Revised 11/29/2000

Motivational Interviewing Skill Code (MISC)

Coder's Manual

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The MISC was developed to encode audiotaped or videotaped motivational interviewing interactions between a therapist and an individual client. The term "therapist" is used here to apply to any professional conducting an interview or treatment session, and "client" refers to the interviewee. The following research staff at the Kaiser-Permanente Center for Health Research (Portland, Oregon) were valuable collaborators in the development and initial testing of this coding system: Kathy Mount, Steve Berg-Smith, Denise Ernst, Douglas Brenneman, and Janice Krumenacker.

Three Coding Passes

Full MISC coding requires at least three passes through a tape.

In the first pass, the rater listens to the entire interview (or section thereof that is to be coded), usually without stopping the tape. The coder may make notes, and by the end of the interview completes the global rating scales. Definitions and guidelines for these ratings are provided in this manual. No behavior counts are to be done during the first pass. Ratings made at the end of the first pass may not be changed on subsequent passes.

In the second pass, the rater counts specific behaviors of both therapist and client. There are two sheets to be used in this pass - one for therapist behavior and one for client behavior - which should be placed side by side in front of the coder during second pass coding. Each therapist utterance is classified into one and only one of the mutually exclusive categories shown (separated by heavy lines) on the second pass coding sheet for therapist behavior. Each client utterance is classified into one and only one of four mutually exclusive categories shown on the second pass coding sheet for client behaviors. For both therapists and clients, an utterance is considered to be a complete thought. An utterance ends either when one thought it completed and a new thought begins with the same speaker, or when the other speaker takes over. A single utterance is classified in one and only one category; it may not be coded in multiple categories. It is common, however, for utterances in different categories to follow one another within the same speaker's speech (e.g., a therapist's reflection followed by a question). It is common for the coder to stop the tape at times during the second pass, and to rewind and replay as necessary to determine proper codes. (Once experienced, however, one should not be stopping the tape after every few utterances.) Behavior counts made at the end of the second pass may not be changed after third pass information is obtained.

A third pass is devoted exclusively to computing talk time for therapist and client. This should be done last, only after first and second pass codes have been completed, or may be done by a separate coder. It is usually done without stopping the tape.

Global Therapist Ratings

All ratings on this form are on a 7-point Likert scale. Ratings should be based primarily on the therapist's own behavior during the observed session. Circle one and only one number for each item, and do not leave any items blank. Do not make ratings that fall between the whole numbers. These are global ratings, based on the *entire* interview or sample. Thus, for example, a rating of acceptance is given for the *whole* interview, which may combine longer periods of high acceptance and a few judgmental exceptions.

Acceptance (also called unconditional positive regard)

Therapists high on this scale communicate acceptance and respect to the client. Acceptance is person-focused (*unconditional positive regard*) and should not be confused with acceptance/approval of the person's behavior.

Therapists at the low end of this scale may be perceived as judgmental, harsh, disrespectful, labeling, or condescending.

Egalitarianism (the opposite pole is authoritarianism)

Therapists high on egalitarianism emphasize by their words and manner the client's personal autonomy, choice, and responsibility. They may offer their expertise when asked for it, or after obtaining the client's permission to inform or advise.

Therapists low on egalitarianism take a more authoritarian approach of directing, ordering, blaming, threatening and confronting. There is a quality of the therapist asserting a "one up" position that implies, "I know best. Listen to me."

Empathy (also called accurate understanding) The focus here is the extent to which the therapist *understands* the client's perspective, and not on warmth, acceptance, genuineness, or identification with the client.

Therapists high on this scale are able to attain and communicate an *accurate understanding* of the client's perceptions, situation, meaning, and feelings through high-quality reflective listening. Their manner shows an active interest in and effort to understand the client's perspective, and their responses actively express an attentive understanding of the client's perspective and experience. They probe to understand more fully, and reflect their understanding back to the client.

Therapists at the low end of this scale show little interest in or appreciation of the client's perspective, little overt understanding or reflection of what the client is experiencing. They evidence little effort at seeking a deeper understanding of the client's perspective. Therapists low in empathy may ask many questions to gain factual information or pursue their agenda, but do not seek to understand the client's own perspective.

Genuineness (also called congruence)

Therapists high on this scale are perceived as open, responsive, and honest. The therapist appears to be saying what he or she is experiencing in this session. They show a quality of congruent transparency, saying what they feel and perceive in the moment. Their response to the client is individual and personal. Do not confuse this with other scales such as acceptance or warmth. High genuineness, for example, can include expression of negative affect or criticism.

Therapists low on this scale do not appear to be responding honestly and openly to the client, and may appear unresponsive or phony. If they self-disclose, it may have the quality of talking about personal history rather than relating in the present. Their response may have a flat, closed, or technical-businesslike quality, or may appear to be rote or mechanical.

Warmth

Therapists high on this scale are perceived as warm, friendly, engaged, compassionate, helpful, caring, and concerned.

Therapists at the low end of this scale present an impression of being cold, distant, detached, or unfriendly, showing little overt evidence of helpful concern and compassion.

