

Logging On: Building a Clinical Alliance in Substance Use Disorder Treatment

Johnna Marcus, LICSW

As the social work profession continues to explore best practices in telehealth and substance use disorder (SUD) treatment in the midst of the COVID-19 pandemic, the creation of strong clinical relationships between practitioners and patients has become even more critical. In the world of SUD treatment, where trust and communication are key, telehealth has created many challenges. Fortunately, our quest to overcome these challenges has led to greater insight into what makes SUD treatment effective, regardless of whether interventions occur through a screen or in-person.



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Within the setting of Beth Israel Deaconess Medical Center's Division of Addiction Psychiatry in Boston, I work as one of the social workers for patients in both outpatient and inpatient settings who have a diagnosis of a substance use disorder. As a team, we have been invested in the idea that quality care for our patients in this current crisis is to be held to the same standards as "pre-pandemic times." This requires attention to ensuring that clinical relationships are valued and developed with the same focus as they always have been, just in the context of increased virtual settings to limit potential virus exposure.

The following strategies to build a mutually beneficial alliance between patient and social worker are especially important during this time where connection and relationship-building are being tested.

Come Prepared to Meet with Patients

It is important to be familiar with a patient's history prior to an exploration of therapeutic interventions. The time it takes upfront to read a patient's chart and understand key elements of their medical and psychosocial history can better prepare the social worker in making informed clinical decisions. It provides a basis for continued exploration of their current needs and treatment options. Examining a patient's history gives the social worker insight into what has and has not worked for the patient and brings into focus what is needed for clinical intervention. We are all busy but investing time in becoming familiar with a patient's record can pay dividends. Patients often notice that you have taken time to read their medical record.

Believe and Validate Patients' Statements Concerning their Pain

The idea of validating a patient's pain has always been a significant part of clinical work, but especially in SUD treatment, as too often a patient's statement surrounding pain is questioned. It has been said that "how we [practitioners] think about pain influences the way in which we go about evaluating patients" and it is important to take this into consideration as we explore a patient's reasons for needing treatment. Often, we hear from those who work with patients with SUDs that patients are "med seeking" or somehow "exaggerating their pain." As an example of how this questioning can occur, let us look at this scenario: I was working in an emergency department and consulting on a case in which a woman came in with injuries resulting from IV drug use and needed SUD support. The nurse was working on putting an IV into her arm in the crowded hallway of the emergency department as I introduced myself. The patient was looking down at her arm with fear as a needle was being inserted for an IV and stated, "That hurts

so much, this really hurts," and the nurse stated, "It will be no different than the needles you usually stick in your arm!"

Pain comes in many forms and should not be ignored through the treatment process. In the above example, the nurse above cared for the patient's pain, but may have developed his own viewpoints about treatment for pain for people with SUDs. An article titled, "You're kind of at war with yourself as a nurse: Perspectives of inpatient nurses on treating people who present with comorbid Opioid Disorder" explains, "you don't want to fuel their addiction, you don't want to set them back, but you want to treat them. So, there's just this clash of really how to go about things." In this way, our role as social workers can be to validate challenges of working with SUDs and provide additional support to others on the clinical team working with such patients. In our own work with patients, we are there to provide an environment of healing if patients have experienced stigma in the process of attempting to receive help.

Substance use disorders are painful, often insidiously so, as they can promise intense alleviation that never stays around long. If I put my hand on a hot stove and my patient puts her hand on a hot stove, we both feel the burn. In order to effectively work with patients who are in pain, we first must believe them.

Recognize the Importance of Teaching Rather than Convincing

As social workers, we are not here to convince patients of our ideas surrounding substance use. I often remind myself that patients know the negative consequences of their substance use. The only rare exception being if they are mandated to treatment with no personal desire of their own to change their substance use behaviors. Otherwise, they come to treatment with some desire to at least decrease their

substance use. As often tends to be the case, I am instead someone who can help illuminate what a patient may already know about the impact of substance use on their lives, relationships, and health.

Once the negative consequences become illuminated, the focus can be in ensuring that those negative consequences stay present in the patient's mind. It is challenging to face the consequences of substance use, which may result in feelings of guilt if they think of their substance use as a choice. For example, a patient may state that they "should be able to stay sober because so many horrible things have occurred due to (the substance)." The reality is that SUD is more complicated than seeing a pattern of negative consequences. Part of the disease is that negative consequences can occur over long periods of time and still a patient can be convinced that "next time" (a patient uses a substance), it will be different. It is not our job to argue with this, but rather show how the patient already has evidence to show this to be untrue.

Assist the Patient in Determining at Least 3-4 Key Beliefs and How they May Impact Treatment

Issues that may be important in the eyes of the medical team, therapeutic team, or even loved ones, may not be the key aspects of treatment motivation for the patient. In SUD treatment, a technique called Motivational Interviewing can be used to "help patients to say why and how they might change" by "using rapid engagement to [have patients] focus on the changes that make a difference" verses simply giving patients advice. Motivations for cutting back or sustaining sobriety may seem obvious (for example, "being sober will provide me with stability, more money, respect, etc."), but we must be careful that we do not assume that any of these reasons are true for our patients.

