ABSTRACT

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Given the pervasiveness of binge drinking among the patient population of university students, university health service providers are often faced with opportunities to conduct brief alcohol interventions during appointments with patients. These interventions can be crucial to patient health outcomes such as decreasing alcohol consumption. However, the general population of medical providers has demonstrated discomfort and inconsistency in conducting screening and intervention regarding patient alcohol use. This study investigates provider perspectives on the communicative aspects of brief alcohol interventions with patients in the unique context of university health services. Providers self-reported communicative techniques that they used and communicative challenges that they faced during alcohol-related conversations with patients. Fourteen university health medical service providers participated in this qualitative study. Providers were employed at four medium to large universities in one region of the Southeast United States. Providers completed in-depth interviews, yielding retrospective insights about the communicative aspects of interpersonal interaction during brief alcohol interventions. Data were coded and analyzed according to the constant comparative method. Providers reported enacting the following communicative techniques during brief alcohol interventions: gathering more information, creating a nonthreatening environment, providing education about consequences, eliciting patient ownership, providing tips for harm reduction, and continuing the conversation. Additionally, providers reported the following communicative challenges to conducting brief alcohol interventions: choosing how and when to start the conversation, diagnosing a resistant
population, establishing necessary rapport for a sensitive conversation, and maintaining credibility despite uncertainty about the efficacy of interventions. This study, which applies the normative theoretical approach, illustrates the communicative dilemmas faced by providers due to conflicting goals and roles of brief alcohol interventions.
University Health Provider Perspectives on the Communicative Aspects of Brief Alcohol Interventions

by
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BIOGRAPHY

In May 2015, I will complete my Master of Science in Communication degree at North Carolina State University. Prior to pursuing this degree, I worked for three years as a communication contractor with more than 10 clients in North Carolina and beyond, many of which were nonprofit organizations. I earned my undergraduate degree, a Bachelor of Arts in Arts Studies, and a minor in Journalism from North Carolina State University, with summa cum laude honors, in May of 2010.
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Introduction

Despite years of efforts to address it, binge drinking among college-age students has risen in recent years (Hingson, Zha, & Weitzman, 2009; Wechsler, Lee, Kuo, & Lee, 2000). College students engage in binge drinking, defined as the consumption of five or more drinks in a row for men and four or more drinks for women on one or more occasions during a two-week period (Wechsler & Nelson, 2008), more so than their non-college-attending peers (Slutske, 2005). More than 80% of college students drink alcohol and almost half report binge drinking in the last two weeks according to the National Institute on Alcohol Abuse and Alcoholism (2013). Binge drinking is considered hazardous to the drinker’s health and is associated with alcohol-related problems such as decreased academic performance (Scott-Sheldon, Carey, Elliott, Garey, & Carey, 2014), increased likelihood of sexual assault (Mohler-Kuo, Dowdall, Koss, & Wechsler, 2004), alcohol-impaired driving (Naimi et al., 2003), and injury or death (Scott-Sheldon et al., 2014). In fact, 18% of college students in the U.S. suffered from clinically significant alcohol-related problems in 2004 (Slutske, 2005). Further, such negative consequences are compounded in that patterns of risky drinking can continue into adulthood (Scott-Sheldon et al., 2014).

Given the gravity of this problem, universities have implemented programs aimed at lowering alcohol consumption and negative outcomes associated with binge drinking, through alcohol education, alcohol screening and brief intervention programs. Though research shows that intervention programs have decreased freshmen drinking on campuses in the U.S. (Scott-Sheldon, et al., 2014), scholars have also reinforced that “implementation of
these [alcohol intervention] programmes is far from straightforward” (Beich, Gannik, & Malterud, 2002, p. 1). Further, research in this area consists mostly of studies regarding efficacy of interventions as a method to reduce harms rather than pragmatic studies regarding effective implementation of intervention programs on campuses (Beich et al., 2002; Larimer & Cronce, 2007). In fact, research shows that communication about alcohol use or misuse can be problematic for providers (Beich et al., 2002; McCormick et al., 2006; Wynn, Karlsen, Lorntzsen, Bjerke, & Bergvik, 2009). This may account for the low rate of alcohol counseling among the general population of providers (D'Amico, Paddock, Burnam, & Kung, 2005; Edlund, Unützer, & Wells, 2004), suggesting that some providers avoid the entire conversation, while others embrace it but lack adequate skills to carry out the conversation. This excerpt from a provider’s interaction with a patient regarding alcohol misuse is illustrative:

‘Right. If you’ve developed that pattern over a long period of time and, you know, I guess, um, when I look at—you know, statistically, um, looking at, um, a drinking pattern that involves, if we say three of those kind of drinks, um, a night, um, 21 over the course of a week, if that’s your pattern, that statistically puts you in a category to be—to have—to have more problems, uh, um, social problems, um, health problems, those kind of things, um...’ (McCormick et al., 2006, p. 970).

This passage demonstrates the discomfort and awkwardness that some medical providers experience during these conversations. Therefore, it is important to examine the role
university health service providers play in screening and providing interventions for this at-risk population of students on campuses.

Implementation of effective interventions can influence patient outcomes, which occur in the specific context of interaction between university health service providers and patients. The literature suggests that providers often avoid alcohol screening or interventions, yet “little is known, however, about how providers actually talk to patients about alcohol use” (McCormick et al., 2006, p. 966). This emphasizes the need to identify and disseminate communication strategies that facilitate effective alcohol-related conversations with patients. Given the pervasiveness of binge drinking despite implementation of intervention programs, and the inconsistency of screening-based intervention efforts in the general population of medical providers, this study sheds much-needed light on alcohol-related conversations in the university health context.
Literature Review

The literature relevant to this study includes screening-based brief alcohol intervention program composition and efficacy, as well as research illuminating brief interventions as an interpersonal interaction between provider and patient.

Screening-Based Brief Intervention

A screening-based brief intervention aims to systematically identify hazardous but non-addictive drinking behaviors. When patients screen positively, providers may conduct an intervention comprised of facets such as expression of concern, feedback regarding the patient’s level of drinking and his or her health, advice to decrease the amount of drinking, and development of a patient-centered plan for next steps (Beich et al., 2002). There are a variety of configurations of brief interventions regarding alcohol use. Design of interventions varies by components included, such as personalized feedback or moderation strategies (e.g., alternating alcoholic drinks with non-alcoholic drinks). Additionally, design of interventions may vary by format of delivery such as one-to-one in person, in a group setting, or electronic delivery. A meta-analysis of research on university alcohol intervention programs found that multiple types of brief interventions have successfully decreased the number of U.S. university freshman who consumed alcohol. Interventions with four or more parts were most effective, including personalized feedback, moderation strategies, goal setting, and identifying especially risky situations (Scott-Sheldon et al., 2014).