Spirit. This is an overall, global rating of the extent to which the therapist manifests the fundamental *spirit* of motivational interviewing. It should not be regarded merely as an average of the other scales, but rather the rater's judgment of the extent to which the therapist "gets it," evidencing a grasp of the "music" and not just the words and techniques.

Therapists high on this scale manifest a directive, client-centered style of facilitating, coaching, and negotiating. The therapist honors and values the client's perspective. There is a naturalness, comfort, and loving or artistic quality to the therapist's style. The therapist is attuned to the client, and actively "mines for the client's own motivation."

Therapists low on this scale show a lack of the balanced directive, client-centered style, erring on the side of passivity or of overcontrol (or both). On the passivity side, the therapist misses or is inattentive to significant client material, and may seem indifferent, isolated, ignoring, preoccupied, or detached. On the overcontrolling side, the therapist may communicate mistrust, disrespect, disregard, or simply the pursuit of the therapist's own agenda without sufficiently involving the client.

Global Client Ratings

For these scales, focus on the *client's* behavior. All ratings on this form are on a 7-point Likert scale. Ratings should be based primarily on the client's own behavior throughout the observed session. Circle one and only one number for each item, and do not leave any items blank. Do not make ratings that fall between the whole numbers. Because clients' behavior often changes markedly over the course of a session, these *are not meant to be averages across the entire session*, but rather reflect the client's "high point" - a period (more than momentary) that reflects the client's highest level of functioning during the session.

Affect (emotion)

Clients high on this scale show clear emotion during (not necessarily throughout) the session, expressing it openly and directly. The emotion is *verbally expressed* and may be positive and/or negative in tone, including anger, happiness, sadness, fear, love, etc. Do not infer affect from nonverbal behavior alone. The affect should be codable from the audio track without a picture. When in doubt, do not interpret or infer affect; it should be evident to a layperson from verbal expression. Note that affect is *not* arousal level. Sadness is affective, for example, but is often characterized by low arousal and activity.

Clients at the low end of this scale express little or no emotion throughout the session.

Cooperation

Clients high on this scale are generally "going with" the therapist during the session. They respond to requests, cooperate with the therapist's efforts, and show little resistance. Clients who are acquiescent are generally high in cooperation. Do not rate low on cooperation based on an intererence that the client is "just going along with" the therapist or "doesn't mean it."

Clients at the low end of this scale appear generally unfriendly and uncooperative with the therapist's direction througout the session, with a sense of detachment (passive resistance) or opposition (active resistance).

Disclosure

Clients high on this scale reveal significant information about themselves during the session, and show a quality of openness and honest transparency.

Clients at the low end of this scale reveal little about themselves during the session, and may be perceived as distant, guarded, deceptive, evasive, or untruthful.

Engagement

Clients high (active) on this scale appear actively involved, openly seeking, interested, and engaged in the session, participating fully and attending. They appear to be thinking, reflecting, experiencing, processing, or discovering during the session.

Clients at the low (passive) end of this scale appear disengaged, uninterested, unattached, and may give the impression of waiting for the session to be over.

Global Interaction Ratings

Finally, there are two global ratings for the *interaction* between therapist and client. As with therapist ratings, these ratings are based on the *entire* interview or sample. Thus, for example, a rating of collaboration is given for the *whole* interview, which might include, for example, longer periods of dancing and a few episodes of wrestling.

Collaboration. This scale has to do with how the therapist and client work together, particularly as regards the sharing of power.

Interactions high on this scale ("dancing") have the quality of partners, companions, or collaborative consultation. The therapist moves with the client's efforts: negotiating, encouraging, collaborating, and empowering. There is a quality of synergy, of the therapist and client moving together.

Interactions at the low end of this scale ("wrestling") have the feeling of an uncooperative, competitive, or adversarial struggle for power. The therapist and client appear to struggle against each other. Wrestling, however, does not require that the client “fights back.” In response to a wrestling therapist, the client may just acquiesce and be “pinned.”

Benefit. This global scale focuses on the extent to which the client showed movement or benefit in the session. It clearly involves an evaluative interpretation by the coder. Did the client move forward (toward positive change) or backward (away from positive change) during the session?

Interactions high on this scale are those in which the client is judged to have shown definite movement toward beneficial change. The client leaves the session "better off" and more likely to move in a positive direction

The midpoint (4) is used when no movement, positive or negative, is perceived in the session; the client leaves the session no different than at the beginning.

Interactions low on this scale are those in which the client is judged to have shown *negative* movement away from beneficial change. The client leaves the session "worse off" or less likely to change in a positive way.

Therapist Behavior Counts

An *utterance* is a complete thought. Two utterances are often run together without interruption. If two consecutive sentences merit different codes (e.g., a reflection followed by a question), they are by definition separate utterances. A client response always terminates a therapist utterance, and the next therapist utterance becomes a new response.

