



Motivational interviewing and the decisional balance procedure for cessation induction in smokers not intending to quit

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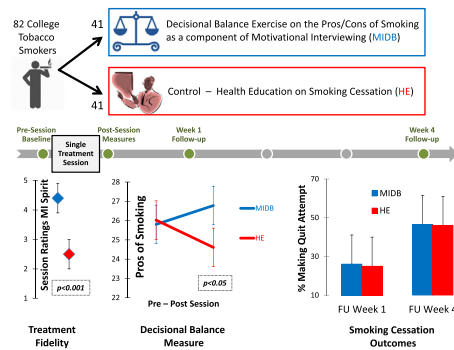
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HIGHLIGHTS

- A decisional balance exercise as a component of MI increased the Pros of smoking.
- No differences between groups on tobacco cessation outcomes.
- Increases in Pros of smoking related to motivational interviewing characteristics.
- Increases in Cons of smoking and therapeutic alliance related to cessation outcomes.
- Decisional balance procedure may be counter-productive within smoking cessation.

GRAPHICAL ABSTRACT



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ABSTRACT

Introduction: The decisional balance (DB) procedure examines the pros and cons of behavior change and was considered a component in early formulations of Motivational Interviewing (MI). However, there is controversy and conflicting findings regarding the use of a DB exercise within the treatment of addictions and a need to clarify the role of DB as a component of MI.

Methods: College tobacco smokers ($N = 82$) with no intentions on quitting were randomly assigned to receive a single counseling session of either Motivational Interviewing using only the decisional balance component (MIDB), or health education around smoking cessation (HE). Assessments were obtained at baseline, immediately post-treatment, 1 week, and 4 weeks.

Results: Compared to HE, the MIDB sessions scored significantly higher on the Motivational Interviewing Treatment Integrity (MITI) scale (all standardized differences $d > 1$, $p < 0.001$). Unexpectedly, self-report Pros of smoking scores increased for MIDB but decreased for HE (MIDB vs HE standardized difference $d = 0.5$; 95%CI 0.1 to 1.0, $p = 0.021$). Both groups showed significant reductions in smoking rates and increases in motivation to quit, quit attempts, and self-reported abstinence, with no significant group differences. Changes in the Pros

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of smoking were correlated with MITI scores, but not with cessation outcomes. In contrast, increases in the Cons of smoking and therapeutic alliance were predictive of better cessation outcomes.

Conclusions: The decisional balance exercise as formulated by earlier versions of MI may be counter-productive and cautions around its use are warranted. Instead, improved cessation outcomes appear associated with increasing perceived benefits of quitting and positive therapeutic alliance.

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1. Introduction

We all talked the hunches over, up and down and through and through. We argued and we bargained! We decided what to do (Seuss, 1982).

While Motivational Interviewing (MI) has empirical support across settings and problematic behaviors, systematic reviews continue to highlight conflicting findings (Burke et al., 2003; Hettema et al., 2005; Li et al., 2016; Lundahl et al., 2010). Despite its widespread use, research is needed to examine how the components of MI work while controlling for intervention intensity and fidelity of implementation (Allsop, 2007; Miller & Rose, 2009). In MI, the therapist focuses on eliciting client's pros of change, or "change talk", while avoiding arguing about the perceived cons, or "sustain talk" (Miller & Rollnick, 1991; Miller & Rollnick, 2013). Early formulations of MI fostered behavior change by "helping clients to explore and resolve ambivalence" (Rollnick & Miller, 1995). One recommended tool was the decisional balance (DB) procedure, which involves an examination of the pros and cons related to a choice (Janis & Mann, 1977). In MI this procedure allowed clients to express reasons for not changing ("sustain talk") while also encouraging clients to express "change talk" in the form of reasons to change (Miller & Rollnick, 1991). It was thought to be beneficial for supporting client autonomy and establishing an alliance by acknowledging the perceived cons, yet also serving as a tool to tilt motivation toward change by highlighting the discrepancy between current versus desired behavior (Miller & Rollnick, 1991). This contrasted with traditional approaches, which focused on educating clients about the importance of change. Preliminary research confirmed that DB may play an important role within MI and might serve as a stand-alone intervention (LaBrie et al., 2006).