Though the U.S. Preventive Services Task Force recommends that medical providers screen patients for both tobacco and alcohol abuse, there are inconsistencies about whether
and when providers should screen and provide brief intervention (Beich et al., 2002). Having initiated an alcohol-related discussion, many providers reported negative reactions from some patients, including uneasiness, lying about their alcohol use, or finding another doctor. Further, providers are more likely to discuss lifestyle health risks – those that are behavioral in nature and, thus, preventable – such as alcohol and tobacco use with healthier, younger, male patients (Bertakis & Azari, 2007). In comparing interventions for tobacco use versus alcohol use, McCormick et al. (2006) found that providers offered more firm advice to patients who screened positive for hazardous tobacco use while giving more tentative or vague advice to patients who screened positive for hazardous drinking. Further, providers failed to educate patients about recommended drinking limits and provide strategies for drinking less. The study concluded that providers face a number of barriers to facilitating alcohol-related discussions, including:

- Confusion as to what constitutes alcohol misuse, fear that asking about drinking could harm the patient-provider relationship, stigmatization of substance abuse, skepticism about the effectiveness of alcohol counseling, lack of time, inadequate training, and a belief that patients will not honestly disclose their drinking practices. (McCormick et al., 2006, p. 966)

Providers may be deterred from conducting a brief alcohol intervention due to anticipated responses from the patient or lack of clarity about how or when they should be conducted.

Some providers are uncomfortable with alcohol-related discussions because "counselling on alcohol easily implies an unwanted moral dimension" (Beich et al., 2002, p.
3). Stigma related to lifestyle risk behaviors such as risky drinking holds ramifications for the encounter. Providers’ communication skills may be affected when stigma associated with lifestyle risk behaviors “infiltrate the medical encounter” (McCormick et al., 2006, p. 971). Stigma affects medical conversations about other lifestyle choices, such as sexual behavior, and, thus, is likely to manifest in this context as well. Another study regarding potentially sensitive or stigmatizing discussion of patient’s sexual behaviors among Obstetrician/Gynecologists (OB/GYN) found that though most providers reported routinely asking patients about their sexual activities, other areas of patients’ sexuality such as sexual orientation/identity are not as routinely discussed (Sobecki, Curlin, Rasinski, & Lindau, 2012). Alexander et al. (2014) found that providers did not initiate any discussion about sex or sexuality for one third of their adolescent patients, and when they did, the conversations lasted an average of only 36 seconds. This reveals that interventions regarding risky sexual behavior may not be conducted regularly, likely causing consequences for patient health outcomes. This study reinforces the importance of overcoming barriers to lifestyle risk behavior conversations between provider and patient. Just as risky sexual activity may be stigmatized, alcohol-related problems may be perceived as linked to the stigmatized condition of alcoholism. In fact, Keyes et al. (2010) found that alcoholism patients are reluctant to seek diagnosis or treatment given the potential stigma, reinforcing a similar barrier to genuine patient-provider conversations on the topic of alcohol consumption.
Few researchers have explored elements of the interpersonal communication between provider and patient during interventions (McCormick et al., 2006), which may prove helpful to addressing stigmas and equipping providers to conduct brief interventions. Provider communication skills can influence quality of care and health outcomes, thus the “outcome of alcohol-related discussions are determined, at least in part, by the way in which providers talk to their patients about drinking” (McCormick et al., 2006, p. 970). McCormick et al.’s study is one of few designed to describe the alcohol-related discussions between primary care providers and patients. By analyzing taped conversations during visits with patients who screened positive for risky drinking, the researchers found that patients often disclosed information regarding risky alcohol use, but providers regularly did not pursue these disclosures. Additionally, the study found that provider discomfort with alcohol-related discussions was evident in many interactions with patients. Finally, McCormick et al. (2006) found that providers responded to patient disclosures of hazardous alcohol use in various ways, including changing the subject and downplaying the significance of the patient’s drinking. Only in very limited cases did providers explore the issue further or follow through with an intervention that included setting a plan for action with the patient.

As illustrated in the earlier quotation from the provider, signs of provider discomfort during alcohol-related discussions included hesitation and stuttering, inappropriate laughter, and ambiguous statements, which did not occur or were less apparent during discussions.
about topics other than alcohol (McCormick et al., 2006). Beich et al.’s 2002 study of Danish primary care physicians who conducted brief alcohol interventions found that:

The doctors were surprised at how difficult it was to establish rapport with the patients who had a positive result on the screening and to ensure compliance with the intervention. Although the doctors considered the doctor-patient relationship robust enough to sustain targeting of alcohol use, they often failed to follow up on initial interventions, and some expressed a lack of confidence in their ability to counsel patients effectively on lifestyle issues. (p. 1)

The study concluded that implementation of intervention programs has proven complicated in part because most research is oriented to program efficacy rather than program implementation (Beich et al, 2002). This is potentially problematic because, if providers are not equipped with information about effective practices for implementing brief alcohol interventions, they may be less likely to conduct them when needed.

Studies of the interpersonal interactions between medical providers and patients are often grounded in biopsychosocial approach to practice of medicine, which prioritizes patient-centered medical care. Patient-centered care incorporates several dimensions, including acknowledging the ‘patient-as-person,’ that is, an individual with a particular experience of illness dependent on the patient’s background, economic circumstances, and cultural influences (Mead & Bower, 2000). Patient-centeredness also emphasizes ‘doctor-as-person,’ meaning that providers are subjective actors during interactions with patients in which both patient and provider influence one another. Additionally, patient-centeredness
involves sharing medical power among provider and patient in which provider encourages collaboration and sharing of ideas by the patient. The approach to medicine moves away from the biomedical understanding of an objective, paternalistic provider who guides a passive patient to the correct treatment. In applying patient-centeredness to interventions, Lauver et al. (2002) suggest that interventions should incorporate assessment of patients’ characteristics that are relevant to the health-related behavior and customization of the intervention based upon this assessment. In fact, due to the variety of treatments available, none which are necessarily superior to the others, and the personal nature of determining the best treatment for the patient, Bradley and Kivlahan (2014) argued that treatment of patients with Alcohol Use Disorders (AUDs) in primary care contexts necessitates patient-centered care and shared decision-making.

Goldsmith’s (2001) normative approach is best applied to more thoroughly address the communicative aspects of brief alcohol interventions in the university health context and their potential ramifications for patient outcomes. The multiple goals normative approach assumes that communication is driven by pursuit of goals which sometimes conflict with one another. The multiple goals perspective addresses several categories of goals – relational (maintaining relationships), identity (managing impressions), and instrumental (fulfilling task through interaction).

Because of the inconsistency with which screening and brief alcohol interventions are conducted, I chose specific terminology for this study to neutralize expectations of providers. Terms such as “heavy drinking” or “risky drinking,” which carry predefined measures for
many providers, were avoided. Rather, a more broad term, “hazardous drinking,” defined as consumption of alcohol that could be hazardous to the patient’s health, was used during interviews with providers. This allowed me to gauge providers’ judgment of what level of drinking requires intervention. Additionally, this allowed providers to self-select when and in what cases they conduct brief alcohol interventions. Further, in place of “brief alcohol intervention,” the broad term “alcohol-related conversation” was used during interviews with providers. Finally, it should be noted that the term “intervention” in this study does not refer to a stimulus within the study design. Rather, it refers to the interaction with patients usually referred to in the literature as a “brief intervention,” defined previously.

Due to the pervasiveness of binge drinking on many university campuses, university administrators face the challenge to continue developing intervention programs that effectively address binge drinking and related negative outcomes. University health providers, then, commonly face the somewhat fraught nature of interpersonal interactions with patients for alcohol-related conversations about hazardous drinking. Fully elucidating the communicative aspects of these conversations seems to be an important component of successful program implementation. Therefore, this study addresses the communicative techniques used by providers and the challenges faced by providers who conduct brief alcohol interventions in the college health context.

