Motivational Interviewing Newsletter: Updates, Education and Training

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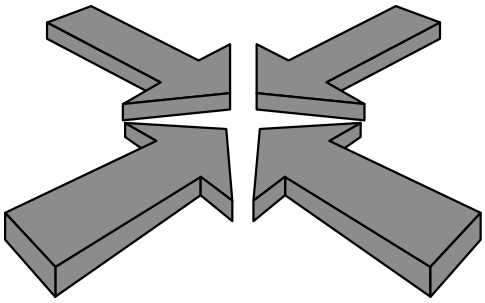

New Perspectives

FROM THE DESERT

One thing that we consciously omitted from the second edition of *Motivational Interviewing* was chapters on applications of MI with specific clinical problems or health behaviors. Thus there are no chapters on using MI with _____ (fill in the blank: diabetes, sex offenders, pain management, exercise and health promotion). There are a few chapters on broad populations (adolescents, corrections, couples, dual diagnosis), but we intentionally avoided specific target issues.

Now that MI-2 is done, we're planning a new edited volume of chapters discussing such specific applications, most likely to be published by Guilford Press. The editorial team is Terri Moyers, Steve Rollnick and myself. At this point, we welcome your creative suggestions of *topics* (not authors) to be included as chapters in this book. Once we decide on the topics, we'll seek input on potential authors for each. Please send me your suggestions for chapter topics: wrmiller@unm.edu. Thanks.

Not On

While living in Australia where I met Steve, I learned a phrase that is unfamiliar to American ears. If one's behavior is off-base, out-of-bounds, over-the-line, inappropriate, it is said to be "not on".

That's how I regard a small but, I think, conceptually significant choice of words in the preposition that follows "motivational interviewing". Now and then I hear or read someone referring to "using motivational interviewing on ...". It might be on certain people (such as adolescents, or people with diabetes) or behaviors (such as gambling or exercise). "Does it work on ...? Can I use it on ...?" Still more painful to my ear are phrases like, "I'm going to MI him" or "I METted her".

To me, these phrases communicate a fundamental misunderstanding of the nature and spirit of MI. They match the fantasy of people coming to an MI workshop in order to learn some techniques for tricking people into doing things that they don't want to do. MI is not something to be used "on" people. That sounds more like a weapon.

When a preposition is needed, I suggest "for" or "with" or even "in". One can practice MI for adolescents, or with problem drinking, or in cardiovascular rehabilitation. To practice it "on" someone, however, construes the person as an object, a target. Similarly, I don't recommend ever using MI or MET as a verb (to MI or to MET). While I suppose that a person (or two) can MI in the same way that they can waltz, there is a distinct danger of it becoming a transitive verb, one that requires an object and can also be expressed in passive voice (She was METted). Never mind the English grammatical nightmares of using MI in the past tense (MIed?), or MET in

the pluperfect (had METled?). It's just unbecoming to talk about METting someone. It's not on.

Levels or Types of Training in MI

For years MINTies have been discussing distinctions among various levels or types of training in MI. I've been thinking about this issue, and want to suggest five levels of training that might be distinguished: (1) an introduction to MI, designed to enhance motivation to learn more, (2) targeted training in a specific application that is in the spirit of MI, (3) basic clinical training in the method of MI, (4) advanced training to enhance clinical skills, and (5) training for trainers. These aren't stepwise so much as having different purposes. Here's a draft for comments:

	Type	**Goals**	**Approx. Length**
1	Introduction to MI	**To experience the basics on MI and decide level of interest in learning more** To be familiar with the fundamental spirit and principles of MI To be acquainted with relevant evidence of efficacy To directly experience the MI approach and contrast it with others	2 hours to 1 day
2	Application of MI	**To learn one or more specific applications of MI** To be acquainted with the fundamental spirit of MI To learn practical guidelines for a specific application "in the spirit of MI" To have direct practice in and experience of this particular application To help participants decide whether they want to learn more	1 hour to 1 day
3	Clinical Training	**To learn the basic clinical style of MI, and how to continue learning it in practice** To understand the fundamental spirit and principles of MI To strengthen empathic counseling skills (OARS) To understand and practice the directive aspects of MI To experience and practice a MI style for meeting resistance To learn the fundamental client language cues (change talk and resistance), that allow continued feedback and learning in practice	2-3 days Might be offered in several 4-8 hour parts
4	Advanced Training	**To move from basic competence to more advanced clinical skillfulness in MI** To have intensive observed practice in advanced MI skills To learn observational/analytic methods to evaluate MI To receive individual feedback regarding MI practice To update knowledge of MI (recent research and developments)	2-3 days
5	Training for Trainers	**To learn a flexible range of skills and methods for helping others learn MI** To learn and practice an array of MI training methods To enhance confidence in training and demonstrating MI To assess the specific needs and context of trainees, and to design and adapt training approaches accordingly To update knowledge of MI and training (recent research and developments) To participate in the international MI Network of Trainers	3 days

STEVE's NOTE

MI and its relatives

So many names have been given to adaptations of MI that an outsider might well conclude that we are a confused bunch. I even heard two new ones last week. That makes it over a dozen different names, and this includes my favourite worst one, *motivational intervention*, which can be used to describe anything that raises levels of motivation, like going on my knees and begging for change. A group of MINTies from both sides of the Atlantic have tried to produce a simple 3-method framework, and this will appear in the second edition of the MI book that is coming out soon. We came up with *motivational interviewing*, *behaviour change counselling* and *brief advice* as related ways of encouraging behaviour change. We forced ourselves to agree on the skills involved. I hope that this will help to prevent MI being diluted beyond recognition. Will it slow down the outbreak of new names? No idea.