Once an utterance is complete (the tape may be stopped), first decide in which of the main behavior categories it belongs. In some cases, subclassification is required within a category. Place a hash mark in the appropriate behavior count box for that row. Then proceed to the next utterance. The same utterance may never be given two different codes.

A *volley* is an uninterrupted utterance or sequence of utterances by one party, before another party speaks. The same behavior code may never be assigned twice within the same volley. Thus, for example, if a therapist confronts, then reflects, and then confronts again all within the same volley (before the client speaks), only *one* Confront response would be coded, along with the Reflect response.

Advise. The therapist gives advice, makes a suggestion, offers a solution or possible action. These will usually contain language that indicates that advice is being given: Should, Why don't you, Consider, Try, Suggest, Advise, You could, etc.. ADVISE requires subclassification for whether the advice was given with or without prior permission from the client. Prior permission can be in the form of a request from the client, or in the therapist asking the client's permission to offer it. Indirect forms of permission-asking may also occur, such as a therapist statement that gives the client permission to disregard the advice ("This may or may not make sense to you").

Differential: *Code as INFORM if the utterance gives information but does not contain direct advice or suggestion. Do not infer that the therapist meant to advise by giving the information.*

Differential: *If the language is imperative, code as DIRECT. For example:*

One possibility would be to avoid drinking when you feel down.	*Advise*
Don't drink when you feel down	*Direct*

Differential: *Code as QUESTION if the apparent advice is phrased in the form of a question. The exception to this is when the therapist is asking for permission to offer advice.*

You could ask your friends not to bring drugs when they come over.	*Advise*
Could you ask your friends not to bring drugs when they come over?	*Closed Question*
What could you ask your friends to do to help you stay clean?	*Open Question*
Would it be all right if I suggested something?	*Advise, with permission*

Affirm. The therapist says something positive or complimentary to the client. The following are examples of AFFIRM responses, but subclassification is not required.

Appreciation. The therapist comments favorably on a trait, attribute, or strength of the client. The reference is usually to a "stable, internal" characteristic of the client, something positive that refers to an aspect of the client that would endure across time or situations (smart, resourceful, patient, strong, etc.), although it may also be for effort ("I appreciate your willingness . . ." "I appreciate your getting here today.").

Confidence. The therapist makes a remark that bespeaks confidence in the client's ability to do something, to make a change; it predicts success, or otherwise supports client self-efficacy. These are related to a particular task, goal, or change.

Reinforcement. These are general encouraging or "applause" statements that do not directly comment on a client's nature, and do not speak directly to self-efficacy. They tend to be short. "Good for you." "Well done!" "All right!" "Great job!" "Thank you!"

***Differential**: Emphasize Control takes precedence over Affirm when a therapist response could be interpreted as both. "I know you have the ability to do this" is certainly affirming, but would be coded as Emphasize Control.*

Confront. The therapist *directly* disagrees, argues, corrects, shames, blames, seeks to persuade, criticizes, judges, labels, moralizes, ridicules, or questions the client's honesty. These are the "roadblocks" that have a particular negative-parent quality, an uneven power relationship accompanied by disapproval or negativity. *Included here are utterances that have the form of questions or reflections, but through their content or emphatic voice tone clearly constitute a roadblock or confrontation.* Examples include:

Rhetorical "Don't you think that . . . ." "Isn't it possible that . . ."

Leading "What makes you think that you can get away with it?"

Argumentative "How can you tell me that . . . ." "How could you . . . ."

Accusatory "You did *what*?" "What were you *thinking*?" "You expect me to believe . . .?"

Disrespect "You *actually* looked for a job this week" (sarcasm)
"You *smoked* a *joint* this week" (disbelief, disapproval)

Re-emphasizing negative consequences that are already known by the client constitutes a confront, except in the context of a double-sided or summary reflection.

Subtle inference is not sufficient reason to code a therapist behavior as confront. If you are in doubt as to whether a behavior was a confront or some other code (i.e., it *might* be interpreted as a confront), do *not* code it as confront.

Direct. The therapist gives an order, command, direction. The language is imperative. "Don't say that!" "Get out there and find a job." Words with the effect of imperative tone include "You need to..." "I want you to . . ." "You have to..." "You must...." "You can't..." and "You should . . . ."

Emphasize Control. The therapist directly acknowledges or emphasizes the client's freedom of choice, autonomy, ability to decide, personal responsibility, etc. This may also be stated negatively, as in "No one else can make you change." There is no tone of blaming or fault-finding. Statements supporting the client's efficacy to accomplish something are also coded as Emphasize Control.

Facilitate. These are simple utterances that function as "keep going" acknowledgments. Mm Hmm. OK. "Tell me more." "I see" Some brief utterances sound like questions, but function as facilitates: "Oh, did you?" "Really!" "Oh, do you?" unless voice tone *clearly* implies skepticism ("Oh you did, did you?")

Do NOT code as Facilitate if the vocal sound is a preface to some other therapist response like a question or a reflect. In these combinations, code only the second response. Facilitate responses stand alone.

