Revised Global Scales:
Motivational Interviewing Treatment Integrity 3.0
(MITI 3.0)

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Learn, compare, collect the facts!
        Pavlov   1849-1936

How well or poorly is a practitioner using motivational interviewing? The MITI is a behavioral coding system that provides an answer to this question. The MITI also yields feedback that can be used to increase clinical skill in the practice of motivational interviewing. The MITI is intended to be used: 1) as a treatment integrity measure for clinical trials of motivational interviewing and 2) as a means of providing structured, formal feedback about ways to improve practice in non-research settings.

It should be noted that the MITI and its parent instrument, the Motivational Interviewing Skills Code (MISC), are not competing instruments for the same task. They are different tools designed to accomplish different tasks. The MISC is typically more useful in conducting detailed process research investigating the critical elements and causal mechanisms within motivational interviewing. It cannot be replaced by the MITI for these purposes. Alternatively, the MITI may be more useful when a simpler question is posed (how much is this treatment like motivational interviewing?) or when more targeted feedback is needed (how can our clinicians improve in their use of motivational interviewing?) for training. Specific differences between the MITI and the MISC are:

1) The MISC provides a comprehensive examination of interviewer and client behaviors, as well as the interaction between the two, while the MITI measures only interviewer behaviors.
2) The MISC may require up to three separate reviews or "passes" of the tape segment, while the MITI typically uses a single pass.
3) The MISC captures dimensions of the client's readiness to change and commitment language, while the MITI does not. Such client behavior can be important in predicting outcomes.
4) The MISC is a mutually exclusive and exhaustive coding system, but the MITI is not. Many specific behaviors that are coded in the MISC are collapsed into a single category in the MITI, or left uncoded entirely.

A.   COMPONENTS OF THE MITI

The MITI has two components: the global scores and the behavior counts.

A global score requires the coder to assign a single number from a five-point scale to characterize the entire interaction. These scores are meant to capture the rater's global impression or overall judgment about the dimension, sometimes called the "gestalt". Five global dimensions are rated: Evocation, Collaboration, Autonomy/Support, Direction, and Empathy. This means that each MITI review will contain five global scores.

A behavior count requires the coder to tally instances of particular interviewer behaviors. These running tallies occur from the beginning of the segment being reviewed until the end. The coder is not required to judge the quality or overall adequacy of the event, as with global scores, but simply to count it.

Typically both the global scores and behavior counts are assessed within a single review of the tape, and typically a random 20-minute segment is used. Careful attention should be paid to ensuring that the sampling of the tape segments is truly random, especially within clinical trials, so that proper inferences about the overall integrity of the MI intervention can be drawn.

The tape may be stopped as needed, however excessive stopping and restarting in actual coding (as opposed to training or group review) may disrupt the ability of the coder to form a gestalt impression needed for the global codes. Coders may therefore decide to use two passes through the tape until they are proficient in using the coding system. In that case, Pass One should be used for the global scores and Pass Two for the behavior counts.

B.   DESIGNATING A TARGET BEHAVIOR

An important component of using motivational interviewing well involves the interviewer's attention to facilitating change of a particular behavior or problem. Skillful interviewers will attempt to reinforce and elicit client change talk about that specific change when they can. Coders should know, in advance of the coding task, what is the designated target behavior for the intervention, assuming that there is one. This will allow coders to judge more accurately whether the clinician is directing interventions toward the target behavior, is floundering or hopelessly lost. The MITI is not designed to be used for interventions in which a target behavior cannot be identified.

C.   GLOBAL SCORES

"What is the short meaning of a long speech?"
                         Schiller (1759-1805)

Global scores are intended to capture the rater's overall impression of how well or poorly the interviewer meets the intent of the scale. While this may be accomplished by simultaneously evaluating a variety of elements, the rater's gestalt or all-at-once judgment is paramount. The global scores should reflect the holistic evaluation of the interviewer, one that cannot necessarily be separated into individual elements. Global scores are given on a five-point Likert scale, with the coder assuming a beginning score of "3" and moving up or down from there.

In the MITI 3.0, the Spirit global rating has been parsed into three global ratings: Evocation, Collaboration, and Autonomy/Support. These ratings are not orthogonal; rather they may be related and influenced by each other. Evocation, Collaboration, and Autonomy/Support are averaged together to yield a Spirit global. It is recommended that you average to two decimal points.

Evocation				
Low				High
1	2	3	4	5
Clinician actively provides reasons for change, or education about change, in the absence of exploring client's knowledge, efforts or motivation.	Clinician relies on education and information giving at the expense of exploring client's personal motivations and ideas.	Clinician shows no particular interest in, or awareness of, client's own reasons for change and how change should occur. May provide information or education without tailoring to client circumstances.	Clinician is accepting of client's own reasons for change and ideas about how change should happen when they are offered in interaction. Does not attempt to educate or direct if client resists.	Clinician works proactively to evoke client's own reasons for change and ideas about how change should happen.

This scale is intended to measure the extent to which the clinician conveys an understanding that motivation for change, and the ability to move toward that change, reside mostly within the client and therefore focuses efforts to elicit and expand it within the therapeutic interaction.