Apologies to Jeff Williams... I got it wrong

Many years ago, in an earlier edition of this newsletter, I entered a debate with MINTie Jeff (I'm sure that this was his first name) about advice-giving. He's been so quiet since then that I might have even got his name wrong. Our computer network is down here at work, so I can't even check out your correct name, let alone the content of our debate. Anyway, I owe you an apology. I believe that my strident views about the dangers of advice-giving were misguided. Hence our inclusion of advice-giving in the three method framework described above.

Why have I changed my views? I have seen too many examples of nurses and doctors doing this with tact, sensitivity and skill. I haven't looked back at Jeff's defence of advice-giving, but I imagine that he had had many similar experiences. A senior medical specialist said to me some months ago: "the better I know the patient, the easier it is to give them advice". Then I recalled my own behaviour with clients, and a particular case came to mind. He had a simple problem, fear of blushing, which had ruined his life. He couldn't cope with any informal social interaction and spent his spare time alone at home. We got on very well, and my patient efforts to encourage him to break out of ambivalence and try different ways of changing reached crisis point. I decided he should blush in my company. He agreed. I literally ordered him to stand up, hold my coffee mug up high, and drop it. He did. The mug bounced, didn't break, there was no blushing and we both lost control laughing. So he set out to practice blushing (he did wonders when a female receptionist came into the consulting room!), and slowly, he improved. I got a broad grin from him when I saw him in a pub many years later. (He had what Jeff Allison calls *false low importance*: ie his view that it was not all *that* important to change was almost entirely influenced by low confidence … but I leave that to Jeff Allison to explain).

Advice-giving seems to be a lot like breaking bad news. It can be done with skill (and lead to change talk) or less so (and lead to resistance). It will always be around as an activity in clinics and wards every minute of every day. It has a very valuable place in consultations. If we criticise this activity too much, we risk undermining the daily activity of practitioners. Should we not help them to use it with skill? In the little chapter written by the group of MINTies in the second edition of the MI text, we have tried to identify the skills involved. If someone sees Jeff Williams, please give him a piece of advice from me: invite him to read this newsletter, and if you know him well, order him to.

Congratulation to Chris Dunn

He's a MINTie from Seattle, USA who tried to do the impossible, review the dozens of studies of MI and related adaptations. It can be found in the December issue of *Addiction*. He, and two colleagues, give a clear impression of having no axe to grind, and they review this subject in a clear and dispassionate manner. Their conclusions are modest, and indicate just how modest we should be when talking about the effectiveness of a method that few researchers were able to adequately monitor as their study unfolded. Many of us are working on measures of process, so that we can help researchers and trainers be clear about exactly what elements of MI are important.

Thanks Chris. How ready are you to do the update in a year or two?

What's the best way to learn MI?

I regret asking this question, because I have only one thought to impart. But it might be useful. A step-wise approach, starting with basic essentials might be easier for people than being exposed to the full complexity of MI. I confess that I've been watching a tennis coach help my 5 year old learn tennis. What then, are the first steps? My work is mostly with general healthcare practitioners.

Most of us see learning about listening as an essential first step. The other day I took a risk and tried a completely different approach when I had two hours with a group of community nurses. I decided to leave listening to last, just to see what happened. I started with advice-giving and considered how it could be done with skill. Most practitioners can answer this question, and list the skills. That's what they did. Then I moved on to behaviour change counselling, when you have a little more time with a patient who needs more time. I elicited the observation that asking open questions was critical. The list got a little longer. Then I turned to situations where someone was well and truly stuck in ambivalence, and gave them an example. They came up with the need to understand values. And to listen. I had the feeling when I left that were I to return for a workshop, we would start with advice-giving, move on to the slightly more complex elements of behaviour change counselling, and then finally, the exploration of personal values and other more complex elements of MI, like the directive use of reflective listening. If practitioners can't give advice with skill and sensitivity, why move on to listening. Armed with this experience, I won't however get too clever and try to teach young Stefan to play tennis, because I'm his father not his coach. No simple step defined by me is ever simple!

Deep & Shallow Learning

When psychologists refer to "deep change" I can get confused. Talking about very personal (ie deep) matters can be rewarding and constructive. Yet I recall encounters with therapists for whom the "deeper is better" notion was an expression of dogmatism, arrogance and insensitivity (I have vivid memories of encounter groups).