Mmmm .. So you aren't sure what to do. (code only Reflect)

Uh huh... What makes you think so? (code only Open Question)

Also, *do NOT code as Facilitate if* the vocal sound serves as a time holder (uh . . . . .) that would delay the client's response, rather than having the "go ahead" function. These are not coded at all.

In videotape coding, *do NOT code as Facilitate* a head-nod or other nonverbal acknowledgment, unless it is accompanied by an audible utterance.

Differential: *Occasionally a therapist will utter a "grunt confront" - something that might appear on a transcript to be a Facilitate, but is unambiguously a response that disagrees, questions the client's honesty, expresses sarcasm, etc. These have a "Hah!" or cynical "Yeah, right!" quality. Using the Confront differential rule, though, when in doubt, code as Facilitate rather than Confront.*

Filler. This is a code for the few responses not codable elsewhere: pleasantries, etc. It should not be used often.

Inform. The therapist gives information to the client, explains something, or provides feedback. This is not advice. If it constitutes advice, code as ADVISE. INFORM requires subclassification as either:

Personal Feedback. Information about the client that was not already available to the client (e.g., not a reflection). These statements will usually but not always have a "You" in them. Do not *infer* that the information was meant to apply to the person. Unless it is direct personal information, it is general information.

Differential: *Personal Feedback is by definition not a reflection. If the therapist is reflecting what the client has said, the client already had the information. Repeating negative consequences, when the information being presented is not new, constitutes a CONFRONT except when contained in a reflection or summary.*

Self-Disclose. This is information given to the client *about* the therapist. It includes disclosure of past events and experiences in the therapist's life, as well as expression of the therapist's present feelings or personal reaction to the client .

***Differential*:** *If a self-revealing statement is codable as Support, do so. Support takes precedence.*

I'm concerned about you	*Support*
I'm happy for you	*Support*
As I listen to your story, I am feeling sad	*Self-Disclose*
I am feeling put off here, like I'm not getting through.	*Self-Disclose*

Differential: *Also differentiate present-tense self-disclosure from immediate personal feedback to the client. If the therapist's "disclosure" primarily communicates information about the client rather than about the therapist, it is personal feedback. This can be a close call, particularly because therapists may use the word "feel" to provide such feedback. One differential here is that in this context, the word "feel" tends to be followed by "like" or "that." For example,*

"I feel like you are pushing me away, keeping your distance" is Personal Feedback.

Note that the same sentence is still Personal Feedback if the word "like" is omitted. When the therapist's own feeling is being expressed (self-disclosure), the word "that" cannot be logically inserted after "feel." Technically, "I feel that . . ." conveys information or opinion, not an emotion.

General Information. Other information that is not about the client himself or herself. This includes information about people in general, but not specifically about the client: hypotheticals, "Someone who..." "People who....." But "Anyone who ...." statements are decidedly Personal Feedback, because they logically include and apply to the client. Also coded here are clarifications of what the therapist meant, usually in response to a client Ask response.

Question. The therapist asks a question in order to gather information, understand, or elicit the client's story. Generally these begin with a question marker word: Who, What, Why, When, How, Where, etc. The question may also be stated in imperative statement language:

Tell me about your family.	Open Question
Tell me more.	Facilitate (does not ask a specific question)
Tell me how old you are.	Closed Question

QUESTION responses require subclassification as:

Closed Question. The question implies a short answer: Yes or no, a specific fact, a number, etc. This includes a "spoiled open question" where the therapist begins with an open question but then ends it by asking a closed question:

What do you want to do about your drug use?	Open Question
What do you want to do about your drug use? Anything?	Closed Question
Tell me about your drinking.	Open Question
Tell me about your drinking. How old were you when you had your first drink?	Closed Question

Closed questions may also be expressed in "multiple choice" format (as on a survey form), where the therapist suggests a series of answers from which the client is to choose one:

What county do you live in? Washington? Multnomah?	Closed Question
What do you want to do about your drinking?	Open Question
What do you want to do about your drinking: quit or cut down?	Closed Question

Open Question. Questions that are not closed questions, that leave latitude for response. Remember that if the question can be answered by yes/no, it is a closed question.

How might you be able to do that?	Open Question
Do you have any idea how you might be able to do that?	Closed Question

In general, stacked questions (before the client gives an answer) are coded as only one question. Sometimes a therapist will stack questions by asking a open question and then giving a series of "for example" follow-up questions before the client answers. These are coded as *one* open question [not, in this case, as two open and two closed questions]

> In what ways has your drinking caused problems for you? [For example] Has it caused any problems in your relationships, or with your memory? What about trouble with the law, or health problems? Have you felt bad about yourself? Things like that.

Differential: *FACILITATE responses sometimes occur in the form of questions: "What do you*

mean?" "Really?" "Oh, do you?" "Tell me more." Code these as FACILITATE.

