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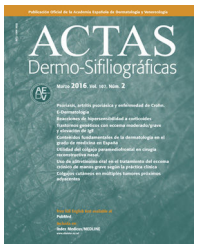

OPINION ARTICLE

Motivational Interviewing in Dermatology☆

La entrevista motivacional en dermatología

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Dermatologists in routine clinical practice do not have a great deal of time to spend with each patient. In the short time available for each visit, we must obtain a clinical history, perform a physical examination, establish the most likely diagnosis, decide on a course of treatment, and motivate the patient to adhere to the prescribed regimen. It would appear that very little time is left to spend on building a therapeutic relationship and finding out about the patient's doubts and concerns relating to their condition; this lack of time could ultimately have a negative effect on the patient's adherence to treatment.

Poor adherence to treatment is one of the leading causes of treatment failure.[1] In dermatology, the average rate of adherence to treatment is between 55% and 66%, and this figure falls even lower in the case of topical treatments[2] and chronic conditions. Moreover, the treatment of chronic diseases often requires patients to change their behavior or habits. Adherence varies according to the disease; the estimated rate is 79% for chronic urticaria[3] and much lower for other diseases, such as acne, atopic dermatitis, and psoriasis, in which some authors estimate that it may be as low as 30%.[4]

This lack of adherence is due, on the one hand, to doubts patients may have about the need for treatment and, on the other, to their worries about possible adverse reactions.[5] Such doubts and concerns can be addressed, but only if a quality patient-physician relationship that facilitates effective communication is established. The results of a survey of 300 patients with moderate to severe plaque psoriasis showed that 54.6% of them had consulted 3 or more dermatologists before coming to the current treatment centre, and 70% of these patients had changed physician because they were unsatisfied with the care they received or with the treatment prescribed.[6]

Several strategies have been shown to increase patient adherence to treatment in dermatology, including more frequent office visits (white coat adherence), asking the patient to keep a written diary of the treatments applied, and personalized educational visits lasting 2 hours (because consultations lasting 15 to 30 minutes failed to increase adherence).[7] However, none of these strategies are very realistic in the context of current clinical practice.

To further complicate matters, patients—especially those with chronic disorders—now expect to feel that their physician listens to them and understands them and believe that they should have some say in decisions about treatment. The phrase ''no decisions about me without me''[8] has become a felicitous slogan describing today's patient-centered approach to medical practice.

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Consequently, dermatologists now face the challenge not only of dealing with the clinical aspects of care, such as performing examinations and tests as well as diagnosis and treatment decisions, they must also try to increase adherence to treatment while taking into account the patient's expectations and being aware of their concerns. And they must do all of this in record time.

How Can Motivational Interviewing Help the Dermatologist?

The aim of motivational interviewing (MI), a style of patient-centered care based on the concept of collaboration, is to increase the patient's motivation to change by addressing their ambivalence and exploring factors that could motivate them to change.[9]

MI is a technique that can help dermatologists to increase adherence to treatment and to persuade patients to change habits that exacerbate skin lesions. The technique is not difficult to learn, and training projects in various countries, including Spain, have been met with great satisfaction by dermatologists.[10] Another factor that has contributed to the success of MI is that it can effectively increase adherence even when the intervention takes the form of a brief intervention lasting between 7 and 15 minutes.[11]

A key element of this interviewing technique is that it allows the dermatologist to quickly identify the patient's readiness to change and his or her attitude towards treatment. This strategy saves time and energy because the clinician does not spend unnecessary time and effort on explaining a course of treatment to a person who is not disposed to follow it or on talking about the consequences of not adhering to treatment to a patient who has already decided to follow the regimen.