Low on Scale

Clinicians low on this scale have only superficial interest in the client's ambivalence or reasons for change, and miss opportunities to explore these in detail. They may make assumptions about the client's intent to change (or not change) without exploring this in detail, or may ignore the client's ideas when they are offered. Clinicians low in *Evocation* may rely on persistent fact gathering or information-giving as a means of facilitating change, and often convey a distrust of the client's current knowledge base about the problem under consideration. Clinicians on the low end of this scale do not respond to change talk when it is offered, or do so in a perfunctory manner. They are likely to *provide* the clients with reasons to change, rather than *eliciting* them.

High on Scale

Clinicians high on this scale are curious about their clients' personal and unique ideas about why change is a good idea or might not be. They not only follow up on these ideas when the client offers them, but also actively seek to explore them when the client does not. Although they might provide information or education, clinicians high in evocation do not rely on it as a means of helping clients to change. Instead, they prioritize exploration of the client's personal reasons for change and the means to go about it, and do not allow this exploration to be neglected amid other content or information in the session. Clinicians high on the *Evocation* scale understand the value of hearing the client's own language in favor of change, and actively create opportunities for that language to occur.

Verbal Anchors

1. Clinician actively provides reasons for change, or education about change, in the absence of exploring client's knowledge, efforts or motivation.

Examples:

- Ignores or misunderstands client statements about target behavior
- Rigidly provides education although client indicates prior knowledge
- Uses list of questions that do not account for uniqueness of client's response
- Dismisses or ignores client contributions
- Lack of curiosity about client circumstances
- Attempts to talk client into changing

2. Clinician relies on education and information giving at the expense of exploring client's personal motivations and ideas.

Examples:
- Does not incorporate client contributions into discussions about change
- Vague or incomplete efforts to respond to client change talk
- Mild or superficial interest in client views and circumstances

3. Clinician shows no particular interest in or awareness of client's own reasons for change and how change should occur. May provide some information or education without tailoring to client circumstances.

Examples:
- Misses opportunities to investigate client motivation for change (for example, by discussing past successes when mentioned)
- Neutral regarding client views and circumstances
- Occasional responses to client change talk

4. Clinician is accepting of client's own reasons for change and ideas about how change should happen when they are offered in interaction. Does not attempt to educate or direct if client resists.

Examples:
- Permits client's ideas about change and motivation to provide direction for interview
- Acknowledges client reasons for change at face value when offered, but does not elicit or elaborate
- Consistently responds to change talk when it occurs with reflections, elaborating questions or interest

5. Clinician works proactively to evoke client's own reasons for change and ideas about how change should happen.

Examples:
- Curious about client's ideas and experiences, especially regarding target behavior
- Helps client talk self into changing
- Uses structured therapeutic tasks as a way of reinforcing and eliciting change talk
- Does not miss opportunities to explore more deeply when client offers reasons for change
- Seeks client's ideas about change and motivation to provide direction to interview
- Strategically elicits change talk and consistently responds to it when offered

Collaboration

Low				High
1	2	3	4	5
Clinician actively assumes the expert role for the majority of the interaction with the client. Collaboration is absent.	Clinician responds to opportunities to collaborate superficially.	Clinician incorporates client's goals, ideas and values but does so in a lukewarm or erratic fashion. May not perceive or may ignore opportunities to deepen client's contribution to the interview.	Clinician fosters collaboration and power sharing so that client's ideas impact the session in ways that they otherwise would not.	Clinician actively fosters and encourages power sharing in the interaction in such a way that client's ideas substantially influence the nature of the session.

This scale measures the extent to which the clinician behaves as if the interview is occurring between two equal partners, both of whom have knowledge that might be useful in the problem under consideration.

Low on Scale
Clinicians low in *Collaboration* do not work towards a mutual understanding during the session. They rely on one-way communication based on the clinician's authority and expertise for progress. They may be dismissive, overly passive or so acquiescent that they do not make a genuine contribution to the interaction. These clinicians rely on their knowledge to respond to the client's problem and do not appear to value the client's knowledge. They are often ahead of their clients in prescribing both the need for change and the means to achieve it. Their interactions with clients appear more like wrestling than dancing.

High on Scale
Clinicians high in *Collaboration* work cooperatively with the client toward the goals of the interview. They do not rely on dominance, expertise or authority to achieve progress. They are curious about client ideas, and are willing to be influenced by them. These clinicians can hold the reins on their own expertise, using it strategically and not before the client is ready to receive it. Clinicians high in *Collaboration* appear to be dancing with their clients during an interview—one moment leading, the next following—in seamless motion.

Verbal Anchors
1. Clinician actively assumes the expert role for the majority of the interaction with the client. Collaboration is absent.

Examples:
- Explicitly takes the expert role
- Denies or minimizes client ideas
- Dominates conversation
- Argues when client offers alternative approach
- Is passive, disconnected or dismissive

2. Clinician discourages collaboration or responds to opportunities superficially.

Examples:
- Difficulty surrendering expert role
- Superficial querying of client input
- Often sacrifices opportunities for mutual problem solving in favor of supplying knowledge or expertise
- Minimal response to client input
- Distracted or impatient with client

3. Clinician incorporates client's goals, ideas and values but does so in a lukewarm or erratic fashion. May not perceive or may ignore opportunities to deepen client's contribution to the interview.