***Differential*:** *Do not code clearly leading, rhetorical, accusatory, argumentative, sarcastic, or disrespectful "questions" here - code these as CONFRONT (see above). The effect of a CONFRONT disguised as a question is usually to reemphasize negative information that is already known to the client, rather than to gather new information.*

Now remind me here - why is it again that you're on probation?	*Confront*
Why should I trust you this time?	Confront

***Differential*:** *Do not code REFLECT responses as QUESTION, even if the voice is inflected upward at the end in a questioning way. REFLECT takes precedence when there are no question marker words.*

You're feeling angry with your mother.	*Reflect*
You're feeling angry with your mother?	*Reflect*
Are you feeling angry with your mother?	*Closed Question*

Raise Concern. The therapist points out a possible problem with a client's goal, plan, or intention. The therapist may do this with or without first obtaining permission directly or indirectly, and subclassification is required in this category, as for Advise. Prior permission can be in the form of a request from the client (What do you think about my plan?), or in the therapist asking the client's permission to offer it (Would it be all right for me to tell you one thing that worries me about your plan?) . Indirect forms of permission-asking may also occur, such as a therapist statement that gives the client permission to disregard the therapist's concern ("This may or may not be something that concerns you, but there is one thing that occurs to me about your plan. . . .").

Differential: *ADVISE is coded when the therapist is suggesting a form of action. RAISING CONCERN does not advise a course of action, but rather points to a potential problem or issue for the client's consideration.*

I wonder what you might do, then, when you hit situations where you have used drugs in the past, like when you feel bored.	*Raise Concern, without permission*
I wonder if you might take a ride on your bike when you're feeling bored, instead of using.	*Advise, without permission*

***Differential*:** *SUPPORT includes statements of compassion that can appear similar in language. The difference is that RAISE CONCERN points to a particular issue, problem, or risk.*

I'm concerned about you.	*Support*
I've been worried about you this week.	*Support*
I'm concerned that this may not work for you because..	*Raise Concern, without permission*
I'm worried that once you leave the hospital, you'll be facing much more temptation.	*Raise Concern, without permission*

***Differential*.** *QUESTION takes precedence if a concern is raised in the form of a question. The one exception to this is when the therapist asks permission to raise a concern, in the form of a closed question.*

I'm concerned that you may have trouble keeping to your plan when you're around your old friends.	*Raise Concern, without permission*
How would you keep to your plan when you are around your old friends?	*Open Question*
Do you think you will be able to stick to your plan when you're around your old friends?	*Closed Question*
Is it OK if I tell you something that concerns me about your plan?	*Raise Concern, with permission*

***Differential*:** *CONFRONT involves direct disagreement, argument, persuasion, criticism, etc. RAISE CONCERN requires language that marks it as the therapist's concern (rather than Truth) or gives the client permission to disagree.*

Can't you see that this plan is going to fail the moment you walk out of this hospital?	*Confront*
There's no way that you are going to be able to stay sober without some additional support.	*Confront*
I wonder if you have thought about what could go wrong with your plan, to get you off track.	*Raise concern, without permission*
This may not seem important to you, but I'm worried that without some extra social support it's going to be tough for you to do this on your own.	*Raise concern, with permission*

Reflect. The therapist makes a statement that reflects back content or meaning previously offered by the client, usually in the client's immediately preceding utterance. Code as REFLECT whether the therapist's voice inflection is up or down at the end of the statement. Never code questions (Who, Why, What, etc.) as REFLECT. If a therapist response includes both a REFLECT and another codable response (such as a REFLECT followed by a QUESTION), code *both* behaviors.

REFLECT responses require subclassification regarding the level/type of reflection, and simultaneously, whether there was reflection of client affect. First, classify the reflection into one of these four types:

Repeat. These reflections add nothing at all to what the client has said, but simply repeat or restate it using some or all of the same words.

Rephrase. These reflections stay close to what the client has said, but slightly rephrase it, usually by substituting a synonym. It is the same thing said by the client, but in a slightly different way.

Paraphrase. These reflections change or add to what the client has said in a significant way, to infer the client's *meaning*. The therapist is saying something that the client has not yet stated directly. Level three reflections include (but are by no means limited to):

Amplified Reflection, in which content offered by the client is exaggerated, increased in intensity, overstated, or otherwise reflected in a manner that amplifies it

Double-Sided Reflection, in which both sides of ambivalence are contained in a single reflective response.

Continuing the Paragraph, in which the therapist anticipates the *next* statement that has not yet been expressed by the client

Metaphor and Simile in reflection

Reflection of Feeling where the affect was not directly verbalized by the client before

Summarize. These reflections gather together at least two different client utterances, at least one of which was not contained in the immediately preceding client statement. Double-sided reflections are coded as SUMMARIZE if and only if the client's immediately preceding speech contained only one side, and the other side is retrieved from prior speech. If the client's immediately preceding speech contained elements of both sides, a double-sided reflection is coded as REPEAT, REPHRASE, or (usually) PARAPHRASE.

Then, before placing your hash mark within the proper row, decide whether the reflection contained direct reference to the client's affect. Be sure that the reference is to emotion, and not other uses of the word "feel." "So you feel THAT your boss is unfair" not a reflection of affect. Within the proper row for the level/type of reflection, place the hash mark in the column for No Affect Reflected or Affect Reflected.

