

Motivational Interviews May Help Smokers Quit

BY DIANA MAHONEY

Motivational interviewing can be an effective counseling technique for smoking cessation, particularly when it is delivered by a primary care physician, a review of intervention studies shows. However, the review results should be interpreted with caution, the authors wrote.

Dr. Douglas T.C. Lai, of the Chinese University of Hong Kong, and his colleagues from that university and the University of Oxford (England), conducted a Cochrane Collaboration review of data from 14 studies involving more than 10,000 individuals and published between 1997 and 2008. The review included randomized controlled trials, identified through the Cochrane Tobacco Addiction Group Specialized Register, in which motivational interviewing or its variants were

used to assist in smoking cessation (Cochrane Database Syst. Rev. 2010 Jan. [doi:10.1002/14651858.CD006936.pub2]).

Motivational interviewing is a non-confrontational counseling technique designed to help people explore and resolve their uncertainties about behavior changes, the authors wrote. The brief psychotherapeutic intervention has been widely implemented as a smoking cessation technique and is recommended in smoking cessation guidelines. However, little attempt has been made “to systematically review the evidence” about the intervention, they wrote.

In the current review, the investigators sought to include studies of interventions that made explicit reference to core principles as described by W. R. Miller and S. Rollnick in their book, “Motivational Interviewing: Preparing People to Change” (New York: Guilford Press, 2002).

The studies had to include a monitoring element, such as the details of counselor training or measures to ensure the quality of interview sessions (videotaping sessions or use of an assessment scale and supervision, for example). The main outcome measure used in the review was abstinence from smoking after at least 6 months’ follow-up, based on the most rigorous definition of abstinence in each trial and biochemically validated rates, where available.

All except two of the intervention studies included in the review took place in the United States, and the most commonly used interview approach was one in which the smoker received nonthreatening feedback designed to develop discrepancy between smoking and personal goals, the authors explained. Dr. Lai and his colleagues noted that the interventions involved face-to-face sessions, except for three in which the counseling was telephone based. Ten of the studies looked at single-session interventions, and the rest looked at three- and four-session interventions. Most of the studies compared the intervention with usual care or brief advice, often accompanied by self-help materials, they said.

The investigators conducted a conventional meta-analysis to estimate pooled treatment effects. They observed a modest but significant increase in smoking cessation among patients who underwent motivational interviewing, compared with those who received usual care. With the strictest definition of abstinence and the longest follow-up, the overall effect across all 14 trials was a relative risk for smoking cessation in the treatment vs. usual care group of 1.27, the authors reported.

A slightly higher but similar effect (relative risk 1.37) was observed in a sensitivity analysis that excluded trials of par-

VITALS

Major Finding: Motivational interviewing had more impact on smoking cessation when delivered by a primary care physician, compared with delivery by counselors or nurses (relative risk 3.9 vs. 1.23 and 1.27).

Data Source: Meta-analysis of 14 smoking cessation studies involving more than 10,000 individuals in which motivational interviewing was utilized.

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ticipants who were already motivated to make a quit attempt, and a comparable relative risk (1.31) was noted in an analysis of findings from the nine trials in which the outcomes were validated biochemically, they said.

In a subgroup analysis by therapist type, the largest effect was observed in the interventions delivered by primary care physicians, followed by those with counselors and nurses, with respective relative risks of 3.49, 1.23, and 1.27, the authors reported. It is possible that primary care doctors are best suited to deliver this type of intervention because they are already familiar with the patients and, presumably, have an established rapport. The authors point out that “this finding is based on two relatively small studies and should not be overstated.”

Despite the positive findings of the meta-analysis, “absolute quit rates were relatively low,” probably because most of the trials included smokers who were not motivated to quit, the authors wrote.

The authors urged caution in interpreting the results because of “variations in study quality, treatment fidelity, and the possibility of publication or selective reporting bias.” Future studies, they noted, “should attempt to identify which core components of the motivational interviewing approach are effective, and whether modifying them enhances or reduces their effectiveness.” ■

Referral Might Be More Realistic

MY TAKE

The systematic review by Dr. Lai and his colleagues affirms the general notion that interventions for tobacco cessation provided by clinicians increase abstinence rates, but also goes further to suggest that primary care physicians may be more effective than other clinicians.

As the authors point out, this conclusion must be interpreted with caution because it is based on two small studies. Even if the authors’ conclusion are true, motivational interviewing is an incredibly powerful tool—but one with limited ability to be disseminated into primary care practices. The “crush of the practice” in primary

care leaves only the optimistic and detached remaining hopeful that providers will be able to apply these skills with their patients who use tobacco.



A more realistic model is the AAR model in which busy clinicians Ask-Advise-Refer. The ideal role of motivational interviewing in primary care may be to overcome patient barriers to accepting referral to a tobacco treatment specialist or to picking up the phone and calling the tobacco quit line (800-QUITNOW).

JON O. EBBERT, M.D., is an associate professor at the Mayo Clinic in Rochester, Minn. He reported no relevant conflicts of interest.

Marijuana May Be Linked to Mood Disorders, But Not SCC

BY SHERRY BOSCHERT

SAN FRANCISCO — The “medical” use of marijuana, which is common among patients diagnosed with illnesses such as HIV or cancer, might lead to depression or anxiety disorders. However, data suggesting that marijuana use is a risk factor for throat and neck cancers are weak, two experts say.

Evidence that marijuana use might play an etiological role in the development of psychotic disorders and schizophrenia has been mounting (Eur. Arch. Psychiatry Clin. Neurosci. 2009;259:413-31; Am. J. Psychiatr. 2009;166:1251-7). The relationship between marijuana (or “pot”) and anxiety or mood disorders, however, is less clear, Dr. Robert B. Daroff Jr., director of the HIV Psychiatry Program at the San Francisco VA Medical Center, said at a meeting on the medical management of HIV sponsored by the University of California, San Francisco.



Patients with HIV often contend that they are self-medicating their symptoms and that the most common “diagnosis” associated with medical marijuana use is “stress,” he said.

“I usually advise—and this doesn’t always go smoothly—that depressed or anxious patients take a trial off of pot before I treat their depression or their anxiety,” he said. If patients are willing to try interrupting marijuana use, often they will find that the drug was a major contributing factor to their psychiatric symptoms.

“At least for patients who have treatment-resistant depression and anxiety, we ought to be pushing harder for them to give a trial off of pot to see if that’s related” to their psychiatric problem, he said.

Deborah Greenspan, D.Sc., professor and chair of orofacial sciences and distinguished professor of dentistry at the university, said anecdotal reports that the practice of using marijuana contributes to the development of oral squamous cell carcinoma (SCC)

prompted her to review studies related to this topic.

A large, population-based case-control study with 407 subjects found no association between marijuana use and SCC either in the cohort as a whole or in any subgroup based on age, cigarette smoking status, or alcohol consumption (Cancer Res. 2004;64:4,049-54). “The bottom line is that, right now, there are no data to support marijuana as a risk factor” for oral SCC, she said at the meeting.

An analysis of five case-control studies with 4,029 cases of head and neck cancer and 5,015 control patients found no significant association between cancer and marijuana use in patients who did not smoke cigarettes (Cancer Epidemiol. Biomarkers Prev. 2009;18:1,544-51).

“There may have been some dual activity going on” from cigarette use by marijuana smokers that contributed to suggestions that marijuana increased cancer risk in some earlier small studies, Dr. Greenspan said. ■

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