Examples:
- May take advantage of opportunities to collaborate, but does not structure interaction to solicit this
- Some connected following, but superficial
- Can yield floor most of the time, but instances of disagreeing
- Sacrifices some opportunities for mutual problem solving in favor of supplying knowledge or expertise

4. Clinician fosters collaboration and power sharing so that client's ideas impact the session in ways that they otherwise would not.

Examples:
- Some structuring of session to insure client input
- Solicits client views
- Engages client in problem solving
- Does not insist on resolution unless client is ready

5. Clinician actively fosters and encourages power sharing in the interaction in such a way that client's ideas substantially influence the direction and outcome of the session.

Examples:
- Actively structures session in a manner that facilitate client input
- Querying client ideas
- Incorporating client suggestions
- Actively "mines" for client input
- Explicitly identifying client as the expert
- Tempers advice giving and expertise depending on client input

Autonomy/Support				
Low				High
1	2	3	4	5
Clinician actively detracts from or denies client's perception of choice or control.	Clinician discourages client's perception of choice or responds to it superficially.	Clinician is neutral relative to client autonomy and choice.	Clinician is accepting and supportive of client autonomy.	Clinician adds significantly to the feeling and meaning of client's expression of autonomy, in such a way as to *markedly expand client's experience of own control and choice.*

This scale is intended to convey the extent to which the clinician supports and actively fosters client perception of choice as opposed to attempting to control the client's behavior or choices. Scores on the autonomy scale include the avoidance of particular behaviors *and* proactively pursuing strategies to enhance autonomy or support.

Low on Scale
Clinicians low on *Autonomy/Support* view the client as incapable of moving in the direction of health without input from clinician. They may assume that the client will change their behavior in the direction that the clinician thinks is best. The clinician may explicitly tell that client that he or she has no choice. In addition, the clinician may imply that external consequences (such as arrest, coercion from others) have removed choice. Clinicians may also insist that there is only one way to approach a target behavior or they may be pessimistic or cynical about the client's ability to change. Clinicians low on *Autonomy/Support* may convey choices but do so dismissively or with sarcasm.

*Note: Do *not* lower Autonomy/Support scores if the clinician is empathizing with the client's perceived lack of choices, hopelessness or resentment about current circumstance.

High on Scale
Clinicians high on *Autonomy/Support* ensure, either directly or implicitly, that the topic of choice and control is raised in session. They view the client as having the potential to move in the direction of health. Clinicians high on this scale work to help the client recognize choices with regard to the target behavior. In addition, clinicians may explicitly acknowledge that the client has the choice to change or maintain the status quo. They may also express an optimism about the client's ability to change.

Verbal Anchors
1. Clinician actively detracts from or denies client's perception of choice or control.

Examples:
- Explicitly states that client does not have a choice
- Implies that external consequences remove choice
- Is pessimistic, cynical or sarcasm in exploring options and choices
- Rigid about change options

2. Clinician discourages client's perception of choice or responds to it superficially.

Examples:
- Does not elaborate or attend to topic of choice when raised by client
- Minimizing client choice or superficially attending to it
- Dismissing topic of choice after acknowledging it
- Absence of genuineness when discussing client's choice
- Actively ignores client choice when client brings it up

3. Clinician neutral relative to client autonomy and choice.

Examples:
- Does not deny options or choice, but makes little effort to actively instill it
- Does not bring up topic of choice in the interview

4. Clinician is accepting and supportive of client autonomy.

Examples:
- Explores clients options genuinely
- Agrees when client states he cannot be forced to change

5. Clinician adds significantly to the feeling and meaning of client's expression of autonomy, in such a way as to *markedly expand client's experience of own control and choice.*

Examples:
- Clinician is proactive in eliciting comments from the client that lead to a greater perceived choice regarding the target behavior
- Explores options in deeply genuine and non-possessive manner
- Explicitly acknowledges client option not to change without sarcasm
- Provides multiple opportunities to discuss client's options and ability to control if client does not respond at first attempt
- Gives credence to client's ideas about change and motivation

Direction				
Low				High
1	2	3	4	5
Clinician does not influence the topic or course of the session, and discussion of the target behavior is entirely in the hands of client.	Clinician exerts minimal influence on the session and misses most opportunities to direct client to the target behavior.	Clinician exerts some influence on the session, but can be easily diverted away from focus on target behavior.	Clinician generally able to influence direction of the session toward the target behavior; however, there may be lengthy episodes of wandering when clinician does not attempt to re-direct.	Clinician exerts influence on the session and generally does not miss opportunities to direct client toward the target behavior or referral question.

This scale measures the degree to which clinicians maintain appropriate focus on a specific target behavior or concerns directly tied to it. Unlike the other global scales, clinicians high scores on this scale do not necessarily reflect better use of MI.

Low on Scale
Clinicians low in *Direction* exert little influence concerning the topic and course of the session. They do not appear to explore any particular behavior change on the part of the client, and do not take opportunities to bring change into the discussion. Sessions with clinician low in *Direction* may lack structure, and are likely to have an aimless quality. Clients may end up discussing any topic of interest to them, without attempts by the clinician to focus on any particular troublesome behavior. The clinician may accept an excessive focus on historical topics or theoretical explanations that divert attention from changing a current behavior. Clinicians low in *Direction* appear to lack a compass to help them move the session toward to a specific, desirable end.