Reframe. The therapist suggests a different meaning for an experience expressed by the client, placing it in a new light. These generally have the quality of changing the emotional valence of meaning from negative to positive (e.g., reframing nagging as caring), or from positive to negative (reframing "being able to hold your liquor" as a risk factor).

Support. These are generally supportive, understanding comments that are not codable as Affirm or Reflect. They have the quality of commenting on a situation, or of agreeing or siding with the client. "I can see what you mean." "That must have been difficult for you." "Sounds awful." Statements of compassion (not AFFIRM) for the client are also coded here as SUPPORT. (I'm concerned about you. I've been worried about you this week.) An "agreement with a twist" consists of a Support followed by a Reframe, and both would be coded.

***Differential*:** *Do not code as SUPPORT if the response is simply a REFLECT of what the client has said.*

Differential: *Sometimes CONFRONT responses are masked in "I'm concerned" language. Again, CONFRONTs have the effect of reemphasizing negative information already known to the client, or placing negative connotations.*

I'm concerned that you haven't been showing up for your appointments.	*Confront*
I'm glad to see you. I was getting worried about you.	*Support*
I'm concerned that you are an alcoholic.	*Confront*
I'm concerned about you, given all these difficulties you've been having.	*Support*

Structure. These are comments made to explain what is going to happen in the session, to make a transition from one part of a session to another, to help the client anticipate what will happen next, etc.

Warn. The therapist provides a warning or threat, implying negative consequences that will follow unless the client takes certain action. It may be a threat that the therapist has the perceived power to carry out (e.g., imposing negative consequences), or simply the prediction of a bad outcome if the client takes a certain course. WARN differs from ADVISE by the element of implied negative consequences.

Client Behavior Counts

Client responses are classified into one of four mutually exclusive categories, with no subclassification. Any therapist utterance (except a Facilitate) ends the client response, and the next client utterance is coded as a new response. The four categories are:

? Ask. The client requests information, asks a question, seeks the therapist's advice or opinion.

0 Follow/Neutral. The client's response follows along, but is neither Resist Change (moving away from change) nor Change Talk (moving toward change), as defined below. (Note, however, that non-following responses are generally coded as Resist Change) The follow/neutral category includes brief words and phrases such as "right," "OK," "I see," etc. *When in doubt between Neutral and - or +, code Neutral*. If it is a nuance that suggests that a client statement *might* be self-motivational or counter-change, the default is Neutral. Note that non-word vocalizations (such as hmm, uh huh, ah) are not coded for clients (whereas for therapists they are coded as Facilitate).

- Resist Change. The client's response is inconsistent with or reflects movement *away* from change. Note that "change" here is defined as a particular target change, not any kind of change. Within the contest of treatment for problem drinking, for example, Resist Change and Change Talk are coded in relation to a change in drinking behavior. Clients may express change talk on other subjects (e.g., change in a relationship, moving to a new apartment), but these are not coded unless directly related to the identified target change.

Resist Change need not have an oppositional quality, and does not necessarily have an emotional charge. The key is that what the client is saying favors *not* changing the target behavior, and in this sense is status quo or movement backward. Four common types are:

> **Arguing**. The client disagrees with the therapist, directly challenges the accuracy of what the therapist has said, questions the therapist's personal authority or expertise, or expresses hostility toward the therapist. Includes "Yes, but . . . " responses.
>
> **Interrupting**. The client breaks in and interrupts the therapist in a defensive manner, by speaking while the therapist is still talking without waiting for an appropriate pause or silence, or directly breaking into the therapist's speech with the effect of cutting the therapist off - "Now wait a minute . . ."
>
> **Negating**. These responses express a lack of problem recognition, or a reluctance to cooperate, accept responsibility, follow advice, or change. They are, in essence, the opposite of self-motivational statements. Examples include giving reasons why change cannot happen or a suggestion won't work, blaming other people for problems, disagreeing with a therapist's suggestion, making excuses for behavior, claiming impunity from negative consequences, minimizing risks or dangers, pessimism, reluctance, or a lack of desire or intention to change. Note that Negating is coded even if the client is answering a question (e.g., the therapist asked for "the good things" about current behavior), or is stating both the pros and cons of change. Each *different* negating response counts; do not code a series of different responses as a single Negating.
>
> **Not Following**. The client does not answer, or shows evidence of not following or ignoring the therapist. This includes inattention (not following what the therapist is saying), not answering a question, giving no audible response, or changing the subject away from the direction the therapist has been taking. Verbal answers that do not give information (e.g., "I don't know") may be coded here. [Note, however, that "I don't know" can also be a factual answer to a closed-ended question, and as such would be Follow/Neutral.]

+ Change Talk. The client makes a statement that directly or indirectly shows evidence of at least one of the following four categories, which have the quality of moving forward in the direction of change in the target beahvior. Each *different* self-motivational statement counts; do not code a series of different SMS as a single + response. For example, if a client lists several different reasons for or advantages of change, each one is coded as Change Talk. Here are four common types of Change Talk:

> **ProblemRecognition**. The client acknowledges risk, danger, negative consequences to self or others; takes personal responsibility for negative consequences, etc.
>
> **Concern**. The client expresses concern about his or her current situation
>
> **Desire/Intention to Change**. The client expressed a desire for change, or states an intention to change.