Now I notice that the phrase, "deep learning" is widely used in medical education. And the people who use it live in a different world to some of the rigid guru therapists I encountered many years ago. They are committed teachers. I shouldn't use this word "teach" because it's becoming taboo; it's part of the traditional model that has been rejected by the medical establishment (UK General Medical Council). Undergraduate medical education in the UK is now guided by *learner-centred education*. The emphasis, they say, is not on teachers and what they teach, but on learners and what they learn. Hence the laughter that came out of our seminar room the other day. Students were watching a video of John Cleese, the long-legged comedian, as part of a module on literature and medicine.

It might be worth downloading a recent brief review of learner-centred approaches (Spencer & Jordan, 1999; British Medical Journal; 318; 1280-1283; www.bmj.com). There's an observation here that a heavy teaching workload is associated with surface rather than deep learning in students. Sounds fun to me!

Let's assume that learner-centred education is more effective and satisfying for participants than the more traditional delivery of expert information approach. Let's be mindful that we are talking here of *methods* of teaching, not the rejection of factually-based material itself. Where does this leave our training work on motivational interviewing? If the medical educators can even contemplate an emphasis on students directing their own acquisition of knowledge, what about us?

I have just typed in "courses motivational interviewing" into a search engine on the Internet. Scores of courses. I checked a random sample. All based on a largely "top-down" teaching approach. Why is this such common practice? It's mirrored in other topics like cognitive-behavioural therapy. Supervision, a learning method that is clearly compatible with a learner-centred approach, is thin on the ground, and hardly emphasised. My hunch is that we don't have access to training methods that can be used in larger groups, and that remain

learner-centred. Hence our ongoing work here in Cardiff on the context bound method. Paul Kinnersley and I have been trying out this method in as many different settings as possible.

Context-bound training: recent developments

We (Paul Kinnersley & I) are definitely thinking differently about our training work. *Everyday experience in the foreground, communication skills in the background*; that's our mantra. Practitioners seem more likely to become interested if we start with their world, and stay with their world, only introducing our own ideas, in gentle nudges and suggestions, when we think the time is right. Simulated encounters before and after brief seminars form the structure of the training. The links with an MI session are striking. Move away from a client's experience towards firm ideas of your own ... and resistance is quite likely …

One way of viewing this learning process is that most practitioners are not quite ready to learn new methods, like MI. They use their own tried and tested ways that feel comfortable. The gentle introduction to new ideas, based on solving their everyday problems is more suitable than immersing them in this or that new method. When they are more ready to do this, fine, but most aren't. Yesterday a senior family doctor approached me, having been exposed to our context bound training among medical students. Could we run a training for his colleagues (nurses and doctors) in their clinic setting? He is more ready for method talk (and even MI talk) and for trying out new approaches. His colleagues might not be. When we get to their clinic, he will get the chance to move at a faster pace than the others, if we get it right … I will definitely introduce new ideas from MI in this training, *rolling with resistance* being a useful platform for answering the question: *how do you avoid resistance?*. One is then a short distance from hunger for learning about empathic listening.

A couple of papers on context-bound training are now *in press* in Medical Education, and I'll let the listserv group know when these are available.

Information

Websites. Rik Bes has put up a new website for the European co-operative of MINT. Many thanks. A somewhat distant relative of the MI websites will be that for the new Communication Skills Unit here in Cardiff which will contain material on context-bound learning, among other things.

Trial in diabetes. We have a trial up and running on MI with adolescents with Type 1 diabetes. Many of you know of the drama that is played out in clinics the world over, with truly awful consequences for some patients. Our colleague Michelle Boycott is facing the task of being the therapist. In what way will MI evolve with this study is a source of real fascination for us.

Paris TNT. The 2002 Paris training for new trainers has been constructed by Rik Bes and Guy Azoulai, and the details are on the websites. Without their efforts … no training. We are trying to widen the pool of new trainers for TNTs. Tom Barth will help me this time, and we plan to do something a little new: ask trainers from the parallel MINT Forum to help in small and significant ways. The following year, 2003, I believe that we should avoid two meetings either side of the Atlantic, but join together once again. Greece is a new country with quite a lot of interest, so I hope we can consider that.

New Video. I am not sure how many trainers have noticed the new little video made by Jeff Allison, Chris Butler and me a few months ago. It is for trainers, and is derived from our book on *Health Behaviour Change* published a couple of years ago. See www.jeffallison.co.uk

New books. Don't forget to see and celebrate the new books by Rick Bothelho and Harvey Skinner, MINTies both, and both immersed in topic of behaviour change (see MI website for details).