RQ 1: What communication techniques do university health service providers use to facilitate brief alcohol interventions?
RQ 2: What communicative challenges do university health service providers report with regard to conducting brief interventions?
Method

This paper employs qualitative method for an exploratory analysis of interpersonal conversations between university health service providers and patients regarding hazardous alcohol use.

Setting

A maximum variation sampling technique was used to recruit providers from university healthcare facilities. This strategy enabled collection of data related to the breadth of provider interactions at varying institutions, while also acknowledging the depth of experiences gained by providers who have seen hundreds of patients with varying results. Patton (2002) asserts that maximum variation sampling enables two findings: “(1) high-quality, detailed descriptions of each case, which are useful for documenting uniqueness, and (2) important shared patterns that cut across cases and derive their significance from having emerged out of heterogeneity” (2002, p. 235). Providers employed at five different universities were contacted via email regarding the study. Recruiting providers from several different university health service facilities on different campuses in the region also ensured anonymity regarding each participant’s employer. Providers who voluntarily agreed to participate were scheduled for an interview. Interviews were conducted off-premises from the participants’ place of employment to maintain participant privacy.

Participants

Participants in the study were medical providers, specifically mid- to high-level providers who are encouraged to conduct brief interventions at university healthcare
facilities. This included nurse practitioners, physician’s assistants, and physicians. Fourteen providers, including seven physicians, three physician’s assistants, and four nurse practitioners participated in interviews. Thirteen of the providers in the sample were female and one provider was male. Collectively, providers self-reported a total of 100.68 years of work experience in the university health services field. Participants were recruited through word of mouth from four university health facilities in one region of the Southeastern United States. Occasionally, snowball sampling occurred in which a participant recommended a colleague for the study, at which point I followed up with the colleague via email. Size of universities represented in the sample range from over 8,000 students to over 30,000 students. Universities represented in the study include both public and private universities and one historically black university. Each university was located in a metropolitan area.

Data Collection

IRB approval was obtained for this research. Data collection was conducted through one-on-one semi-structured interviews with participants. Interviews often included follow-up questions to allow for further exploration of topics as they arose. Spradley’s (1979) ethnographic interviewing process was used in order to establish rapport with participants to attain meaningful information. Interviews were conducted in person with the exception of four interviews, which were conducted via telephone due to the demanding schedules of providers. The interview schedule emphasized provider opinions and insights about alcohol-related conversations with patients. The schedule included questions such as “What kind of triggers or circumstances lead to alcohol-related conversations with patients?” and “In your
opinion, what are the characteristics of an effective alcohol-related conversation with a patient?” In total, 10.6 hours of interview data were collected. The average length of the interviews was 45.53 minutes. All interviews were transcribed, yielding 162 pages of single-spaced transcripts. Each participant was assigned a pseudonym immediately following the interview. These pseudonyms are reflected in the results section.

Data Analysis

Data analysis was conducted using the constant comparative method (Strauss & Corbin, 1998). The transcribed data was first reduced to 625 individual units consisting of single insights, descriptions, or examples that represented a provider’s perspective on communicative aspects of brief alcohol interventions. For example, when responding to a question about atypical alcohol-related conversations with patients, Cassandra responded with an example: “When the patient comes to me asking for help. Or says to me well you know, the reason I have all these problems is because I drink a pint a day or whatever.” This unit represents her suggestion that atypical conversations are those initiated by the patient. Cassandra followed this example by saying, “when you’re doing a routine physical or just trying to go through all of the points of the social history and you ask that question, and they willingly answer it.” This second portion of the transcript was designated as a second unit of data as it represented a separate insight: that patients are not typically willing to answer alcohol screening questions.

The initial reading of the transcripts suggested Goldsmith’s (2001) normative approach as a sensitizing concept. After this initial reading, open coding was conducted by
assigning data to categories and iteratively comparing the categories. This procedure allowed the researcher to inductively identify thematic categories in the data. The researcher confirmed theoretical saturation among the data when interviews generated the same information and no significantly new information emerged (Strauss & Corbin, 1998). Patton’s (2002) criteria of internal homogeneity and external heterogeneity were used to attain precision in the categories. For example, the initial themes of “using humor to diffuse tension” and “focusing on patient health rather than patient character” were reduced during coding of multiple transcripts to a single category that reflected a larger concept of “creating a nonthreatening environment.” The next round of axial coding explored thematic relationships between categories, particularly related to the normative approach as a theoretical lens. This round of coding emphasized the variety and breadth of objectives providers seek in these conversations, some of which conflict with one another. Finally, selective coding enabled the researcher to refine thematic categories according to the theoretical framework and articulate overarching conceptual connections among all categories as related to the conceptual framework.

One limitation to this study is that all coding was conducted by one researcher. However, standard checks for validity were conducted in order to account for this limitation. At the conclusion of data analysis, a member check, viewed as the primary method for checking validity (Lincoln & Guba, 1985), was conducted to ensure that researcher interpretations of themes reflected the reality for participants. Three of the fourteen participants were provided with preliminary results and asked to respond about how well the
results reflected their experiences regarding brief alcohol interventions. Of the three participants contacted for member checking, 100% responded with feedback, which was integrated into final revisions to the results. Additionally, peer debriefing (Lincoln & Guba, 1985) was conducted with three researchers – two researchers in health communication and one researcher in instructional communication. This additional check for credibility is meant to expose the researcher to any assumed biases and confirm plausibility of findings among other researchers in the area of specialty.
Results

Providers reported six communication techniques that they use for brief alcohol interventions with patients: gathering more information, creating a nonthreatening environment, providing education about consequences, eliciting patient ownership, providing tips for harm reduction, and extending the conversation beyond the appointment. Providers also reported four communication challenges that they faced during brief alcohol intervention conversations: choosing when and how to start the conversation, persuading a resistant population, establishing the rapport necessary for a sensitive conversation, and maintaining credibility despite uncertainty about efficacy of interventions.

Communication Techniques Providers Used To Facilitate Brief Alcohol Interventions

Given the multifaceted nature of many brief alcohol interventions, providers reported that they used a variety of communication techniques to facilitate these conversations with patients. These techniques signify provider efforts to influence the patient in order to ultimately decrease hazardous drinking for positive health outcomes.

Gathering more information. Beyond merely asking how many drinks the patient consumes per week or whether or not the patient was drinking when an injury occurred, providers reported the need to gather more information to better assess the patient’s usage. Providers reported that each brief intervention differed based upon the circumstances surrounding the patient’s appointment and the patient’s responses. Consequently, the conversation is iterative as providers gather information from the patient, which informs the conversation’s flow. Dan, a physician’s assistant with 18 years of experience in university
health, said he tries to avoid being “formulaic” and “putting the patient in the box because it is simpler for me.” Like Dan, many of the providers, said they do not approach brief interventions with a script. Patty, a physician’s assistant who has worked in college health for eight years, agreed that as a provider, you have to “target your audience.”