Optimism. The client indicates optimism (self-efficacy) regarding his or her ability to achieve a change (with or without a stated desire to change).

Change talk *can* occur in response to a therapist's question. In fact, open questions represent one common way to elicit change talk in motivational interviewing. Even simple monosyllabic responses can constitute Change Talk. In the following excerpt, each check mark (**T**) designates one Change Talk code. A total of seven Change Talk responses can be counted from this segment.

Therapist: What are you thinking, then, about your marijuana use? Do you want to keep on using pot as you having during the past year? [Closed question]
Client: No. **T**
T: What are some of the reasons you see for making a change? [Open question]
C: Do you mean in my marijuana use? [Ask]
T: Yes [General Information]
C: Well, it gets me in trouble, like on this urine test at work. **T**
T: Uh huh [Facilitate]
C: And I can't really think the next day – not on simple things, but when I'm trying to do something complicated like statistics, my head just doesn't work. **T**
T: So marijuana seems to affect you in that way. It interferes with your ability to think and concentrate. [Reflection / Paraphrase / Nonaffective]
C: Yes **T** [Coded as new Change Talk because it follows a Therapist response]
T: What else? [Open Question]
C: Some people say it makes you unmotivated, kind of lethargic. **T**
T: Do you agree? [Closed question]
C: Well, I do get pretty mellow, and don't feel like doing much, so I guess so. **T** And I also don't like the idea that I might *have* to have it, you know? **T**
T: You kind of resent having to depend on something. [Reflection / Paraphrase / Affective]
C: Yeah. **T** But still, I don't think I'm an addict or anything. [Resist Change]

Third Pass Time Coding

In a separate third pass that may not precede first or second pass coding by the same coder, the interview is coded for talk time by the client and therapist. Two timer clocks are needed that can be easily set in motion by pressing a switch, and stopped by lifting the switch. Total silence in which neither is talking (both clocks stopped) must also be allowed, which is why an ordinary chess clock will not suffice. A speaker's (client's or therapist's) clock is started when he or she begins an utterance, and ends when he or she finishes the utterance or the other person speaks, whichever comes first. If a speaker pauses in the middle of an utterance, with the apparent intention of completing the thought, the clock continues to run until the thought is finished or the other person speaks. When coding a videotape, use *only the audio channel* when doing third pass coding, because attending to the picture may alter ratings. *Do not watch the picture*. Watch the timer-clock while doing third pass coding, and turn your back to the picture.

Total cumulative talk time is then read from each clock and recorded on the third pass coding sheet lines provided for this purpose. Be very careful not to mix up the times; ensure that therapist time is recorded on the therapist line.

Record time in decimal minutes, not in minutes and seconds, to allow for calculations:

secs =	minutes	secs =	minutes	secs =	minutes
01	.017	21	.350	41	.683
02	.033	22	.367	42	.700
03	.050	23	.383	43	.717
04	.067	24	.400	44	.733
05	.083	25	.417	45	.750
06	.100	26	.433	46	.767
07	.117	27	.450	47	.783
08	.133	28	.467	48	.800
09	.150	29	.483	49	.817
10	.167	30	.500	50	.833
11	.183	31	.517	51	.850
12	.200	32	.533	52	.867
13	.217	33	.550	53	.883
14	.233	34	.567	54	.900
15	.250	35	.583	55	.917
16	.267	36	.600	56	.933
17	.283	37	.617	57	.950
18	.300	38	.633	58	.967
19	.317	39	.650	59	.983
20	.333	40	.667	60	1.00

Tape #_____ **Coder:_____** 5/5/98

First Pass Ratings

Global Therapist Rating Scales (Overall Session)

Acceptance		1 2 3 4 5 6 7 Low High
Egalitarianism		1 2 3 4 5 6 7 Authoritarian Egalitarian
Empathy/ Understanding		1 2 3 4 5 6 7 Low High
Genuineness/ Congruence		1 2 3 4 5 6 7 Low High
Warmth		1 2 3 4 5 6 7 Cold Warm
Spirit		1 2 3 4 5 6 7 Low High

Global Client Rating Scales (High Point)

Affect		1 2 3 4 5 6 7 Low High
Cooperation		1 2 3 4 5 6 7 Resisting Cooperative
Disclosure		1 2 3 4 5 6 7 Low High
Engagement		1 2 3 4 5 6 7 Passive Active

Global Interaction Rating Scales (Overall Session)

Collaboration		1 2 3 4 5 6 7 Wrestling Dancing
Benefit		1 2 3 4 5 6 7 Worse No Different Better