RIK's NOTE

As every year, Drs. Miller and Rollnick will offer an opportunity to attend the MI Training for New Trainers (TNT) in 2002. The difference in 2002 will be, that there will be two TNT sessions, instead of the usual one. In this way, the Motivational Interviewing Network of Trainers (MINT) tries to accommodate for the high demand for these training sessions. There are several benefits to attendance, beyond the event itself. Participants automatically become members of the MINT (Motivational Interviewing Network of Trainers) and receive their first year of membership free, which includes the newsletter. Participants also receive access to the restricted MINT List Serve, through which MINT trainers share training experiences, ideas and materials with other trainers. In addition, participants gain access to other restricted Web resources, information about future MINT Training events (MINT members typically meet annually at the same time and place as the TNTs, and join Drs. Miller and Rollnick in training new trainers). One TNT will be held on Hawaii (5, 6 & 7 June 2002) and will be delivered by Dr. Miller and Dr. Moyers. The second one will be in Paris (13, 14 & 15 June 2002), delivered by Dr. Rollnick and Dr. Barth. For more information on TNT and MINT Forum in Hawaii, contact:

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Parallel to the TNT sessions, MINT Forum meetings will be organised in both Paris and Hawaii. MINT members wanting information about, or registration for one of these meetings, can also refer to the two above mentioned addresses.

We look forward to meeting you in 2002!

The FAS DPN First Bridges Program: Using Motivational Interviewing Techniques for Fetal Alcohol Syndrome Prevention

David Rosengren, Beth Gendler, and Heather Carmichael Olson

A team of University of Washington researchers, led by Heather Carmichael Olson, has been exploring the use of MI techniques to prevent the birth of children with FAS and other alcohol-related disabilities. We recently completed a pilot study that examined the feasibility of a brief, MI-based intervention to prevent subsequent alcohol-affected births to women who have already had at least one child born affected by alcohol consumption during pregnancy. Research suggests that women who have one alcohol-affected child are at increased risk to bear further children with alcohol-related disabilities, and that later children are likely to show even more severe effects – so that prevention efforts are needed with this population (Abel & Sokol, 1986; Clarren et al., 2000).

The first step in our research program was carried out as part of the overall clinical research efforts of the Fetal Alcohol Syndrome Diagnostic and Prevention Network, initially funded by the Centers for Disease Control and Prevention, and now sustained by funding through the Washington State Division on Alcohol and Substance Abuse. Susan Astley, and her colleagues Diane Bailey and Tina Talbot, established the feasibility of identifying and locating women who already had a child with diagnosed alcohol-related disabilities (Astley et al., 2000a, 2000b). In the pilot study reported here, our goals were to further evaluate the feasibility of the protocol for finding these women, and then to engage these high-risk birth

mothers in a conversation about alcohol use, contraception, and risk to later children – with the aims of increasing their readiness to change and decreasing self-reported risk behavior. What follows is a brief description of that project, the MI intervention, observations about the outcomes, and thoughts about developing and using the intervention. The full results of this project will be published elsewhere.

Study Design

Study participants were women identified through the FAS Diagnostic and Prevention Network (FAS DPN). This is a statewide network of six FAS diagnostic clinics in Washington that diagnose FAS and the full range of alcohol-related disabilities, and provide referral services for caregivers of these children, including birth mothers. It should be noted that not all birth mothers are aware of the alcohol effects in their children, because their children have been adopted. To participate, women had to:

- be a resident of Washington State;
- be of childbearing age and still fertile;
- have already produced an alcohol-exposed child with confirmed central nervous system dysfunction using a standardized diagnostic scheme for characterizing alcohol-related disabilities, called the 4-Digit Diagnostic Code (Astley & Clarren, 2000); and
- report at least one incident of alcohol use in the two-year period prior to study enrollment (although women actually enrolled reported mild to severe addiction severity).

The study enrolled a total of 8 women and randomly assigned them to either an MI condition or the community standard of care (minimal or no services), following a baseline assessment. The participants completed a follow-up evaluation at three months post-baseline. All assessments and interventions occurred at a place chosen by the birth mother, including their home or a comfortable public setting (e.g., library, restaurant).

The MI Intervention

The MI condition involved two to four sessions, with the number of sessions determined jointly by the participant and clinician. As with most MI intervention studies to date, women received a personal feedback report (PFR) during the first clinical session. This first clinical contact was carried out within a week following an assessment performed by First Bridges research staff. The PFR contained information on a variety of topics related to alcohol and birth control, including information about the pros and cons of drinking and contraception, current alcohol consumption levels, and normative information about women's alcohol use and birth control methods. The PFR not only included information on the participant's problem areas, but also on personal strengths. The final page of the PFR was for goal-setting, which was initially completed during the feedback session, but could be changed in an ongoing manner over the treatment contacts. A copy of the PFR used in this study is appended to this newsletter (Appendix A).

Because the aim of the First Bridges Program was FAS prevention, the focus of the intervention was on changing attitudes and behavior toward reducing participant's alcohol intake, increasing use of effective birth control, or both. The Stages of Change model guided intervention methods and goals. Session One provided feedback on the assessment results, and worked towards developing a change plan. Sessions Two, Three, and Four had less formalized, more fluid content but followed a typical MI session flow. The sessions focused on participant-identified needs and issues developed in consultation between the clinician (BG) and supervisor (DR). Supervision was conducted on a near weekly basis, timing the contacts for shortly after a session occurred. All sessions were audiotaped.