Providers also emphasized the importance of gathering information to assess the patient’s pattern of drinking – whether episodic binging or sustained drinking habits that may reflect drinking as a coping mechanism – and the level of consumption. Elaine, a physician who has worked for nine years in college health, said she typically asks several follow-up questions to the initial screening question about how often a patient uses alcohol. “Usually the answer is ‘sometimes’ or ‘occasionally’ or ‘socially,’ which means nothing. I don’t know what that means (laughs).” She said, “I usually ask the question, ‘how much, how often?’…and then my usual follow-up question is ‘no more than how many…in any given setting?’ So I want them to quantify the max.” Cassandra, also a physician with nine years of experience in university health services, said she tries “to get an accurate assessment of how much it’s impacting their health, their function, their performance.”

Providers expressed the importance of accuracy in the conversation. Dan said when asking about a patient’s drinking patterns, “I try to use the larger numbers. Maybe you had 10 or 20 drinks last night? …I think if you often overestimate the usage, it’s much more comfortable [for patients] to say, ‘no, I would only have 10 beers.’” Dan said this technique makes the reporting “more realistic or accurate.” Dan said he uses open-ended questions to get patient’s responses and to show that he is “willing to listen and not interrupt.” Dan said
this process is like “asking the person to tell me your story” and if he listens, “a lot can be learned.” Rose, a nurse practitioner who has worked for four years in college health, said she pursues accuracy by confirming with the patient any information that was taken down during the intake, which is often done by computer or by a nurse who rooms the patient. Rose said she confirms with the patient by saying, “I’m looking over your chart and I’m seeing that…you record that you’re drinking this many drinks. Is that true, is that accurate?” Rose added that she does this “because sometimes …people are just clicking through” on intake forms and are not paying attention to the accuracy of what they report.

Providers also sought to assess the patient’s receptivity to behavior change. Joy, a physician who had just begun a new role in college health, said that defensive body language and lack of engagement in the conversation tell her that the patient is not receptive to behavior change. Brandy said she can “gauge whether or not they perceive it as an issue.” If not, then Brandy ends the conversation because the patient is not ready for change, and ultimately, it is up to the patient to commit to changing behavior. Dan said he “can always sense if somebody’s open to change” since “you can hear words that…mean that they are willing or open to the idea of change.” For example, Dan said sometimes patients use language such as “that was a really stupid thing,” “I should have never done that,” or “I’m never going to do that again,” which shows the patient is willing to make a change to his or her behavior. Patty said she starts alcohol-related conversations with the question, “do you think you have a problem with alcohol?” She added that “most of the time they say ‘no.’” Betty, a physician who has worked in university health for eight years, said she receives
responses from some patients who are not receptive to change who say, “’I don’t really think it’s a problem. Or I’m not drinking as much as my friends are. It’s just not causing me any problems, I don’t think it’s a big deal.’” Therefore, providers use the technique of gathering more information about the patient’s pattern of drinking and receptivity to change to inform and craft a customized brief alcohol intervention.

**Creating a nontthreatening environment.** Providers agreed that it was important to ensure the patient does not feel judged regarding his or her alcohol use. Louise, a nurse practitioner with 10 years of experience in university health, said, “I think the more you put them in a situation where they feel threatened the less you’re going to get through to them. So I try to do it in a way that makes them feel like I’m not putting them down, I’m giving them the information. And I’m letting them do with it what they want to do.” Susan, a physician with 20 years of experience in college health, said she strives to be “blunt but not…judgmental.” Elaine said it can be “interesting to have to sit in front of someone and [neutrally] say…Oh, so I see that you’re drinking…17 drinks a week.” However, Elaine said that being nonjudgmental sometimes allows the patient the space to come to their own realization. She said sometimes after she repeats the figure back the patient, “they’re like, ‘oh that doesn’t sound so good. You know, when you put it that way’ (laughs)… I’m like, ‘you know I’m just reading what it says!’” (laughs)

One way providers reported creating a nontthreatening atmosphere was by focusing on the patient and the patient’s health rather than on the patient’s character. Providers said they wanted to avoid shaming the patient or being punitive. Patty said “I don’t talk about ‘you
have a problem or [are] out of control.’ I focus on behaviors and physical health.” Lori, a physician with four years of experience in the field, said she tries to avoid seeming like a “punitive school teacher sort of figure” during brief interventions. Vanessa, a physician’s assistant who worked for one year in college health, said to create a nontargeting atmosphere she reminds patients that the conversation is confidential: “you are 19 but I’m not going to go tell on you…like you’re drinking or…you have a stash of alcohol.” Janice said that to emphasize the patient’s health rather than the patient’s character, “I just say, ‘it’s not that I particularly care one way or the other, I just need to know how much you’re drinking so we can figure out if that’s at all related to your problem.” Providers also reported framing the conversation around their care for the patient and their concern for the patient’s health.

Lori said that for a brief intervention, she tells the patient:

‘I’m just concerned about your health. I want to make sure that you’re not drinking to the point where you’re making decisions that you might later regret. You know, I just want to know that you’re safe. And I would like for you to consider making an appointment with counseling. You know, so you can talk more about this with somebody and get plugged into some of the resources that we have here.’

Louise said “sometimes I do become a little maternal, and I tell them, ‘the momma is coming out in me now.’ You know, ‘forgive me but momma’s coming out. I gotta talk to you about this.’” Dan said as a provider, “we can’t often cure, but at least we can care” so he wants patients to know that “there’s people out there who wants to help.”
Additionally, providers reported trying to diffuse tension of the conversation. Joy said it “can be hard to get them to talk” but “staying light hearted” helps keep patients talking. Providers also reported using humor to keep the patients at ease. Vanessa recalled an appointment in which she pointed out the irony of the patient’s health-conscious focus on fitness in comparison to his unhealthy drinking. She recalled saying to him,

‘I see you’re really buff. I can tell you work out (laughs). I can see your six pack from here’ (laughs). Because I could be their mother, I can get away…with that. You know, if I were much younger, I probably couldn’t. You know, they see me as their mother, so I can tell them whatever.’

In these ways, providers emphasized patient health rather than patient character and diffused the tension through humor and light-heartedness.

**Providing education about consequences.** Providers reported that their primary role during brief interventions is to provide education about healthy and unhealthy alcohol consumption. Betty said her role is “to educate and try to present further issues related to [hazardous drinking]. I see myself more as a teacher.” Patty said that during brief interventions, she focuses “on how drinking brings your judgment down, you make poor decisions like drunk driving or conceiving a child without intending to.” Providers shared information about short-term consequences of alcohol misuse such as risky sexual behavior, sexual assault, decreased academic performance, injury, and increased expenses due to injury. Joy said she tries to change thinking from “I can come and get treatment” after high risk behavior to “thinking about longer term consequences.” When her patients request a
sexually transmitted infection (STI) screening due to risky sexual behavior while under the influence of alcohol, she tells them “that STIs are kind of the least problematic consequence of what could happen [with hazardous drinking].” Elaine said she warns patients about these four risks to hazardous drinking: accidents, injuries, assault, and poor decision-making. Elaine said to drive the point home, she gives patients a visual. She said, “I go like this, so I’m holding my arm up and…describing, so this curve is number of drinks versus accidents, injuries, assault, and poor decision making.”