High on Scale
Clinicians high in *Direction* exert substantial influence concerning the topic and course of the session. They are transparent in their focus on a target behavior or referral question and they make consistent efforts to return to the target behavior when conversation wanders. A clinician who is domineering and unyielding in their focus on the problem at hand would score high in Direction, however clinicians high in *Direction* need not be harsh or authoritarian. They may exert direction by selectively reinforcing client discussion toward the possibility of concern or change with regard to the target behavior. Clinicians high in Direction seem to use a compass to implement course corrections when the focus of the session drifts too far away from the target behavior.

Verbal Anchors
1. Clinician does not influence the topic or course of the session, and discussion of the target behavior is entirely in the hands of client.

Examples:
- Fails to provide structure for session

- Session is almost entirely focused on topics only tangentially related to a current problem
- Clinician focuses discussion on client's personality, childhood or trauma history with only superficial attention to target behavior
- Clinician engages in non-directive, client-centered listening
- Passively follows as the client wanders off in various directions
- A target behavior is not stated or cannot be inferred from the session

2. Clinician exerts minimal influence on the session and misses most opportunities to direct client to the target behavior.

Examples:
- Provides some structure, but session wanders markedly from stated intent
- Some discussion of target behavior, but majority of session is spent on other topics
- Clinician makes only superficial attempts to tie client's discourse to target behavior
- Most of the session is spent in non-directive, client-centered listening with no evidence of selective reinforcement toward consideration of target behavior

3. Clinician exerts some influence on the session, but is easily diverted away from focus on target behavior.

Examples:
- Clinician provides some structure for session, but is inconsistent in following it
- Clinician provides some selective reinforcement of client discourse regarding target behavior, but does so inconsistently
- Clinician is willing to bring up target behavior, but is easily diverted
- Clinician focuses substantial parts of session on off-target discussion
- Balance of session time spent on discussing history rather than present or future

4. Clinician generally able to influence direction of the session toward target behavior; however, there may be lengthy episodes of wandering when clinician does not attempt to re-direct.

Examples:
- Clinician makes modest attempts to use stated plan for session
- A target behavior is apparent but the clinician seems uncertain about whether to focus attention on it
- Clinician can easily be diverted by the client away from the target behavior
- Clinician misses several opportunities to turn the conversation toward the target behavior once it wanders

5. Clinician exerts influence on the session and generally does not miss opportunities to direct client toward the target behavior or referral question.

Examples:
- Agenda-setting mentions the target behavior

- Clinician is transparent in concern about the target behavior
- Clinician manages time well and transitions between therapeutic tasks smoothly
- Clinician consistently and smoothly directs the client's discourse toward change of a target behavior
- Balance of time in the session is spent discussing possible change, rather than the history of the problem
- Clinician dominates session and does not allow client to wander from target behavior

Empathy				
Low				High
1	2	3	4	5
Clinician has no apparent interest in client's worldview. Gives little or no attention to the client's perspective.	Clinician makes sporadic efforts to explore the client's perspective. Clinicians' understanding may be inaccurate or may detract from the client's true meaning.	Clinician is actively trying to understand the client's perspective, with modest success.	Clinician shows evidence of accurate understanding of client's worldview. Makes active and repeated efforts to understand client's point of view. Understanding mostly limited to explicit content.	Clinician shows evidence of deep understanding of client's point of view, not just for what has been explicitly stated but what the client means but has not yet said.

This scale measures the extent to which the clinician understands or makes an effort to grasp the client's perspective and feelings: literally, how much the clinician attempts to "try on" what the client feels or thinks. Empathy should not be confused with warmth, acceptance, genuineness, or client advocacy; these are independent of the empathy rating. Reflective listening is an important part of this characteristic, but this global rating is intended to capture all efforts that the clinician makes to understand the client's perspective and convey that understanding to the client.

Low on Scale
Clinicians low in *Empathy* show indifference or active dismissal of the client's perspective and experiences. They may probe for factual information or to pursue an agenda, but they do so to "build a case" for their point of view, rather than for the sole purpose of understanding the client's perspective. There is little effort to gain a deeper understanding of complex events and emotions, and questions asked reflect shallowness or impatience. They might express hostility toward the client's viewpoint or directly blame the client for negative outcomes.

High on Scale
Clinicians high in *Empathy* approach the session as an opportunity to learn about the client. They are curious. They spend time exploring the client's opinions and ideas about the target behavior especially. Empathy is evident when providers show an active interest in understanding what the client is saying. It can also be apparent when the clinician accurately follows or perceives a complex story or statement by the client or probes gently to gain clarity.

Verbal Anchors
1. Clinician has no apparent interest in client's worldview. Gives little or no attention to the client's perspective.

Examples:
- Asking only information-seeking questions (often with an ulterior motive)
- Probing for factual information with no attempt to understand the client's perspective

2. Clinician makes sporadic efforts to explore the client's perspective. Clinicians' understanding may be inaccurate or may detract from the client's true meaning.

Examples:
- Clinician offers reflections but they misinterpret what the client had said.
- Clinician displays shallow attempts to understand the client.

3. Clinician is actively trying to understand the client's perspective, with modest success.

Examples:
- Clinician displays average empathy to client.
- Clinician may offer a few accurate reflections, but may miss the client's point.
- Clinician makes an attempt to grasp the client's meaning throughout the session, but does so with mild success.

