Yes	drinks 6–8 drinks daily		Yes		Patient still somewhat confused, hard to understand, denies problem, no plan to change, does not want f/u. Admitted from rehab for confusion.	1(34)	
		Not done				Yes		pt states sober since 2012	2(15)	
	Yes	3	Yes					patient & husband deny problem	1(9)	1(3)
	Yes	0					Yes	pt states very motivated to	3(9)	

								stop using drugs, not etoh issue.		
		3		binge drinking 18 beers on weekends, consult states pmh etoh abuse				didn't want to complete AUDIT tool, wants to concentrate on health before sobriety	1(2)	
	Yes	1		uses IV heroin daily, last was 1 week ago, uses marijuana	Yes			pt self report PTSD, depression, bippolar, anxiety, war veteran. plans to discharge to xxxx for rehab.	1(14)	
	Yes	0	Yes	ED–SBAR states (–) etoh, (+) heroin abuse, drug screen (+) opiates, cannabinoids		Yes		heavy PTSD from war, down to 1 bag heroin daily then had MVA and now pain 10/10 and can hardly get through the day, AA/VA useless and he doesn't need referral list	1(9)	
	Yes	Not done	Yes					pt's wife states he drinks more than he says	1(40)	
	Yes	0						states he takes suboxone for knee pain and denies opiate problem	1(7)	

Data Report by: Lise Cooper, MSN, RN–BC, DMH(c), 2017. [Image].

Appendix N

The CAGE Questionnaire for Detecting Alcoholism

CAGE Questionnaire for Detecting Alcoholism		
Question	**Yes**	**No**
C: Have you ever felt you should **C**ut down on your drinking?	1	0
A: Have people **A**nnoyed you by criticizing your drinking?	1	0
G: Have you ever felt **G**uilty about your drinking?	1	0
E: Have you ever had a drink first thing in the morning (**E**ye opener)?	1	0
A total score of 0 or 1 suggests low risk of problem drinking A total score of 2 or 3 indicates high suspicion for alcoholism A total score of 4 is virtually diagnostic for alcoholism		

Singh, O. (2017). Is it alcohol abuse or alcohol dependency? *Zululand Observer*. [Image]. Retrieved March 15, 2019 from https://zululandobserver.co.za/135626/alcohol–abuse–alcohol–dependency/

VITA

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Educational Institutions:

School	Place	Degree	Date
Secondary:			
Montclair Kimberley Academy	Montclair, NJ	Highschool Diploma	1980
Collegiate:			
Susquehanna University	Selinsgrove, PA	Bachelor of Science	1984
Nursing:			
Mountainside Hospital School of Nursing	Montclair, NJ	Nursing Diploma	2007
Graduate:			
Ramapo College of New Jersey	Mahwah, NJ	Masters Nursing Education	2014
Post-Graduate:			
Drew University	Madison, NJ	Doctor Medical Humanities	2019