Providers also discussed with patients the long-term consequences of hazardous drinking – both physical and otherwise. Providers sometimes discussed long-term physical harms including damage to the brain and liver, though several providers said they thought this was not compelling to their patients. Patty said she tries to address the risk of long-term drinking habits or alcoholism. She said, “Many seem to think that they’ll change as soon as they graduate. I try to stress that behaviors that we establish in early adulthood tend to stick with us.” Rose, who referred to some patients as “alcoholics in formation,” said she “sometimes asks about family history…it could be they’re hardwired for this and they…need to sort of be equipped with the tools they need.” This technique allowed providers to acknowledge the patient’s role as a student by emphasizing education about healthy and unhealthy behaviors, particularly short and long-term consequences of hazardous drinking.

**Eliciting patient ownership.** Though providers emphasized their role to inform patients of consequences of hazardous drinking, they also reported the need for patient participation and “buy in” during alcohol-related conversations for the intervention to be
effective. Rather than focusing only on negative consequences, this technique involved empowering patients to participate in identifying consequences and solutions through insight and reflection. Many providers reported using the motivational interviewing style of inquiry in order to facilitate patient responses and reflection. Providers reported acting as facilitators of new thinking on the part of patients. Louise said “I’d like for them to be more involved in the solving [of the issue]. I’m not there to save them.” Joy said one technique she uses when discussing with patients who request STI screening after risky sexual encounters due to alcohol is to “ask them [if they] are they wanting to have children. Most say no (laughs).”

Rose said she tries to “brainstorm” with the patient if there is time during the appointment. She asks questions such as “what situation were you in when this happened?” and “what do you think about that situation caused you to drink more than you wanted to?” Rose said she thinks patients learn better and “it stick[s] longer” when they can “integrate [their] personal experience.” Dan said during these conversations, he aims for the patient to come to his or her own conclusion – “to look at this and say, ‘hey maybe this isn’t helpful to me.’” He said he and the patient will together “come up with strategies and options, tools, that might help them to detach from this type of behavior.” He added that interventions in which providers are “not listening, but just telling” are ineffective because “nobody likes to be pushed.” Providers used this technique to move beyond education during the conversation and to engage patients in developing judgments and solutions by prompting patient reflection and participation in the conversation.
Providing tips for harm reduction. Having stated negative consequences of hazardous drinking and encouraged patient participation in the conversation, providers often supplemented this with a harm reduction discussion in order to provide patients with practices to reduce the likelihood of problems while drinking. Louise said she tells students under the age of 21 to stop illegally drinking. She said, “However, you know they’re going to do it. Just like I know they’re going to have sex and all the other things they do that they’re not supposed to be doing.” For this reason, Louise said she wants to share information with her female patients about how to be safe while drinking. Louise reported that she focuses on “giving them some measurement of what is too much.” She said, “So I say…my big concern is I don’t want you drinking and driving, and I don’t want you driving with someone who’s drinking and I want you to make sure you can trust the people you’re with. If you’re out with girls, you buy your drink, you drink your drink. If you sit your drink down to go dancing, don’t pick it back up.” Some providers offered patients specific limits on how much alcohol should be consumed. For example, Patty reported that she tells patients, “If you’re still going to drink five drinks in a night, drink one an hour instead of three.” Louise said that she wants to give “them some measurement of what is too much.”

Some providers also offered suggestions for managing interactions with others during social situations involving alcohol consumption. Dan said he might tell the patient that “maybe after two or three [drinks] you’d consider stopping…or setting to your mind that you could limit the amount, or you could even employ friends to help you with that.” Rose said she provides suggestions on handling social expectations or pressure to drink alcohol: “I’ll
say, too, ‘look if you really feel like you want to have something in your hand, bring like a diet soda or a ginger ale, and put that in ice, or you can even bring club soda. Nobody knows that you’re [not] drinking vodka or gin.’” Hence, providers found themselves reinforcing the illegality of underage drinking and harmfulness of binge drinking, yet they often supplemented these messages with tips about how to drink safely.

**Extending the conversation beyond the appointment.** Though providers reported that they wanted to take advantage of opportune moments to conduct a brief alcohol intervention during their appointments with patients, many also sought to continue the conversation beyond the appointment. One way providers did this is by follow-up communication with patients after the appointment, whether via email, secure email message, or phone. Lori said sometimes when she is concerned about a patient, she will set a reminder in the electronic medical record system to send a secure email message to the patient. She said a message might say “hey, just…wanted to touch base and see if you’ve thought any more about this” and “I just wanted to remind you that I’d recommend these things and you may want to consider that in the future.” She said this serves as a second “nudge” for the patient.

Providers also reported that they sometimes request that patients return to them for a follow-up appointment to further discuss the patient’s alcohol consumption. Susan sometimes recommends the patient cut back on alcohol consumption through an experiment:

‘Try to just do the experiment for yourself…say I’m not going to drink for a month. See how it works. If you have trouble with that, then you have a problem and you
need to come back for help. If you can do that, examine how you feel during that month, and really think about what your drinking behavior is going to be going forward.’

Patti said her goal for brief interventions is always setting a follow-up plan – whether a referral, or to draw labs and come back in a month. At the end of a conversation with a patient, Patty said, ‘I’ll say, ‘I’d like you to stop or cut back and check back [with me] in a month.’” She said, “Sometimes I find liver abnormalities which leads to a conversation. I’ve had several patients who stopped drinking all together. Whether or not that was the reason, it was enough for them to reflect and totally stop drinking.”

Further, providers frequently utilized additional health-related services on campus for which private practice providers and their patients may have less access. Recommendations for follow-up are often related to other university services that are available only within the university health context. For example, many providers reported referring patients to the university counseling center or other educational services such as Alcohol.edu or B.A.S.I.C.S. (Brief Alcohol Screening and Intervention of College Students), where patients could access free services for further support in examining or decreasing alcohol consumption. Some providers use referrals to university counseling or other university alcohol education programs in place of a full multi-faceted brief intervention, while others only use it sparingly when patients have concluded that they would like to change their drinking behavior. Joy said she refers patients to university counseling services often and more so than she did in her previous role in private practice. She said this is because
university counseling services are “readily available” to patients. Janice said that university counseling is “more equipped to handle [brief alcohol interventions].”

Some providers felt that patients were not very likely to follow through by making an appointment and then attending the appointment. Because of this, some providers wanted to take advantage of the “captive audience” they had during the appointment by taking that time to conduct a full multi-faceted brief alcohol intervention. Lori said she sometimes tries to increase the likelihood that a patient will follow through with scheduling an appointment with counseling services by saying, “you know what, do you have time right now, how about I let…my nurse walk you down there, show you exactly where to go, and you can go ahead and meet with them and make an appointment.” Thus, when they were concerned about a patient’s drinking, providers acknowledged the importance of this health issue by extending the conversation beyond the appointment through follow-up communication, requests for follow-up appointments, or referral to university counseling or other alcohol education programs.

To address a patient’s hazardous drinking, providers reported utilizing a variety of communication techniques including: gathering more information, creating a nonthreatening environment, providing education about consequences, eliciting patient ownership, providing tips for harm reduction, and continuing the conversation.

**Communicative Challenges Providers Faced During Brief Alcohol Interventions**

In addition to communication techniques suited for brief alcohol interventions, providers also articulated communication challenges they faced during these conversations.
The challenges were often specific to the context of their particular form of medical practice – treating college-age patients while serving as member of a university institution. These challenges represent some of the conflicts and difficulties providers experience during the interpersonal exchange that occurs during a brief alcohol intervention conversation with a patient.