Observations

Interest in services. The First Bridges pilot study recruited participants in two ways: (1) retroactively, through an extensive FAS DPN chart review of children who had come to the FAS DPN clinics between January 1993 and December 2000; or (2) prospectively, determining women's

interest when birth mothers brought their children into FAS DPN clinics from January to June of 2001. There was a complex tracking protocol used to locate and contact potential participants. Ultimately 16 birth mothers were found eligible for the pilot study, with 12 participants identified retroactively and 4 participants found prospectively. Of the 12 retroactive participants, 6 consented and participated in the study; of the 4 prospective participants, 2 consented and participated in the study. Three of these women could never be located. Those ultimately choosing not to participate were far harder to initially contact than were those who eventually consented to enroll in First Bridges. The five birth mothers that declined to participate did so for a variety of reasons. Several women preferred not to deal with sensitive topics that might arise in either the assessments or intervention. Several others felt overwhelmed by their lives, and did not feel that participating would be of benefit. Finally, one potential enrollee was overtly hostile, stating that her child did not have the full FAS, and therefore felt that she did not need to be involved in the study. Each of these non-participants was given the phone number for First Bridges, should she change her mind and wish to enroll. This did not, however, happen during the course of the project.

All eligible and interested participants accepted their group assignment. While some women from both conditions expressed a desire to be placed in the other group, no one felt strongly enough to refuse participation.

A brief description of study participants. In many ways, these birth mothers were quite a diverse group – but most did report significant and chronic addiction and mental health concerns, and both childhood and adulthood histories of abuse and neglect. Thus, they resembled the larger population of chemically-dependent women, and so seemed likely to benefit from treatment strategies designed for this larger population.

On average, women enrolled in the First Bridges Program were in their late 20's to early 30's, with the oldest aged 35 years. Two were Native American, two black, and four were white. Their estimated IQ ranged from borderline to the average range, and they had typically completed 10.8 years of school. On average, they had begun drinking at 15.6 years and using birth control at 16.5 years. Addiction severity ranged from mild to severe. On the T-ACE test, which examines drinking from the standpoint of what constitutes risky drinking during pregnancy, the group mean was 3.62. Any woman with a T-ACE score > 3.0 is considered to be a problem drinker.

Surprisingly, birth mothers eligible for First Bridges services were *not* predominantly those who had borne a child with the full fetal alcohol syndrome. Only one of their eight children had a diagnosis of FAS (with evidence of frank neurological damage), while the remaining seven had been given diagnoses within the broader range of alcohol-related disabilities.

Acceptability of services provided. There were no formal measures for evaluating treatment acceptability. There was, however, secondary evidence of treatment acceptability to participants. Most women took advantage of all possible MI sessions. Participant comments following intervention were quite favorable.

Women enrolled in First Bridges agreed to participate in at least two sessions as part of their informed consent. After the second session, the participants could choose whether they wanted to continue for Sessions Three and/or Four. Although the birth mothers ultimately made this decision, the MI therapist also expressed her views about meetings for the last two sessions. Three of four intervention group participants opted to meet for all four possible sessions. The MI therapist referred the remaining intervention group participant to a comprehensive three-year case management/advocacy program for addicted women. Because of the program's long duration and high intensity, we determined that it was more important that this woman spend her limited free time with the advocate rather than with the MI therapist. Once referred by the MI therapist, this woman was very eager to start her involvement with to the advocacy program advocate.

Participants were proactive if they needed to change session times. There were several occasions when women contacted the MI therapist to change a session due to other conflicts (usually work demands). There was only one occasion when a participant did not show up, and did not call first. Another woman reported an initial preference for the control condition, but at her final MI session stated that she really had needed

the intervention and was glad that she had been assigned to that group. Other participants also commented favorably on services received.

Again, although there are no quantitative data to document "acceptability of services" by participants in the intervention group, the qualitative data do seem to indicate that these high-risk birth mothers welcomed and benefited from their brief MI intervention.

Elements deemed helpful by participants. Because this was a pilot study, staff were interested in finding out what participants found most helpful. At the end of the follow-up assessment, the interviewer asked the participants a series of open-ended questions to ascertain what they found most helpful about the First Bridges Program. One consistent theme emerging from women's answers was that the intervention offered time with a person who would listen. The four intervention group participants also commented that it was helpful for the intervention to take place at a location near them so they did not have to travel far to attend sessions. Several participants commented that they enjoyed the individual session. Finally, participants stated that information and referrals received from the MI therapist (such as referrals for adolescent parenting classes or long-term advocacy) were real assets to them.

Additional Thoughts

As researchers and clinicians, we had several difficult issues to address in this study. Here is a sampling of those issues: (1) how to contact and engage birth mothers once they were identified through their child's alcohol-related diagnosis; (2) where to meet with women for assessments and intervention sessions; (3) how to handle the presence of children when the therapist met with the birth mother; and (4) how to manage unresolved issues of these birth mothers.