Change is difficult, however, and as part of their medical training physicians in general and dermatologists in particular have been taught that their job is to resolve the patient's problems quickly and to make patients change unhealthy behaviors by telling them how and why they should do this (the so called *correction reflex*). Almost everyone knows that tobacco is harmful to our health, but merely repeating this fact to our patients will not make them stop smoking. In the case of adherence of treatment, the situation is slightly different: patients want to feel well, of course, but they also have ambivalent feelings about taking medication, either because they are afraid of possible adverse effects or because their perception of the need for treatment differs from that of their doctor, a particularly common problem in patients with chronic conditions. If, when dealing with an ambivalent patient, the dermatologist insists on the need for treatment, the most likely outcome is that the reaction will be ''yes, but''—a response that cancels out the prior explanation.

The underlying premise of MI is a simple one: a short dialogue during which the dermatologist empathizes with the patient and shows an interest in and understanding of the patient's reticence is more effective than a brilliant explanation about which the patient has serious doubts. Studies show that empathy on the part of the physician increases adherence to treatment and that a lack of empathy and a confrontational style are associated with a weak therapeutic alliance and higher drop-out and relapse rates.[12]

Unlike the traditional directive or instructional style, in which the clinician educates and persuades patients in regard to what they should do, MI is more focused on guiding the client. The role of the dermatologist-guide is to listen to and guide the patient while providing support and offering expert information when this is needed. At the end of the process, the clinician collaborates actively with the patient to draw up a treatment plan.[13]

What is the Evidence Supporting the Use of Motivational Interviewing?

Although there is more evidence for the use of MI in patients with addictive behaviors, the setting in which the technique was developed, its application has spread rapidly to other areas of medicine. Some 200 randomized clinical trials on the effectiveness of MI have been published. In 2005, a systematic review found a significant clinical effect in 3 out of every 4 studies and reported that in 80% of studies MI was more effective than the traditional approach to giving medical advice.[14] Brief IM sessions of under 15 minutes were also shown to be effective in 64% of studies.

The authors of a systematic review published in 2013 found an overall advantage for MI compared to traditional interventions, which reached statistical significance in several addiction care settings. The technique was effective in improving adherence to treatment recommendations, reducing sedentary behavior, improving diet, and increasing physical activity.[15]

Why Does Motivational Interviewing Work?

MI works for 2 reasons: 1) it favors patient autonomy and commitment to the decisions taken because the intervention of the healthcare professional serves to support patients and strengthen their resolve[16]; and 2) it helps patients to talk about the possibility of change (something that has to be voiced by the patient and not the dermatologist) and when patients hear themselves talking about change their motivation and outcomes improve.[17]

What is the Method Used In Motivational Interviewing?

MI involves 4 sequential and recursive processes: *engaging, focusing, evoking, and planning*. The technique is analogous to climbing a staircase with 4 steps, taking each step one at a time. Each new step is based on the preceding one and leads to the next step and, like on a staircase, we can always return to the previous step in the course of the interview if more attention to that process is needed.

On the first step the dermatologist's task is to *engage* and bond with the patient. Creating a bond or therapeutic alliance with the patient is not a technique specific to MI, but it is the first step in the creation of a doctor-patient relationship based on trust; the bond can be formed very quickly if first impressions are positive or it may develop over the course of several office visits. Creating such a bond

entails more than merely being kind or friendly, it involves engaging with the patient and ensuring that he or she feels comfortable and understood.

The second step involves *focusing* and consists in establishing—with the agreement of the patient—the direction of the conversation about change. At this point, MI can save dermatologists time by helping them to avoid the common error of rushing to ''direct'' a change in behavior before ascertaining whether the patient is ready to take action. A very useful schema for use in this step is the stages of change model, which explains the stages an individual moves through before actually deciding to make a change.[18]

Let us take addictive behaviors as an example. Imagine a patient with psoriasis whose alcohol consumption represents a risk but who is not yet aware of the negative health effects of their drinking. The patient does not see their alcohol consumption as a problem and will not therefore look for a solution when they consult a physician. This patient is in the ''precontemplation'' stage. A patient who begins to notice that a problem exists may start to consider a change (''I really should stop drinking'') but will experience a high level of ambivalence and be torn between a desire to drink and concern about some of the noticeable effects of their alcohol consumption. The patient has now moved on to the ''contemplation'' stage. If, at this point, the clinician focuses on the harmful effects of alcohol consumption, the patient will tend to adopt an opposite viewpoint and focus on the positive effects of the behavior. If this ambivalence can be resolved, the patient can move on to the next stage, that is, taking ''action''. Finally, when they manage to sustain the change in behavior they are in the ''maintenance'' stage. ''Relapse'' is also considered to be a normal stage in the stages of change process and should not discourage us from starting again. When we talk about *focusing* in MI we are referring to the need to ascertain what stage the patient is currently in and to adapt our discourse accordingly.