**Choosing when and how to start the conversation.** Providers agreed that alcohol-related conversations were nearly always initiated by the provider rather than the patient. Patty described an instance in which a patient sought help quitting drinking as “surprising” since patients so rarely initiate the conversation or initiate treatment. Rather than patients reporting problems with alcohol consumption, providers reported that the onus was on them to determine whether hazardous drinking was a problem for the patient, and if so, to initiate a conversation.

Providers reported that they most often initiated brief intervention conversations situationally based upon the patient’s presenting problem during the appointment. Providers reported that certain circumstances led them to question whether alcohol consumption was involved in the presenting problem. Dan said “any time that alcohol could be related to the presenting problem, definitely I’ll bring it up.” When patients responded that yes, alcohol consumption was involved, the provider was faced with the opportunity to conduct a brief alcohol intervention. Some providers felt this was the most timely opportunity to conduct an intervention. Cassandra said patients in these circumstances are more likely to be receptive. Cassandra offered the example of a patient saying, “oh my god I woke up with, I’m worried
I have an STI.’ You know, what a great moment. They want to try to figure out how to prevent that from happening again.” Providers reported that presenting problems that typically led to brief intervention included alcohol-related injuries, illnesses, and risky sexual behavior. In fact, some providers reported that they only initiate alcohol-related conversations if the presenting problem is related to alcohol consumption.

Providers in the sample differed on whether they initiated alcohol-related conversations proactively based upon patient-reported alcohol consumption during intake. In fact, providers employed at the same university healthcare facility reported varying accounts of whether patient intake protocol at their university health center included alcohol screening. Other providers reported that screening during intake occurred only for annual checkup appointments, indicating that not all providers even have this data available in order to conduct proactive brief alcohol interventions. This is problematic because providers – even at the same institution – are not operating under the same procedure for when and how to start brief interventions. This suggests inconsistency with frequency of brief interventions being conducted.

Providers agreed, however, that brief alcohol interventions must be conducted “judiciously” and that some circumstances are not the right time. Many providers said they felt it is inappropriate to initiate a brief intervention in some circumstances, for example, when the patient is in pain or distress. Rose said she does not conduct a brief intervention if the patient is bleeding, vomiting, or in a medical crisis. Rose said that providers must take advantage of “teachable moments” but “a lot of times it’s not a teachable moment when
somebody’s in there worried about whether they have you know an infection in their leg. They’re not worried about drinking.” Further, Brandy articulated her concern for ramifications of alienating a patient by raising the conversation at the wrong time: “if you’re working with someone who doesn’t perceive it as being a problem, then you run…the risk of them being like, ‘this person’s lame, I don’t like them, I’m never going to come back to see them’.” Whether initiated in response to an alcohol-related incident, or in response to screening, providers almost always initiated conversations with patients about alcohol consumption which led to brief interventions. Providers relied upon their own judgment regarding when and in what circumstances to conduct brief alcohol interventions, given the potential for a negative reaction from the patient.

**Persuading a resistant population.** Providers reported that the particular patient population they serve is unique, and therefore so is the way they discuss with patients risky lifestyle behaviors such as hazardous drinking. This can be problematic because this lifestyle behavior is common for patients in their population, many of whom do not view hazardous drinking as a health problem. Providers reported that they often face patient resistance about the need to change this behavior, and it can be a challenge to convince them of the danger of the behavior. Commenting on the particular lifestyle health risks faced by patients in this population, Elaine said, “I spend more time talking about bike helmets and drinking and seat belts than I do talking about cholesterol screening because it has no bearing on my population for the most part.” Based upon her understanding of the behaviors and habits of this population, Janice said, “I’m under the assumption that they all drink. I just want to
know how much.” Referring to the age of this unique patient population, Dan said, “Because their bodies recover fairly quickly, they’re not always seeing the consequences of the alcohol use…when we’re not feeling much pain, there isn’t really always an incentive to stop something that is somewhat pleasant or pleasurable.” Rose said for some patients, “there’s denial…that what they’re doing is abnormal or is over the top” because “everybody else does it.” Brandy said patients often “don’t perceive [hazardous drinking] to be a problem,” and when that is the case, she said, “we can’t go any further with [the intervention] at that point.”

Susan said the specific life stage of the patient population she serves makes it harder to persuade them of the danger of their behaviors. “The unique thing about college health is these are sort of man-child, women-child people. And they’re really in between being a kid and being told what to do and learning how to make judgments on their own.” Susan added, “These are still kids. And sometimes they just need to know what the rules are.” Similarly, Brandy said, “Having a permissive environment like that is very dangerous” because it “sends a message to students like ‘yay, students, do whatever you want’.”

Providers reported that patients are sometimes even resistant to screening or inquiries about alcohol consumption. Providers reported barriers to accurate reports of alcohol consumption, such as patients underreporting the amount of alcohol consumed, which Rose referred to as “creative loss of memory.” According to providers, patients are also concerned about confidentiality of their medical records given their age and that patients are often still covered through their parents’ insurance plans. Janice said, “Some students feel like we’re going to tell their parents [about the drinking]. Because they’re on their [parents’]
insurance…They edit what they say or they don’t tell us everything until they know for sure that…their medical record is private and your mom can’t see this just because you’re on her insurance.” Additionally, some patients worried about getting in trouble with the university. Therefore, providers must overcome patient resistance to disclosing accurate information about alcohol consumption that is required for providers to conduct brief alcohol interventions.

In this way, providers faced an uphill battle in terms of persuading patients of the harmfulness of hazardous drinking, as well as sometimes even persuading patients to accurately report their alcohol consumption.

Establishing rapport necessary for a sensitive conversation. According to providers, conversations about patient alcohol use can be sensitive or uncomfortable for some patients. Providers said that alcohol-related conversations compare to other sensitive topics for patients such as sexual health, STIs, and mental health. The sensitivity of the conversation may be intensified by the low rapport providers have with patients given that it is often the first time they are seeing the patient. Susan said, “Most people come in because they have 15 minutes between class and they can get an appointment. And so they see whoever they can see. And that makes it much more difficult to have those relationships [with patients].” Joy had recently joined the staff at a university health center, having previously worked in private practice. Joy said that patients may access university health services once or twice, but “may not always see you for a visit” which is different from “private practice, where I have a set panel of patients that I know over time, you can build a
rapport where you can delve into sensitive issues [like drinking habits].” Joy said it can be “harder for you to…have those types of conversations with a student you’re just meeting for the first time.” Faye, a physician with less than one year of experience in college health, compared brief alcohol interventions to an instance in which a patient neglected to disclose his HIV-positive status to her. Faye said, “I’m sure it would be difficult for them say seeing somebody for the first time to really admit that.” Vanessa said that these conversations are sensitive and require rapport between provider and patient. She compared it to an interaction she had with a patient of hers who had an eating disorder. Vanessa recognized it but waited until a later appointment when they had made a connection and the patient “knows who I am” to initiate a conversation about the eating disorder. Providers must often figure out how to establish a connection with the patient in the short amount of time between the start of the appointment and moment the sensitive topic of alcohol consumption is broached.

Though providers saw themselves as primary care providers for patients on campus, the nature of providing care at a university health center can inhibit rapport-building with patients. Providers, then, are challenged to quickly build rapport with patients in order to raise sensitive topics such as hazardous drinking behavior.