Contacting birth mothers. Recruitment of women differed depending on whether they were retroactively or prospectively recruited, and whether they had retained custody of their children. After identifying retroactive recruits via chart review, we contact most of these women by telephone. Children whose birth mothers did not retain legal custody were the greatest challenge. In order to contact these birth mothers about the study, First Bridges staff first had to obtain permission from the legal guardian. The only information that could be released to the birth mother was the actual alcohol-related diagnosis of the child. There were several instances in which the legal guardian was quite reticent about providing permission to contact the birth mother. The First Bridges staff respected the legal guardian's wishes, and did not press for permission if they expressed discomfort. Participants identified prospectively were recruited to the study when they actually brought their children to the FAS diagnostic clinic.

There were specific scripts written to follow when informing participants about the study. The interviewer began with a brief introduction, an acknowledgment that the child had come into the diagnostic clinic, and a brief outline of the study. The interviewer then inquired about the birth mother's interest in hearing more about First Bridges, and if this was a good time for discussion. If she responded positively, the interviewer would then give a description of the study. If she wanted a callback, the interviewer would schedule a time to do so. If she indicated she was not interested, the interviewer thanked her for her time and ended the call. After hearing the initial introduction and if still interested, participants were given a series of screening questions to ascertain whether they met study eligibility criteria. If eligible for the project and still interested, the interviewer set up the assessment session with the MI therapist, interviewer, and participant.

If the birth mother was not the legal guardian, permission was obtained from the legal guardian before calling the mother to ask about her interest in First Bridges. There was only one case where the birth mother had not actually come to the FAS diagnostic clinic with her child. In all cases, the birth mothers were aware that their child had been alcohol-affected.

Meeting places. Finding appropriate locations to meet proved one of the more difficult aspects of the study. There was only one intervention group participant who felt comfortable meeting in her home for all sessions. In this instance, the woman owned her own home and had children in school. As a result, the MI therapist and participant could

meet during school hours and not be interrupted. For other participants, however, meeting in their homes was not an option and so we jointly located a public place near the woman's home that allowed sufficient privacy to carry out the MI session. We conducted several sessions in either fast food restaurants or the public library. The MI clinician made every effort to find areas within these public settings that ensured participant confidentiality. It is interesting to note that it was not until the supervisory sessions that the MI clinician became aware of the background noise level present during these sessions. It is also important to note that although the MI therapist did not always feel comfortable meeting in these public locations, the women themselves never expressed reluctance about meeting in public places or about audiotaping the sessions. Instead, they expressed gratitude that they did not have to travel to the University of Washington to meet.

Children. Although every effort was made to complete MI sessions without children present, this was not always possible. There was a woman, with few childcare options, who brought at least one of her children to every session—and at times she brought all three. For this woman, her eldest son (who was diagnosed with FAS, ADHD, and behavioral disorders) became a treatment barrier. This young man became disruptive in a public setting, so his mother terminated the session early. Although his presence and behavior made it difficult to conduct sessions, it also provided an opportunity for the clinician to observe her parenting context in a natural venue, especially since many of her personal goals centered on improving management of this child. The presence of children required careful discretion in discussing sexuality and birth control, as well as become more time-efficient because of the children's inability to tolerate extended MI sessions.

Unresolved issues. It is not surprising that this brief intervention left unresolved issues in these women's complicated and, at times, overwhelming lives. Brevity was an issue for both the birth mothers and the clinician. Trust and strong working relationships were critical elements in this intervention, and in some cases these were just being established when the intervention was completed. For all birth mothers, it was very hard to talk about their child's alcohol-related diagnosis as it related to the woman's own drinking. As expected, for women further along in their recovery process, this was not as sensitive an issue. However, it was very important for the clinician to remain nonjudgmental in session with these women. Sessions never focused on how a woman's drinking had "caused" her child's problems. Instead, sessions focused on how to prevent subsequent alcohol-affected births. As difficult as this topic was, all four women in the intervention group commented during exit interviews how helpful it was to have someone to talk to regarding these issues.

Final Thoughts

This MI intervention was brief, and primarily aimed at changing participants' attitudes towards drinking and contraception. First Bridges staff did not expect to see significant changes in actual behaviors over the three-month study period, although data analysis to follow will provide information on behavior change as well as attitudinal changes arising from this intervention. The First Bridges project has, however, already answered several important questions. First, women who have previously given birth to an alcohol-affected child can successfully be contacted about participating in FAS prevention services. Second, although it can be difficult, these women are willing to engage in a discussion about alcohol use, birth control, and preventing FAS and other alcohol-related disabilities in subsequent children. Third, both the clinician and the intervention must remain flexible to meet these women's many needs. Fourth, MI techniques are a promising way to conduct FAS prevention services, but linkage to appropriate referral resources is a critical component to this type of program. Access to more intensive treatment services for more severely chemically-dependent women is an important feature in program success across the full range of addiction severity. Finally, clinician feelings about using brief interventions with these high-risk women require attention and access to ongoing supervision.

Acknowledgements

We wish to acknowledge the valuable contributions of our database specialist, Kristen Daniels, M.A., and the FAS DPN Director, Susan Astley, Ph.D. We also extend our deep appreciation to the women who willingly participated in this project, without whom our work would not be possible.