The third step in the MI process is *evoking*. The process of evoking involves eliciting the patient's own motives for making a particular change. It is not possible to do this without first consolidating the previous step: before we can explore motivations, ideas, and possible ways to achieve change, we must understand the objective of the change. In this step, the aim is to encourage the patient to talk about how he or she can make a change and what would help them to achieve their goal. This is a fundamental step in MI and perhaps the one that differs most from the approach generally used in traditional advice giving.

Sometimes it is possible to reach the final step—*planning*—quickly if the patient is clearly disposed towards change and asks the physician for advice on how to proceed. However, if this is not the case, it is important to ascertain whether the patient is ready to undertake the plan. There are a series of clear signs that indicate a positive disposition: the patient talks more about the advantages of change than about the difficulties it entails and has begun to visualize what their life would be like once the objective has been achieved.

At this point, the clinician can help the patient by providing information and making suggestions, but should always remember to take the patient's own ideas and solutions into account.

In the course of all the processes involved in MI, the dermatologist will find some basic communication skills to be very useful. Training in such skills is standardized and a recent meta-analysis[19] has shown that, with suitable training and practice, anyone can develop skill in the technique without being a psychology professional. These communication strategies, referred to in Spain by the acronym PROSA,[20] are simple and easy to learn; very briefly, they include open questions, reflective listening, offering information and advice, summarizing, and making affirmative statements. All of these strategies are used to get patients to collaborate and to strengthen their motivation.

Open, as opposed to closed, questions are those that cannot be answered with a simple ''yes'' or ''no'' but instead encourage patients to reflect and openly express their worries, allowing the clinician to quickly ascertain what these are. *Reflections* are a potent strategy for building a fast track to mutual understanding. The aim is to allow patients to reflect without interference and based on a feeling that they are understood. It is also a strategy that allows the physician to guide the patient; the direction is defined by which aspects of the patient's discourse the interviewer chooses to reflect. The third communication skill that represents a change from the traditional approach is the way *information and advice are offered*. There are times when a patient directly asks for advice and, of course, in such circumstances the clinician must give it. On other occasions, however, we may discern that the patient already has some information and, in such cases, a direct question about what they know will spare us unnecessary work and will give us an opportunity to correct any erroneous conceptions and offer additional information, if needed. Finally, when a patient does not ask for advice but we consider that he or she needs guidance, asking permission to give advice before starting to offer explanations will increase the likelihood that the patient will listen. *Summarizing* is a technique that allows us to clarify and organize the most important aspects of the interview and to incorporate elements of previous conversations. Summaries show the patient that we have listened attentively and help them to carefully weigh up what is best for them. Finally, *affirmation* is a very motivating strategy, and one that increases the patient's confidence that their objectives can be fulfilled. No one changes when they are made to feel bad.

Conclusions

MI is a technique that can be incorporated into the dermatological consultation much in the same way as it has been incorporated into other medical disciplines. Evidence on its use in short interventions shows that MI can save time during office visits, foster collaboration with the patient, and improve adherence to treatment and the acquisition of healthier habits—all outcomes that will undoubtedly lead to satisfaction on the part of both dermatologists and patients. Using strategies that are simple to learn and apply, the clinician's core task is to elicit and strengthen the motivation that already exists in the patient but may not be obvious at the outset. To paraphrase Blaise Pascal, ''People generally arrive at their beliefs based on reasons

they discover themselves rather than as a result of reasons explained to them by others''.

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