**Maintaining credibility despite uncertainty about the efficacy of interventions.**

Many providers expressed uncertainty about the efficacy of the brief interventions they conducted and their power to influence patients to make behavioral changes regarding alcohol consumption. Patty, who said she tries to be sensitive to the patient during brief
interventions, expressed her ambivalence: “You can be as gracious and as sensitive, and of course you might not change the outcome. So I’m not sure how much it gets me.” She added, ‘I actually wish that we didn’t ask about [alcohol] every time [a patients comes in] – it makes the provider feel obligated to address it every time and it can be less effective that way. Because studies show that each time someone in a white coat tells a patient to stop smoking, they’re more likely to. I’m not sure if the same thing is true about alcohol.’

Patty concluded, “I want to address it if I can make a difference.” Lori expressed a similar lack of confidence: “There are different studies for different things that say that what we as physicians say actually does matter to a patient. Although I often feel that it doesn’t.” Many providers, then, must overcome uncertainty about personal ability to persuade patients regarding lifestyle behavior change.

Further, some providers questioned whether conducting full brief alcohol interventions was the best use of their limited time with the patient. Janice said these conversations can be time consuming. Janice reporting commonly referring patients to the counseling center, saying “I do know where you can go and get that addressed and so how about you go there.” Louise also sometimes refers patients to the counseling center to discuss alcohol consumption. She said, “I think that [referring patients] probably may be more effective than me sitting there preaching to them, as if with my gray hair, they’re going to listen to me.” Brandy said she does not feel equipped or skilled in conducting brief interventions. She said, “I don’t know how to do that, how to be like, hey, you really should
[not] be walking around at two in the morning and drunk.” Brandy said that the brief intervention style of communication feels “inauthentic” to her, adding that “some folks are better at it than others.” Cassandra said she sometimes feels “impotent” during these conversations. When describing what she says to patients during the intervention, she said, “I could go into ‘someone this size could drink this much an hour, someone this size could drink that much an hour.’ I don’t really know. I know the smaller, the less you can drink…I could do that but I, I don’t.”

Due to the high demand and drop-in nature of university health services appointments, providers do not always see return patients and rarely get feedback from patients. Susan said she rarely gets feedback from patients regarding brief alcohol interventions. She said,

‘I think I’ve just been around enough that I know, I know that you gotta try. And sometimes you’re going to succeed and usually you don’t know. Usually you just never get to know. So you just have to sort of put it out there in the cosmos and let it marinate.’

Providers in this context may receive less feedback about the success of their brief alcohol interventions given design of university health services. This lack of feedback may increase providers’ sense of uncertainty about outcomes of the brief alcohol interventions that they conduct.

Because of the prevalence of alternative sources of alcohol counseling such as counseling services for patients on many university campuses, and lack of feedback from
patients, providers reported uncertainty about the efficacy of their brief alcohol interventions. Providers, then, must overcome this uncertainty to conduct a credible, persuasive brief alcohol intervention.

Overall, providers reported enacting a variety of communication techniques during brief alcohol interventions to garner participation and, hopefully, decreased alcohol consumption on part of their patients: gathering more information, creating a nonthreatening environment, providing education about consequences, eliciting patient ownership, providing tips for harm reduction, and extending the conversation beyond the appointment. Providers also, however, reported four significant communication challenges that they faced during brief alcohol intervention conversations due to the unique nature of university health services: choosing when and how to start the conversation, persuading a resistant population, establishing the rapport necessary for a sensitive conversation, and maintaining credibility despite uncertainty about efficacy of interventions.
Discussion

Given the complexity of interpersonal interaction that occurs during brief alcohol interventions, providers in this sample reported pursuing multiple goals during these conversations. Goldsmith’s (2001) normative approach serves as a framework with which to understand the pursuit of multiple goals, which sometimes conflict with one another. This conflict creates a communicative dilemma for the provider. According to the normative approach, the efficacy of a brief intervention will be at least in part determined by how well a provider is able to reconcile these dilemmas during the intervention. Providers in this sample managed the following dilemmas, which seem to suggest their experience of conflicting goals in addition to conflicting roles.

**Projecting authority while enacting nurturance.** Most prominent is the dilemma that is perhaps inherent to conducting patient-centered interventions. Providers asserted authority in confronting patients with the notion that their lifestyle behavior poses a health problem. Additionally, the providers projected authority when making recommendations for decreasing or ceasing alcohol consumption. At the same time, providers also sought to maintain a nonthreatening environment, often by expressing concern for the patient as an individual and his or her health. Thus, the relational goal of nurturing the patient may conflict with the instrumental goal of persuading the patient to cease or decrease alcohol consumption.

**Upholding institutional messaging while offering practical assistance.** Additionally, providers may face the dilemma of upholding institutional university
messaging about the legality of alcohol consumption while also including other practical facets to the intervention such as harm reduction tips for safe drinking, which may seem in conflict with institutional messaging. Providers reported feeling responsible for reminding underage patients that drinking alcohol is illegal. However, providers also sought to offer patients assistance about how to safely consume alcohol. Reminding underage patients of the illegality of their actions through the eyes of the institution may disrupt the conversation by raising punitive or legal consequences and moving away from the patient’s well-being. This instrumental goal may again undermine the relational goal of establishing rapport with the patient.

**Protecting the self while acknowledging lack of control.** Finally, the finding that providers conducted these interventions without being entirely sure about efficacy of the interventions may create a dilemma for providers. Pursuing the instrumental goal of trying to decrease patient drinking through intervention may conflict with providers’ identity goal of maintaining certainty and credibility as a competent and extensively trained professional. Providers reported that at times they entered interventions anticipating outcomes in contrast to those being pursued. Providers recognized that patients may react negatively, refuse to engage in the conversation, or merely acquiesce with no intention of changing their behavior.

These dilemmas hold ramifications for conceptualization of the relationship between providers and patients. The provider-patient relationship was historically envisioned in terms of a paternalistic father-child relationship (Beisecker & Beisecker, 1993) in which the provider managed decision-making. Though the paternalistic metaphor of a fatherly doctor
served for many years as the primary way of understanding the provider-patient interaction, this metaphor has more recently received significant criticism (Beisecker & Beisecker, 1993; Mead & Bower, 2000). Providers did report enacting communication associated with masculine or paternalistic values of authority and dominance. Yet, in contrast to these masculine values, providers also enacted alternative techniques associated with a feminine style of communication involving sensitivity, receptivity, nurturance, and collaboration (Burrell, Buzzanell, & McMillan, 1992). Thus, providers felt called upon to utilize both masculine styles and feminine styles of communication when conducting brief alcohol interventions. Additionally, providers may utilize the corresponding relational metaphors of paternalism and maternalism to relate to patients and navigate the communication challenges of conducting brief alcohol interventions. Thus, providers may experience tension or conflict between these two differing roles.

Previously, Baldwin et al. (2006) attempted to explore provider and patient perspectives about brief alcohol interventions in a university health context from the discipline of public health. Just as much of the research about interventions has taken for granted the seamless implementation of intervention programs, that study addresses only situational factors impacting the interaction, but neglects to address the dilemmas faced by providers during these conversations, and thus, how they may be resolved. The study concluded “how important it is to understand the contrasting perspectives of health-care providers and their student patients,” yet only in passing mentioned the “communication difficulties that are inherent in the provider–student relationship” (2006, p. 114). The study
did not address how these difficulties manifest or how providers sought to overcome difficulties. The present study built on Baldwin et al.’s (2006) study to identify why these communication difficulties arise in the college health context as well as some communicative techniques to ease these conversations.

