Professional training in motivational interviewing as a strategy to overcome the therapeutic nihilism in smoking☆

Capacitación profesional en entrevista motivacional como estrategia para superar el nihilismo terapéutico en tabaquismo

Dear Editor,

Only 58% of healthcare professionals in Spain consider nicotine addiction to be a chronic disease. In spite of this, in our country these professionals are generally becoming increasingly involved in controlling and preventing nicotinism.[1] In our surgeries we see one of the population segments with the highest rates of prevalence and for whom smoking is, if possible, more harmful[2] (smoking more cigarettes per day, with higher plasma levels of nicotine and greater dependency than the general population, among other factors). I carefully read and reflected on the recent editorial in this journal, ''Smoking cessation programs for individuals with schizophrenia: an urgent and unmet need''.[2] We are able to use the whole pharmacological therapeutic arsenal now that the European Medicine Agency (EMA) has withdrawn its warning about the possible risk of suicide with varenicline. This is due to the results of the EAGLES[3] study (a fact that now has to consolidate among professionals, as the warning given by the highest authority in clinical safety may be foreseen to be hard to revert). Studies are now available which accredit the efficacy and feasibility of intervening, especially in this population.[4] The authors raised the challenge of asking what more would have to be done to motivate managers and doctors to cease old habits (along the lines of the always correct ethical reflections of Lolas-Stepke in this journal[5]). Smoking cessation should be included as a care objective at the level it deserves in terms of health and ethics (and efficiency for managers). However, among the barriers cited in this relevant editorial, we missed one that may be of key importance in overcoming these prejudices in care: training in motivational interviews, an approach that has proven its usefulness in many areas to encourage healthy behavior. Empirically it is a highly effective way of giving medical advice and improving compliance with therapy.[6] We know how effective advice or short interventions are, as well as cessation rates using nicotine replacement therapy, bupropion and varenicline[7] (always in combination with psychological and social support). Thanks to initiatives such as the Socidrogalcohol ''Autumn School'', which runs workshops for beginners and more advanced levels in this field, healthcare professionals in different fields are developing the motivational spirit. Working on nicotine abuse means working on an addiction, and therefore involves working on a chronic condition. It is necessary to increase training in the field of addiction from university onwards, to overcome the stigma of care. It is also necessary to give professionals the tools they need to overcome the frustration of dealing with patients who have often been smoking for years and have never attempted cessation. They often seem (and in fact, are) impermeable or completely unreceptive to cessation advice,[8] and there is an urgent need for the system to accept the need to attain the care goals proposed.

Regarding the cost of pharmaceutical therapies, we would like to add that there should be public and ideally universal coverage, although in these times of necessary spending controls it would seem to be common sense to concentrate on those patients for whom smoking is especially harmful; those with serious mental disorders, but without forgetting those at high cardiovascular risk (diabetics, those with ischemic cardiopathy or metabolic syndrome).

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Usefulness of the Short Personality and Life Event Scale (S-PLE) for detection of suicide attempters☆

A propósito de la utilidad de la Escala Abreviada de Personalidad y Acontecimientos Vitales (S-PLE) en la detección de las tentativas de suicidio

Dear Editor,

Suicide is a worldwide public health problem, and it is the primary cause of non-natural death in our country.[1] The genesis of suicidal behaviour is influenced by multiple biological and social factors that often, as is the case with the economic recession, may have effects which are hard to determine.[2] To date previous attempted suicide (AS) has been considered to be the best predictor of the risk of suicide.[3] We therefore consider that all efforts to predict and prevent AS to be an indirect way of contributing to a reduction of suicides.

One of the most interesting efforts aimed at identifying individuals at risk of suicidal behaviour was undertaken by Blasco-Fontecilla et al.[4] They developed the Personality and Life Event scale (PLE) which includes 27 of the most discriminatory items from a series of questionnaires that are commonly used to evaluate suicidal behaviour (personality disorders scale, impulsiveness, aggressiveness, stressful life events and sociodemographic data) with excellent results in terms of sensitivity (80.8%) and specificity (89.6%). The authors developed this further with the brief version of the said scale (S-PLE),[5] which with only 6 items makes it possible to indirectly and non-intrusively evaluate the risk of suicidal behaviour in situations where time is lacking.

The authors themselves propose the following cut-off points to maximise the precision of the classification: (i) healthy individuals, scores lower than 1.70; (ii) individuals with a possible mental disorder, scores from 1.70 to 2.46, and (iii) individuals at risk of suicide, scores higher than 2.46. Nevertheless, the authors accept that the S-PLE performs less well in differentiating individuals with a mental disorder and no history of AS and patients with a history of AS, although the area under the curve (AUC) of the receptor operative characteristic (ROC) remains acceptable (0.756).

Our group tried to replicate these earlier results in an independent sample of 197 patients [35.5% men; average age (SD) = 54.15 (10.54) years old], diagnosed with mood disorder [unipolar depression (74.6%); bipolar depression (8.1%) and dysthymia (17.3%)] with clinical severity of depression at the time of evaluation measured using the Hamilton Depression Rating Scale (HDRS)[6] of 18.56 (5.95), which is equivalent to moderate to severe depression. 38.6% (n = 76) of the patients had a history of AS. The patients with a history of AS were significantly younger [51.79 (10.70) vs 55.64 (10.21); Student t-test = 2.526; p = .012] and they scored significantly higher in the S-PLE [2.10 (0.48) vs 1.79 (0.46); Student t-test = −4.424; p = .000], while they were similar in terms of sex and their average score on the HDRS.

When the precision of the scale was evaluated by means of ROC analysis, an AUC of 0.675 was obtained, which is lower than the AUC figure reported by the authors. When the cut-off point they proposed to differentiate individuals with a mental disorder without a history of AS from those with a history of AS/(scores higher than 2.46), we found a sensitivity of 17.10% and specificity of 95.90%, i.e., there are a high number of false negatives. If it is wished to use this scale as a screening tool, we believe it would be prudent to suggest a modification of the cut-off point to reduce the large number of false negatives, at the least when the aim is to detect the risk of suicide in patients with mental disorders. After evaluating our results we suggest that a more suitable cut-off point for the evaluation of the risk of suicide would be 1.70. With this cut-off point, at least in our sample, a major increase in sensitivity is achieved (85.5%), although specificity falls by 32.2%. Nevertheless, given the severity of the consequences of the event we wish to predict and the possibility of using the S-PLE in screening for the risk of suicide in situations where time is lacking, such as hospital emergency or primary care departments, we consider it to be clear that good sensitivity has to take priority over specificity.

We believe that the S-PLE may be a useful clinical instrument for detecting the risk of AS, although it is necessary to set a more precise cut-off point for the tool and determine

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