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Motivational Interviewing and Exercise Behaviour Change

Vannessa Tobin

At a recent workshop with Steve Rollnick (and in the second edition of the motivational interviewing book), a distinction was made between Brief Advice Giving (BA), Behaviour Change Counselling (BCC) and Motivational Interviewing (MI); with BA being the most basic and brief, and MI being the most complex and lengthy to use. Some of the participants envisaged this relationship using a Venn diagram format, whereas others (myself one of them) preferred to envisage the connections using a pyramid representation (Appendix B). I am currently working towards a PhD in "exercise psychology" at University of Wales, Bangor (UK) and as part of my training I work with people who have difficulty adopting and maintaining a regular exercise regime. The doctor refers patients to me who would benefit from exercise (diabetics, hypertensives, overweight people and people with arthritis). They arrive in a state of ambivalence; they know the health implications of being inactive and part of them wants to become more active. One thing I have discovered about working with clients of this type is that they are extremely keen to elicit very directive advice about exercise. In fact they seem to prefer to be told what to do, rather than being served a menu of options and request practical advice in detail, and if possible accompanied by a demonstration!

As a supporter of MI and a fully qualified exercise instructor, I find it very difficult to keep myself from imparting this information to the client, and I get the impression that if I were unable to be prescriptive with them, that they would lose interest in the new behaviour and remain sedentary. At the same time however, I feel that being so prescriptive is almost like a betrayal MI – note my own ambivalence here! I believe that there are fundamental differences between cessation behaviours such as drinking and smoking cessation, which contributes to this difficulty. Unlike drinking and smoking cessation, where the individual is giving up a behaviour and is returning to a state with which he or she is at least familiar (i.e. not drinking / smoking), exercise for these people is a new departure; a behaviour which they have to take on, and it is often a very daunting one at that. In this respect one of the key roles of the exercise practitioner is to provide the client with adequate and accurate information about exercising. Apart from anything else, this is essential for safety reasons.

One can still use the principles of MI such as developing a therapeutic relationship with the client, developing discrepancy, and resolving ambivalence. However as exercise practitioners we need to be able to combine the skills of MI with a more prescriptive approach. I therefore see Exercise Behaviour Counselling (EBC) positioned

between MI and BCC. EBC is more than BCC, but at the same time it does not entirely adhere to the tenets of MI, although it certainly incorporates many of them.

My PhD research examines the exercise attitudes and behaviour of individuals referred onto exercise schemes by their doctor. I am interested in the relationship between MI and a needs-based theory of motivation known as "Self-Determination Theory" (SDT) which states that in order to develop intrinsic motivation an individual needs to have three psychological needs adequately fulfilled. These needs are autonomy (feeling free to make one's own decisions); competence (knowing what action needs to be taken to achieve a given outcome, and feeling able to do it); and relatedness (feeling socially connected to others). MI appears to share common features with SDT as: 1) it tries to enhance a person's sense of choice and autonomy; 2) it supports an individual's self-efficacy (hence helps enhance competence); and 3) the empathic component helps the individual feel more understood and in this way enhances relatedness. Results so far indicate that for the exerciser who is relatively low in competence, supporting one's competence (i.e. providing clear instructions and feedback) appears to be most important in order to boost their sense of autonomy. This is perhaps contrary to the needs of the more competent exerciser who would prefer to be given less instruction and more choices and options.

My final study will compare a group of exercisers who are exposed to a motivational interviewing based treatment (EBC), to a group who is educated about exercise, and to a group who receives no extra treatment apart from the exercise programme itself. One of the study's aims is to elucidate whether giving an MI based treatment produces better long-term exercise adherence than giving education only or no extra treatment at all. The results of this research will have implications for the medical and leisure centre staff involved in such schemes, as if the MI treatment group demonstrates superior long-term exercise adherence rates, then training in the basic skills of MI would be highly recommended.

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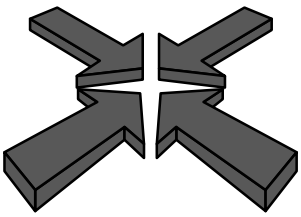

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This newsletter is a free publication made available to members of the Motivational Interviewing Network of Trainers.

Appendix A

The FAS DPN First Bridges Program: Personal Feedback Report

Personal Feedback Report:

Health and Lifestyle Assessment

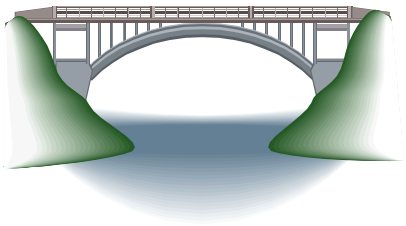


Table of Contents

1

Here are the strengths you listed:

1.

2.

3.