Weighing the advantages versus disadvantages around a decision has a common sense appeal and a long history (Miller & Rose, 2015; Prochaska et al., 1994) and has demonstrated predictive value in addictions treatment (Collins et al., 2010; Okechukwu et al., 2011); e.g., the self-reported pros and cons for change shift as individuals move from pre-contemplation to action (Hall & Rossi, 2008). Clinical practice guidelines for addictions treatment discuss the negative consequences of continued use versus the positive consequences of cessation (Fiore et al., 2008). The use of DB in treatment has been associated with better addictions outcomes (Apodaca & Longabaugh, 2009). The DB procedure has been included in many multi-component interventions (Miller et al., 2013; Carey et al., 2006), continues to be included in MI interventions (Colby et al., 2012), and has been successfully used as a stand-alone intervention (LaBrie et al., 2006; Collins et al., 2014; Geller et al., 2012).

Despite positive findings, DB's role in MI has recently been questioned because it is inconsistent with recent formulations of MI (Miller & Rollnick, 2009), which emphasize "eliciting and exploring the person's own reasons for change" (Miller & Rollnick, 2013) and discourage the balanced exploration of ambivalence. The review by Miller & Rose (2015) asserts that the traditional DB procedure, with equal attention to the pros and cons of change, hinders treatment progress in ambivalent clients and should **not** be used when the goal is to foster behavior change. DB could be viewed as a divergent approach to MI, only used when the clinician wishes to maintain neutrality. Consistent with this assertion, DB has been related to poorer outcomes in addictions

treatment (Matzger et al., 2005) (Carey et al., 2012). Doing a DB may heighten awareness of the benefits of the problematic behavior and thereby reduce the effectiveness of other treatments (Carey et al., 2006). Given the bias in cognitive processing around addiction (Cox et al., 2015; Reich & Goldman, 2015), any exploration of the appetitive features of continued use might be dangerous.

Given this controversy and conflicting findings, additional research is needed. Much of the research relies on correlational or quasi-experimental designs, or in studies not explicitly testing DB. Many studies of MI include DB as one of many components, thereby preventing the examination of this tool in isolation. Comparison groups that equate treatment duration and intensity, while also ensuring fidelity of MI delivery, are lacking. Furthermore, this research area would benefit from assessment with other addictive behaviors such as tobacco smoking in clients low in motivation to quit. College students represent an important target population for interventions focused on enhancing motivation to quit smoking, such as MI (Harris et al., 2010). Experimental approaches with shorter follow-ups may be useful before conducting more costly long-term clinical trials.

This study, implemented before the established controversy on DB, was originally intended as a preliminary examination of the efficacy of one component of MI, the DB procedure (MIDB), in comparison to an intensity-matched traditional health education intervention (HE). MIDB was delivered according to original formulations of MI (Miller & Rollnick, 1991) in that, rather than being 'neutral', therapists explored the pros and cons around smoking with an underlying agenda aimed at increasing motivation for smoking cessation. HE presented the health consequences of smoking and the benefits of quitting in an instructional format. The sessions were coded to assess fidelity of MI relative to HE (Moyers et al., 2010), and participants rated the therapeutic working alliance (Tracey & Kokotovic, 1989). These measures allowed for examination of how MI-relevant process measures might relate to outcomes (McCambridge et al., 2011). Decisional balance (pros and cons of smoking) was measured (Velicer et al., 1985) and expected to be more tilted toward cessation with MIDB. The primary hypothesis was that MIDB would lead to greater motivation to quit and greater cessation-induction behaviors (e.g., quit attempts) when compared to HE.

2. Method

The Institutional Review Board of the University of Missouri–Kansas City approved the study protocol. All participants provided written informed consent.

2.1. Participants

From February to September of 2009, college smokers (N = 82) were recruited from an urban university using the psychology department research pool, direct solicitation, and advertisements through fliers, internet, and campus newspapers. Recruitment materials made no mention of quitting smoking and participants were informed they would receive up to \$20 for study completion. Eligibility, determined by phone, included smoking at least one cigarette during the last 7 days, having no intentions to quit in the next 30 days, age of at least 18, college enrollment, and reachability via phone & email. Participants were told that the study aimed to understand how counseling affected

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