4. Clinician shows evidence of accurate understanding of client's worldview. Makes active and repeated efforts to understand client's point of view. Understanding mostly limited to explicit content.

Examples:
- Clinician conveys interest in the client's perspective or situation
- Clinician offers accurate reflections of what the *client has said.*
- Clinician effectively communicates understanding of the client's viewpoint.

5. Clinician shows evidence of deep understanding of client's point of view, not just for what has been explicitly stated but what the client means and has not said.

Examples:
- Clinician effectively communicates an understanding of the client *beyond* what the client says in session.
- Showing great interest in client's perspective or situation
- Attempting to "put self in client's shoes"
- Often encouraging client to elaborate, beyond what is necessary to merely follow the story
- Using many accurate complex reflections

D.   BEHAVIOR COUNTS

"It has long been an axiom of mine that the little things are infinitely the most important."
> Sherlock Holmes (A.Conan Doyle, 1892)
> A Case of Identity

Behavior counts are intended to capture specific behaviors without regard to how they fit into the overall impression of the interviewer's use of MI. While the context of the exchange will have some influence on the rater, behavior counts will *generally* be determined as a result of categorization and decision rules (rather than attempting to grasp an overall impression). Relying on inference to determine a behavior count is to be avoided.

Parsing Interviewer Speech to Assign Behavior Codes

An utterance is defined as a complete thought. An utterance ends when one thought is completed. A new utterance begins when a new idea is introduced. One utterance can succeed another in the flow of the interviewer's speech, as with a sentence that conveys successive ideas. A client response always terminates an interviewer utterance, and the next interviewer response following client speech is therefore always a new utterance.

Not all interviewer utterances will receive behavior codes. Unlike the MISC, the MITI does not represent an exhaustive list of all possible codes; therefore, some clinician utterances will likely remain uncoded. Although they are not exhaustive, MITI codes are mutually exclusive, such that the same utterance does not receive more than one code.

Any utterance may be assigned one of six primary behavior codes. Within three categories, further sub-classification is required. As mentioned before, each utterance receives one and only one code: the same utterance may not receive more than one code. However, consecutive utterances, even if they occur in the same sentence, may *each* receive different codes. Thus, in the course of a relatively long reply, if a clinician reflects, then confronts, then asks a question, these could each qualify for a distinct behavior count, assuming they are separate utterances (ideas).

A volley is defined as uninterrupted sequence of utterances by the interviewer. Once a behavior code is assigned once within the volley, it is not assigned again. A volley may contain only one of each behavior code.

Consider the following interviewer statement:

> Well, let me ask you this: since you've been forced to come here and since you're feeling like everyone's kind of pecking on you like a crow, there's a bunch of crows flying around pecking on you about this thing about your drinking, what would you like to do with the time you spend here? What would be helpful for you?

This statement is parsed in the following way:

> Utterance One: Well, let me ask you this: since you've been forced to come here and since you're feeling like everyone's kind of pecking on you like a crow,

there's a bunch of crows flying around pecking on you about this thing with your drinking,

Utterance Two: What would you like to do with the time you spend here? What would be helpful for you?

What about this interviewer statement?

What you say is absolutely true, that it is up to you. No one makes that choice for you. No one can make that choice for you. Even if your wife wanted to decide for you, or your employer wanted to decide for you, or I wanted to decide for you; nobody can. It really is completely your own choice; how you live your life, what you do about drugs, where you're headed; so that is yours. And what I hear you struggling with is, "what do I want? Is it time for me to change things? Is this drug test a wake-up call?"

We've parsed it like this:

Utterance One: What you say is absolutely true, that it is up to you. No one makes that choice for you. No one can make that choice for you. Even if your wife wanted to decide for you, or your employer wanted to decide for you, or I wanted to decide for you; nobody can. It really is completely your own choice; how you live your life, what you do about drugs, where you're headed; so that is yours.

Utterance Two: And what I hear you struggling with is, "what do I want? Is it time for me to change things? Is this drug test a wake-up call?"

Behavior Codes

1. **Giving Information**

This category is used when the interviewer gives information, educates, provides feedback or discloses personal information. When the interviewer gives an opinion, without advising, this category would be used. No subcodes are assigned for giving information. Specific examples of Giving Information include:

1a. *Providing Feedback from assessment instruments*

> You indicated during the assessment that you typically drink about 18 standard drinks per week. This places you in the 96th percentile for American men your age. (Giving Information)

> * Note that this is not a reflection. Reviewing information contained on assessment instruments does not typically qualify as a reflection, although the reflection code MAY be given if the interviewer skillfully emphasizes or enriches the material the client has given.

1b. *Personal Feedback about the client that is not already available.*

> Your doctor tells me you've been struggling with your glycemic control. (Giving Information)

> I talked to your wife and she said she was really worried about your drinking. (Giving Information)

1c. *Explaining ideas or concepts relevant to the intervention*

> This homework assignment on logging your cravings is important because we know that cravings often lead to relapses. A craving is like a warning bell, telling you to do something different. (Giving Information)

1d. *Educating about a topic*

> Individuals who eat five fruits and vegetables each day reduce their cancer risk five fold. For certain kinds of cancer, like colon cancer, it's even more of a reduction. (Giving Information)

> If I do find that you've relapsed, I'll have to disclose that to your probation officer. (Giving Information; coder may consider MI Inconsistent instead)

Coders need not distinguish among types of Giving Information. Once the coder has decided that the behavior is either one or another item in this category, she assigns the Giving Information code without further distinction.