2

In the past 90 days you experienced problems in the following areas:

	Slightly (a little)	Moderately/ Somewhat	Considerably (a lot)	Extremely
Drug Use				
Alcohol Use				
Physical Health Psychological/ Emotional				
Child				
Partner				
Parents				
Friends/Others				
Finance				
Legal				
Housing				

3

In the past 90 days you felt you needed help in the following areas:

	Slightly (a little)	Moderately/ Somewhat	Considerably (a lot)	Extremely
Drug Use				
Alcohol Use				
Physical Health Psychological/ Emotional				
Child				
Partner				
Parents				
Friends/Others				
Finance				
Legal				
Housing				

4

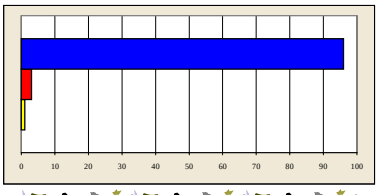
Here is some information on your alcohol use:

- You were ___ years old when you started drinking
- In the last 90 days you drank ___ times.
- On the days you drank in the last 90 days you had on average ___ drinks.
- Your longest period of abstinence has been _____ and it occured in _____.

5

Here is how your drinking compares to other women of childbearing age:

- 89.5% of these women drink less than 5 drinks when they drink. Only 10.5% drink 5 or more drinks.



6

In these situations you feel most confident that you won't drink:

1.

2.

3.

In these situations you feel that you are more likely to drink:

1.

2.

3.

7

Here are some things you thought were good about drinking:

1.

2.

3.

Here are some things you thought were not so good about drinking:

1.

2.

3.

8

Now here are some facts about your use of birth control:

- You were ____ years old when you started using birth control.
- These are the methods of birth control you have ever used in your life:

9

Here are some reasons why you stopped using various birth control methods:

1.

2.

3.

4.

Now you are using _____.

Many women struggle to use birth control consistently. How consistent is your birth control use?

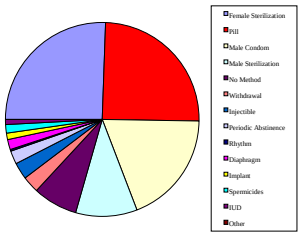
not very somewhat extremely

1 2 3 4 5

10

- Of all women at risk of becoming pregnant, 93% use some form of contraception. Only 7% use no contraception at all.

The most used forms of birth control are:



11

Here are some situations where you feel more confident that you would use birth control:

1.

2.

Here are some situations where you feel less confident that you would use birth control:

1.

2.

12

GOALS

In the next three months I would like to:

1.

How important is this goal to you?
1 2 3 4 5 6 7 8 9 10
How confident are you that you will achieve this goal?
1 2 3 4 5 6 7 8 9 10
How close are you to meeting this goal?
1 2 3 4 5 6 7 8 9 10

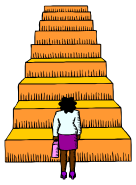
2.

How important is this goal to you?
1 2 3 4 5 6 7 8 9 10
How confident are you that you will achieve this goal?
1 2 3 4 5 6 7 8 9 10
How close are you to meeting this goal?
1 2 3 4 5 6 7 8 9 10

13

3.

How important is this goal to you?
1 2 3 4 5 6 7 8 9 10
How confident are you that you will achieve this goal?
1 2 3 4 5 6 7 8 9 10
How close are you to meeting this goal?
1 2 3 4 5 6 7 8 9 10



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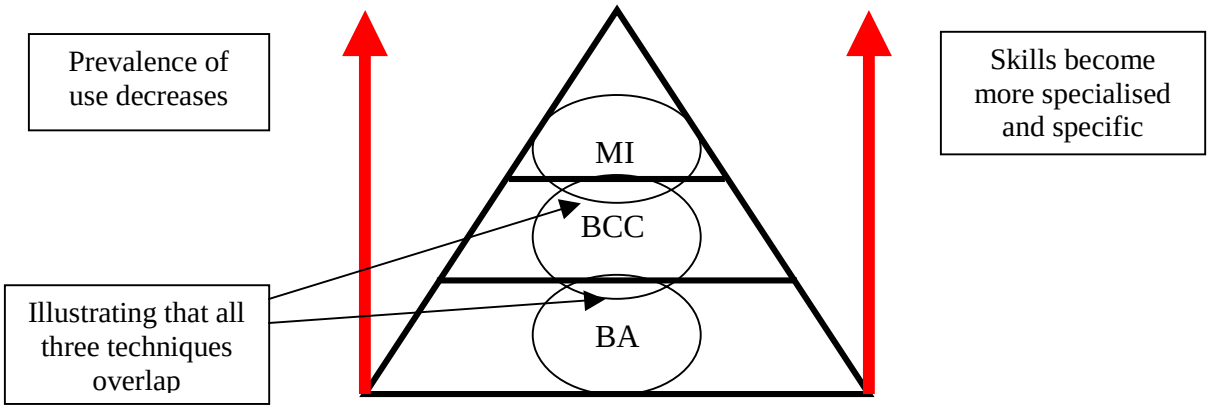
Appendix B

Motivational Interviewing and Exercise Behaviour Change: Relationship of MI with regard to other styles



MI = motivational interviewing; BCC = behaviour change counselling
BA = brief advice giving