Tape #_____ **Coder:_____** 5/5/98

Second Pass Behavior Counts: Therapist

		Behavior Tabulations		Totals
Advise (subclassify)	**With Permission**			
	Without Permission			
Affirm	Appreciation, expressed confidence, reinforcement			
Confront				
Direct				
Emphasize Control	Emphasis on client personal control, choice, and responsibility			
Facilitate				
Filler				
Inform (subclassify)	**Personal Feedback**			
	Self-Disclosure			
	General Information			
Question	**Closed Question**			
	Open Question			
Raise Concern	**With Permission**			
	Without Permission			
Reflect (subclassify)	**TYPE/LEVEL**	**No Client Affect Reflected**	**Client Affect Reflected**	
	Repeat			
	Rephrase			
	Paraphrase			
	Summarize			
	TOTAL REFLECTIONS:	Nonaffective Total:	Affective Total:	
Reframe				
Structure				
Support				
Warn				

Tape #_____ **Coder:_____** 5/5/98

Second Pass Behavior Counts: Client

		Behavior Tabulations	Totals
? Ask	Client requests information, asks questions, seeks advice or opinion from the therapist		
0 Follow/ Neutral	Neither counter-change nor self-motivational statement; following, answering a question, etc.		
- Resist Change	Arguing Interrupting Negating Not Following		
+ Change Talk	Problem recognition Concern Desire/intention to change Optimism for change		

Coder:_____

Timing Pass **Record time in decimal minutes, not minutes and seconds** (see chart)

Total Talk Time	**Therapist time:** _____._____ min	**Client time:** _____._____ min
Divide by:	**Total of therapist + client time**: _____._____ min	
to get:	**Percentage of therapist talk time**: _____ %	

MISC Summary Scores

The following behavioral indices are recommended as provisional summary indicators of the quality of motivational interviewing. These are derived from second-pass therapist behavior codes.

Ratio of Reflections to Questions (R/Q)

R/Q is the ratio of the number of Reflect responses to the total number of Questions asked.

Percent Open Questions (%OQ)

%OQ is a ratio in which the numerator is the number of Open Questions asked, and the denominator is the total number of Questions asked (open + closed).

Percent Complex Reflections (%CR)

%CR is a ratio in which the numerator is the number of Paraphrase + Summarize reflections, and the denominator is the total number of Reflections.

MI-Consistent Responses (MICO)

MICO responses are those directly prescribed (e.g., affirmation, emphasizing client control, reflection, reframing) in *Motivational Interviewing* (Miller and Rollnick 1991). MICO responses are:

Advise with permission
Affirm
Emphasize Control
Open Question
Reflect
Reframe
Support

MI-Inconsistent Responses (MIIN)

MIIN are those directly proscribed (e.g., giving advice without permission, confronting, directing, warning) in *Motivational Interviewing*. MIIN responses are:

Advise without permission
Confront
Direct
Raise Concern without permission
Warn

Percent MI-Consistent Responses (%MIC)

%MIC is a ratio in which the numerator is the number of MI-consistent responses (MICO), and the denominator is the number of MI-consistent plus MI-inconsistent responses (MIIN).

Percent Therapist Talk Time (%TTT)

%TTT is a ratio in which the numerator is the number of minutes of therapist talk time (TTT), and the denominator is the sum of therapist talk time (TTT) and client talk time.

Rates of Therapist Responses

The *rates* of therapist responses can also be informative. This takes into account the total talk time of a coded session. For example, one can compute the rate of reflections by dividing Total Reflections by the number of minutes of Total Talk Time (therapist + client). This can be standardized as the number of reflections per 10 minutes (RR10).

Client Responses

Percent Client Change Talk (%CTT)

Client responses can also be used as an indicator of the effectiveness of motivational interviewing. %CTT is a ratio in which the numerator is the number of client Change Talk (+) responses, divided by the sum of client Change Talk (+) plus client Resist Change (-) responses. Our data indicate that the absolute level of %CTT is less informative than the pattern of change in %CTT over the course of a counseling session.

Target Practice Behavior Criteria for Motivational Interviewing Training

Center on Alcoholism, Substance Abuse, and Addictions
University of New Mexico

Based on the performance of novice and expert therapists, we suggest the following as possible performance benchmarks for proficiency in motivational interviewing:

Behavioral Indicator	**Ideal (Expert) Level**	**Threshold Proficiency**
Global Therapist Ratings	> 6.0	> 5.0
Reflections to Questions Ratio (R/Q)	> 2.0	> 1.0
Percent Open Questions (%OQ)	> 70%	> 50%
Percent Complex Reflections (%CR)	> 50%	> 40%
Rate of Reflections per 10 minutes (RR10)	> 15	> 10
Percent MI-Consistent (%MICO)	> 90%	> 80%
Percent Therapist Talk Time (%TTT)	< 50%	< 60%

or said more plainly:

Talk less than your client does
Your most common response to what a client says should be a reflection
On average, reflect twice for each question you ask
When you reflect, use complex reflections more than half the time
When you do ask questions, ask mostly open questions
Avoid getting ahead of your client's level of readiness (warning, confronting, giving unwelcomed advice or direction, taking the "good" side of the argument)