Differentiating Giving Information from MI Non-Adherent Behaviors
Giving information should not be confused with giving advice, warning, confronting, or directing.

> You indicated during the assessment that you typically drink about 18 standard drinks per week. This far exceeds social drinking. (MI Inconsistent)

> Keep track of your cravings, using this log, and bring it in next week to review with me. (Direct)

> Well, you are only eating two fruits per day according to this chart, even though you said you are eating five. It can be easy to deceive yourself. (Confront)

> It worked for me, and it will work for you if you give it a try. We need to find the right AA meeting for you. You just didn't find a good one. (Advice)

2. **Questions**

2a. *Closed Question*

This behavior code is used when the interviewer asks the client a question that can be answered with a "yes" or "no" response.

> Did you use heroin this week?
> Did you eat five fruits and vegetables this week?
> Have you been having trouble with your memory?

It is also coded when the question specifies a very restricted range or one that is intended to satisfy a questionnaire.

> How long have you been using heroin?
> How many fruits and vegetables did you eat each day this week?
> Who is the president of the United States?

2b. *Open Question*

An open question is coded when the interviewer asks a question that allows a wide range of possible answers. The question may seek information, may invite the client's perspective or may encourage self-exploration. The open question allows the option of surprise for the questioner.

"Tell me more" statements are coded as open questions unless the tone and context clearly indicate a Direct or Confront code.

> How did it go with your heroin cravings since we last met?
> Tell me about your fruit and vegetable intake this week.
> What is your take on that?

In general, stacked questions (before the client gives an answer), are coded as only one question. Sometimes a clinician will stack questions by asking an 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 one open and two closed questions).

> In what ways has your drinking caused problems for you? Has it caused 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.

2c. *Questions-trying-to-be-reflections*

Occasionally the interviewer will offer a statement that otherwise meets the criteria for a reflection, but is given with an inflection at the end (thereby making it "sound like" a question). These statements are coded as Questions (either open or closed), NOT as reflections.

3. **Reflection**

This category is meant to capture reflective listening statements made by the clinician *in response to* client statements. A Reflection may introduce new meaning or material, but it essentially captures and returns to clients something about what they have just said. Reflections must be further categorized into Simple or Complex categories.

3a. *Simple Reflection*

Simple reflections typically convey understanding or facilitate client/clinician exchanges. These reflections add little or no meaning (or emphasis) to what clients have said. Simple reflections may mark very important or intense client emotions, but do not go far beyond the client's original intent in the statement. Clinician summaries of several client statements may be coded as simple reflections *if* the clinician does not use the summary to add an additional point or direction.

3b. *Complex Reflection*

Complex reflections typically add substantial meaning or emphasis to what the client has said. These reflections serve the purpose of conveying a deeper or more complex picture of what the client has said. Sometimes the clinician may choose to emphasize a particular part of what the client has said to make a point or take the conversation in a different direction. Clinicians may add subtle or very obvious content to the client's words, or they may combine statements from the client to form summaries that are complex in nature.

Speeding Tickets
Client: This is her third speeding ticket in three months. Our insurance is going to go through the roof. I could just kill her. Can't she see we need that money for other things?
Interviewer: You're furious about this. (Reflection, Simple)
Interviewer: This is the last straw for you. (Reflection, Complex)

Controlling Blood Sugar
Interviewer: What have you already been told about managing your blood sugar levels? (Open Question)
Client: Are you kidding? I've had the classes, I've had the videos, I've had the home nurse visits. I have all kinds of advice about how to get better at this, but I just don't do it. I don't know why. Maybe I just have a death wish or something, you know?
Interviewer: You are pretty discouraged about this. (Reflection, Simple)
Interviewer: You haven't given it your best effort yet. (Reflection, Complex)

Mother's Independence
Client: My mother is driving me crazy. She says she wants to remain independent, but she calls me four times a day with trivial questions. Then she gets mad when I give her advice.
Interviewer: Things are very stressful with your mother. (Simple Reflection)
Interviewer: You're having a hard time figuring out what your mother really wants. (Reflection, Complex)
Interviewer: Are you having a hard time figuring out what your mother really wants? (Closed Question)
Interviewer: What do you think your mother really wants? (Open Question)

3c. DECISION RULE: When a coder cannot distinguish between a simple and complex reflection, the simple designation should be used. Default category: simple.

3d. *Reflection and Question in Sequence*

Sometimes the interviewer begins with a reflection, but adds a question to "check" the reliability of the reflection (either open or closed). Both elements should be coded.

> So you don't ever want to use heroin again. Is that right? (Reflection, Closed Question)

> Your boss said you can't work overtime anymore. What do you make of that? (Reflection, Open Question)

3e. *Reflections-Turned-Into-Questions*

Occasionally the interviewer will offer a statement that otherwise meets the criteria for a reflection, but is given with an inflection at the end (thereby making it "sound like" a question). These statements are coded as Questions (either open or closed) NOT as reflections (see 2c.).