Motivation for cutting down or stopping substance use has to be unique to be the patient and lies in a belief that I always call the "2am rule." The 2am rule explores the importance of reasons for sustaining sobriety holding up not only in the light of day, but in the middle of the night when

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our desires sometime cross the line over what is “logical.” Stopping alcohol use seems completely possible in the light of day, but when patients are “hungry, angry, lonely, and tired” (often called HALT), logic tends to be less present in decision making. I often tell patients to write down three to four significant reasons why they wish to have sobriety and when they have the urge or desire to use a substance to go through the list. Then I ask the patient if exploring the list was helpful. If the reason did nothing more than delay the use for the seconds it took to read the statement, then it may be important to examine other reasons.

An important factor in this equation is for the clinician to create a clinical space where it is safe and comfortable to be honest. Certain reasons for sobriety sound great—being sober for their child, family, health, etc., but sometimes being sober lies in things truly unique to that person, perhaps even reasons not uncovered or clear to the patient yet. To obtain the most honest reasons for change, the clinical relationship needs to be built upon non-judgmental and open communication.

Be Confident in the Effectiveness of Good Substance Use Disorder Treatment

This sounds simplistic, as if there is one way to determine what is “good” treatment. The truth is there is rarely one specific treatment or modality that “works,” but the clinician must be confident that alleviation of suffering can be achieved. The social worker’s belief that SUD treatment can be effective and life-changing is a powerful statement. Sometimes, practitioners try to “warn patients” about the challenges of SUD (“You know, some people don’t get these many chances at changing their life... take advantage of it”). Treatment is often multi-layered and can involve various kinds of interventions.

I want patients to believe in treatment and the work that it takes, not necessarily one miracle cure (any one medication, inpatient stay, program, etc.) that changes everything. Often, identifying what has

worked and has not in the past is especially important in the clinical relationship and can assist in creating a clinically-sound plan for next steps. Once the clinical relationship explores a patient’s challenges and successes, you can set the stage for shared decision-making, which can improve the clinician’s perceived alliance and involvement.

Communicate with Other Members of the Patient’s Care Team

In my work, referrals often come to the team from medical teams concerning the effects of the patient’s SUD on medical conditions. Sometimes referrals are sent to the Addiction Psychiatry team because a medical team member spoke to the patient and something about substance use was communicated in the medical assessment.

One way to engage with patients in this setting is to open with a statement regarding the medical team members concerns, or potentially the patient’s own primary care physician’s concerns. The patient’s knowledge about the collaborative nature of treatment demonstrates cohesiveness on the part of the treatment team and can also indicate to the patient that there are many people involved who care about how the patient is doing, and will continue to care, in the future.

Guide Patients into Having Autonomy Over their Decisions Surrounding Substance Use

There is significant talk about powerlessness is SUD treatment and sometimes this concept can vary in meaning within the context of treatment. We are only powerless when we allow the substance to take our power away, but a patient is not powerless over a substance if they are not actively using it. There is power in spending hours struggling with the decision to use or not and then deciding they need more help. There is hope in someone cutting down in drinking when they cannot make the decision to achieve sobriety at any given time. The key is that these decisions (to decrease substance use, work toward sobriety, etc.) are for the patient to make, not the practitioner.

For example, one of my patients opened up the clinical session by stating that he “had a bad week and didn’t do the right thing.” I had assumed that this involved relapse, but when he clarified this statement, he had been “thinking about using but never actually did.” While this was upsetting and concerning for the patient that he was thinking about relapse, the reality was that he exhibited power in being sober despite strong feelings of wanting to use. Reframing the dialogue about relapse “failure” can be a powerful clinical tool.

The Work is Relational

In the end, the importance of building an alliance speaks to the attention made to the relationship as the basis of any clinical intervention. Social workers ask people about their relationships, substance use, legal history, relapses, trauma, and medical concerns - information and problems most people do not want to admit! The basis of any clinical intervention within addiction social work has to be relational. Patients know when the care shown to them is genuine. How we speak (i.e. non-judgmental, patient-centered communication) and the language we use when working with patients matters.

A clinical alliance implies that those involved are mutually benefitting from the relationship. We hope that patients receive skills, confidence, and peace through the treatment process. In return, the practitioner gains something in the satisfaction of the work. The above steps help ensure that this relationship is built on trust and honesty, thereby providing the necessary support for the patient struggling with their SUD during a pandemic. 🌐

About Johnna:

Johnna Marcus, LICSW, specializes in the substance use disorder field within the setting of Beth Israel Deaconess Medical Center. Her experience includes clinical social work within the settings of emergency departments, inpatient substance use disorder treatment facilities, and outpatient psychiatry centers. Johnna received her MSW at the University of Pennsylvania.