However, this study did not account for patients’ perspectives about the communicative aspects of brief alcohol interventions. This study also cannot point to demographic and psychographic factors – such as level of training, age, gender, etc. – that might influence style and likelihood of conducting brief alcohol interventions. Future research should explore these aspects of brief interventions. Additionally, this is not a systematic study about intervention message design. Rather, the study does provide a broad sense of the common techniques used by providers and challenges faced by providers in this sample. This is an important next step to understanding barriers that university health providers experience during brief alcohol interventions. A better understanding of what communicative aspects of brief alcohol interventions are accessible and comfortable – as well as those that seem difficult and uncomfortable – for providers can help inform institutional priorities regarding internal communication and training on brief alcohol interventions. This effort drives toward the ultimate goal of developing, implementing, and improving brief intervention programs to decrease harms associated with hazardous drinking among university students.

The present study has implications for institutional internal communication about brief intervention programs. The four components recommended by Scott-Sheldon et al. 
(2014) to be included in a multi-faceted brief alcohol intervention – personalized feedback, moderation strategies, goal setting, and the identification of especially risky situations – were commonly discussed by providers as items that were incorporated into their brief alcohol interventions. However, results demonstrate that providers define brief intervention in different ways and incorporate varying layers of persuasiveness in their messages. Some providers described interventions as simply expressing concern about patient alcohol consumption and making a referral to counseling to further discuss it, whereas others described multi-faceted interventions involving patient brainstorming, goal-setting, and follow-up appointments. This may suggest that providers are structuring brief interventions in a way that is comfortable for them individually given their communication style, preferences, and perhaps even perceived level of authority. Given that some providers at the same institution approached interventions differently, this may also suggest a lack of clear guidance about institutional objectives for addressing hazardous drinking among the institution’s patient population – or that providers are unclear about institutional objectives. Universities that have identified brief intervention programs as a priority should also provide clear, unified guidance about objectives and components of interventions. This study also has implications for provider training regarding brief intervention programs. Providers in this sample seem not to have embraced the literature showing that face-to-face brief interventions are effective at reducing harms due to hazardous drinking. Thus, university health administrators should consider how to encourage awareness of positive research about medical care providers’ role in conducting effective brief alcohol interventions. This may
include building into brief alcohol intervention trainings some of the research about efficacy
of face-to-face provider delivered interventions.
Conclusion

Even given the limitations, this study provides much needed insight about how university medical providers are meeting the demand to address hazardous drinking among their patient population of university students. Providers are on the “front lines” of many universities’ quest to address and reduce binge drinking and its associated harms. Results show that providers utilized six communication techniques to conduct brief alcohol interventions with university health patients: gathering more information, creating a nonthreatening environment, providing education about consequences, eliciting patient ownership, providing tips for harm reduction, and extending the conversation beyond the appointment. Additionally, providers reported four communication challenges that they face during brief alcohol interventions: choosing when and how to start the conversation, diagnosing a resistant population, establishing the rapport necessary for a sensitive conversation, and maintaining credibility despite uncertainty about efficacy of interventions. Applying a normative approach illustrates the communicative dilemmas faced by providers due to conflicting goals and roles during brief alcohol interventions. Providers reported utilizing both masculine and feminine communication styles related to paternalistic and maternalistic metaphors for provider-patient relationships when conducting brief alcohol interventions. This study has implications for university health center internal policies regarding brief intervention programs as well as provider training programs about brief alcohol interventions.
References


Appendices
Appendix A

Interview Schedule for Student Health Service Providers

Thanks so much for agreeing to talk with me. As a reminder, feel free to skip any questions or stop at any time. Everything you say will be confidential, as is your employer. You as a participant will remain anonymous. Your name is never taken down as I will assign you a pseudonym that is used throughout the remainder of the project.

Organizational background
First, just a few background questions.

1. How many years collectively have you worked in student health services (SHS)?
   a. What position do you hold currently?
2. Of all the health problems experienced by patients in your student population, what do you perceive is the significance of heavy or hazardous drinking? That is, drinking that could be hazardous to the patient’s health or consumption of hazardous amounts of alcohol.
3. What, if any, is the protocol at SHS for identifying patients who participate in hazardous drinking behavior?
4. In your opinion, what level of hazardous drinking by a patient, if any, suggests the provider should initiate an alcohol-related discussion with the patient?
5. If a patient reports or exhibits hazardous drinking behavior, how do you determine whether to initiate a conversation about a patient’s hazardous drinking behavior?
6. In your opinion, what role, if any, does student health services (SHS) play in addressing hazardous drinking among the patient population of students?
7. In your opinion, what role, if any, do you as a university provider play in addressing hazardous drinking among the population of patients?

Alcohol-related conversations
This next set of questions are about how these types of conversations unfold from your own experience. Each of these questions assumes you are speaking with a patient who has reported or exhibited hazardous drinking behavior.

8. What kind of triggers or circumstances lead to alcohol-related conversations with patients?
9. Pretend I’m a patient who reported or exhibited hazardous drinking behaviors. Would you initiate a conversation, and if so, what would you say to me?
10. What information do you share, if any, when discussing a patient’s hazardous drinking behavior?
   a. What kind of recommendations, if any, do you make regarding a patient’s hazardous drinking behavior?
   b. What resources or materials do you draw upon, if any, when discussing the patient’s hazardous drinking behavior?
11. What is an example of a typical conversation you have with patients regarding their hazardous drinking?
12. What is an example of an alcohol-related conversation that did not follow this typical pattern and stands out to you?
13. What factors, if any, might lead you not to initiate a conversation with the patient about his/her hazardous drinking behavior?
14. How difficult or easy are alcohol-related conversations with patients in comparison to other sensitive topics?

**Communication challenges**

Next, I’d like to turn to some of the challenges or roadblocks of these conversations. Again, we are assuming a conversation with a patient who has reported or exhibited hazardous or dangerous alcohol use.

15. What, in your opinion, are some of the communication challenges or roadblocks that patients face during alcohol-related conversations with providers at SHS?
16. What, in your opinion, are some of the communication challenges or roadblocks that SHS providers face during alcohol-related conversations with patients?
17. What strategies or actions do you use, if any, to ease any challenges or avoid roadblocks of alcohol-related conversations with patients?

**Provider objectives**

Finally, I’d like to wrap up with a few questions that relate to provider objectives during alcohol-related conversations regarding a patient’s hazardous drinking.

18. If you initiate an alcohol-related conversation with a patient, what is your objective or goal for the conversation?
19. In your opinion, what are the characteristics of an effective alcohol-related conversation with a patient?
20. In your opinion, what are the characteristics of an ineffective alcohol-related conversation with a patient?
21. What types of responses do you receive from SHS patients with regard to alcohol-related conversations?
   a. To what extent do you perceive that SHS patients are receptive to your recommendations regarding hazardous drinking?
22. What is an instance, if any, in which you had a follow-up conversation with a patient with whom you previously had an alcohol-related conversation?
23. What advice would you give another SHS providers about facilitating effective alcohol-related conversations with patients?