4. **MI Adherent**

This category is used to capture particular interviewer behaviors that are consistent with a motivational interviewing approach. Coders may be tempted to code especially good examples of MI practice in one of these categories, even if they do not genuinely "fit". Instead, the coder should consider such examples within the overall rating assigned for Global Ratings, as appropriate, reserving the MI Consistent behavior counts for the designated behaviors only. The MI Adherent Category is comprised of:

4a. Asking permission before giving advice or information or asking what the client already knows or has already been told about a topic *before* giving advice or information. Permission is implied when the client asks directly for the information or advice and the clinician is answering. Indirect forms of permission can also occur, such as when the clinician invites the client to disregard the advice as appropriate.

> I have some information about how to reduce your risk of colon cancer and I wonder if I might discuss it with you. (MI Adherent)

> What have you already been told about drinking during pregnancy? (MI Adherent)

> This may not be the right thing for you, but some of my clients have had good luck setting the alarm on their wristwatch to help them remember to check their blood sugars 2 hours after lunch. (MI Adherent)

> Note: when permission is asked prior to advising, the MI Non-Adherent Code is *not* used for the subsequent advice. The entire volley is coded as MI Adherent.

4b. Affirming the client by saying something positive or complimentary. Affirming may also take the form of commenting on the client's strengths, abilities or efforts in any area (not simply related to the target behavior).

> You are the kind of person that, once you make up your mind, you usually get the job done. (MI Adherent)

> It's important to you to be a good parent, just like your folks were for you. (MI Adherent)

4c. Emphasizing the client's control, freedom of choice, autonomy, ability to decide.

> Yes, you're right. No one can force you stop drinking. (MI Adherent)

> You're the one who knows yourself best here. What do you think ought to be on this treatment plan? (MI Adherent)

> The number of fruits and vegetables you choose to eat is really up to you. (MI Adherent)

> You've got a point there. (MI Adherent)

4d. Supporting the client with statements of compassion or sympathy.

> With the parking problems and the rain coming down, it hasn't been easy to get here. (MI Adherent)

> I know it's really hard to stop drinking. (MI Adherent)

Well, there is really a lot going on for you right now. (MI Adherent)

No differentiating subcodes are assigned to the MI Adherent behaviors. The rater merely identifies them as belonging to this category and assigns the MI Adherent code.

4e. DECISION RULE: The MI Adherent code takes precedence when the utterance *clearly* falls into the MI Adherent category. When in doubt, an alternate code (for example, Open Question or Reflection) should be given.

5. **MI Non-Adherent**

This category is used to capture those interviewer behaviors that are inconsistent with a motivational interviewing approach. No differentiating subcodes are assigned to the MI Non-Adherent behaviors. The rater merely identifies them as belonging to this category and assigns the MI Non-Adherent code.

5a. Advising without permission by making suggestions, offering solutions or possible actions without first obtaining permission from the client. Language usually, but not always, includes words such as: should, why don't you, consider, try, suggest, advise, how about, you could, etc. Note that if the interviewer first obtains permission either directly or indirectly, *before* advising, the code would be different.

What about trying to get a ride from a friend? (MI Non-Adherent)

Checking your blood sugars five times a day is best in the beginning. (MI Non-Adherent)

It might not be as bad as you think. People are usually civil if you give them a chance. (MI Non-Adherent)

5b. Confronting the client by directly and unambiguously disagreeing, arguing, correcting, shaming, blaming, criticizing, labeling, moralizing, ridiculing, or questioning the client's honesty. Such interactions will have the quality of uneven power sharing, accompanied by disapproval or negativity. Included here are instances where the interviewer uses a question or even a reflection, but the voice tone clearly indicates a confrontation.

Restating negative information already known or disclosed by the client can be either a confront or a reflection. Most confrontations can be correctly categorized by careful attention to voice tone and context.

You were taking Antabuse but you drank anyway? (MI Non-Adherent)

You think that is any way to treat people you love? (MI Non-Adherent)

Yes, you are an alcoholic. You might not think so, but you are. (MI Non-Adherent)

Wait a minute. It says right here that your A1C is 12. I'm sorry, but there is no way you could have been counting your carbohydrates like you said if it's that high. (MI Non-Adherent)

5c. Directing the client by giving orders, commands or imperatives. The language is imperative.

Don't do that! (MI Non-Adherent)

Bring this homework back next week. (MI Non-Adherent)

You need to go to 90 meetings in 90 days (MI Non-Adherent)

Again, coders are not required to subcategorize MI Non-Adherent behaviors. Once a coder has decided that the behavior is either a Confront or a Direct (or has narrowed it down to any other two codes in this category), he assigns the MI Non-Adherent code and moves on.

5d. DECISION RULE: The MI Non-Adherent code takes precedence when the utterance *clearly* falls into the MI Non-Adherent category. When in doubt, an alternate code (for example, Giving Information) should be given.

