Motivational Interviewing Might 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, a family physician affiliated with 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 over 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 (MI) is a nonconfrontational counseling technique designed to help people explore and resolve their uncertainties about behavior changes, the authors wrote. The brief 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.

In the current review, the researchers sought to include studies of interventions making explicit reference to core MI 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 MI 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 MI 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 MI 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 MI, 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 participants 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, 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 author pointed out that "this finding is based on two relatively small studies and should not be overstated."

The authors reported no conflicts of interest. ■

MY TAKE

Be Realistic

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.

This conclusion must be interpreted with caution because it is based upon 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.*