Tantrums
Client: "What do you think I should do about these tantrums my child is having? You're the doctor."
Interviewer: "Solving this yourself hasn't worked, so you're finally willing to ask for help." (MI Non-Adherent)

Client: "What do you think I should do about these tantrums my child is having? You're the doctor."
Interviewer: "Your child is normal. These are not tantrums." (MI Non-Adherent)

E.   CHOOSING THE LENGTH AND TYPE OF THE CODED SEGMENT

The development of the MITI was done using 20-minute segments of therapy tapes. It may be possible to use the MITI for longer segments of tape (for example, the entire therapy session). We only caution that our attempt to increase the length of the coding segment was associated with 1) problems with sustained coder attention, 2) difficulty forming global judgments with increased data, and 3) logistical difficulties in obtaining uninterrupted work time in a busy setting.

Similarly, most of our initial data have been gathered using audiotapes rather than videotapes. The MITI can be used to code videotapes, but should not be altered to gather visual information.

F.   SUMMARY SCORES FOR THE MITI

Because critical indices of MI functioning are imperfectly captured by frequency counts, we have found that many applications of therapy coding are better served with summary scores computed from codes, rather than the individual scores themselves. For example, the ratio of reflections to questions provides a concise measure of an important MI process. Below is a partial list of summary scores that serve as outcome measures for determining competence in MI, as well as formulas for calculating them.

- Global Spirit Rating = (Evocation + Collaboration + Autonomy/Support) / 3

- Percent Complex Reflections (% CR)
  = Rc / Total reflections

- Percent Open Questions (% OC)
  = OQ / (OQ + CQ)

- Reflection-to-Question Ratio (R:Q)
  = Total reflections/(CQ + OQ)

- Percent MI Adherent (% MiA)
  = MiA / (MiA + MiNa)

G. TRAINING STRATEGY FOR THE MITI

Give me a fruitful error any time, full of seeds, bursting with its own corrections.
Pareto 1848-1923

Training coders to competency, as measured by interrater reliability and matching to a gold standard, usually requires a stepped learning process. We have found that coders do best beginning with fairly simple tasks, proceeding to more complex ones only when competence on the simpler tasks is solid. We recommend that coders begin by learning Level I tasks to an acceptable reliability standard prior to attempting Level II tasks. Only when acceptable standards for simultaneous I and II tasks have been accomplished should coders begin on Level III tasks. The self-review of MI text and video learning tools can be used at any time (perhaps as a prelude to beginning Level I tasks).

Behavior Count or Summary Score Thresholds	Beginning Proficiency	Competency
Global Clinician Ratings	Average of 3.5	Average of 4
Reflection to Question Ratio (R:Q)	1	2
Percent Open Questions (%OC)	50%	70%
Percent Complex Reflections (%CR)	40%	50%
Percent MI-Adherent (% MIA)	90%	100%

The use of pre-scored gold standard transcripts will assist in evaluating coder competency and areas for improvement. We have found that coders often have difficulty in one area or another, requiring a more intensive focus. Problem areas can be identified using standardized transcripts as a quiz for each level. More than one quiz per level is often needed. We have found that coders typically require 40 hours of training to reach interrater reliability using the MITI. In addition, regular (probably weekly) group coding sessions are optimal to insure drift does not occur. Clinical experience (i.e. being a clinician) has *not* predicted ease of training or eventual competence in our laboratory.

Level I   competencies: parsing utterances, giving information and open/closed questions
Level II competencies: add reflections, MiA and MiNa
Level III competencies: add global ratings

Below are recommended proficiency and competency thresholds for clinicians, based on the MITI coding system. Please note that these thresholds are based on EXPERT OPINION, and currently lack normative or other validity data to support them. We are in the process of gathering normative data for the revised MITI now. Until such normative data is available, these thresholds should be used in conjunction with other data to arrive at an assessment of clinician competency and proficiency in using MI.

Motivational Interviewing Treatment Integrity Code (MITI)
Coding Sheet   Revised June, 2007

Tape #_____   **Coder:**_____ **Date:**_____

Global Ratings

Evocation		1 2 3 4 5 Low High
Collaboration		1 2 3 4 5 Low High
Autonomy/ Support		1 2 3 4 5 Low High
Direction		1 2 3 4 5 Low High
Empathy		1 2 3 4 5 Low High

Behavior Counts

Giving Information			
MI Adherent	**Asking permission, affirm, emphasize control, support.**		
MI Non-adherent	**Advise, confront, direct.**		
Question (subclassify)	**Closed Question**		
	Open Question		
Reflect (subclassify)	**Simple**		
	Complex		
	TOTAL REFLECTIONS:		

First sentence:_____

Last sentence:_____

Revised 25 June 2007

List of MITI Codes

EVOCATION	(Global rating of evocation)
COLLABORATION	(Global rating of collaboration)
AUTONOMY/SUPPORT	(Global rating of Autonomy/Support)
DIRECTION	(Global rating of direction)
EMPATHY	(Global rating of empathy)
SPIRIT	(Global rating of MI Spirit; Average of Evocation, Collaboration, Autonomy/Support)
GI	(Giving Information)
MiA	(MI Adherent)
MiNa	(MI Non-adherent)
OQ	(Open Question)
CQ	(Closed Question)
Rs	(Reflection simple)
Rc	(Reflection complex)

Note: Coded transcripts of two MI interviews, taken from the Professional Training Series, are available to assist you in learning to use the MITI. For ease in learning, each interview is coded twice—once for global ratings and once for behavior counts—although in practice both tasks would usually be done simultaneously. These transcripts, along with the MITI manual itself, can be downloaded free of charge from.