Motivational Interviewing Treatment Integrity Coding Manual 4.2.1

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Revisions for 4.1

Text change in Persuade with Permission to clarify the length and extent of permission
Correction of formatting errors
Revision of examples

Revisions for 4.2

A. Sustain Talk

Added sentence to Softening Sustain Talk global indicating that therapists may receive high scores on this scale even if no sustain talk is present in the session. Also added this point as FAQ # 6.

Added FAQ to elaborate on use of sustain talk to build empathy and how this might be reflected in scoring for Softening Sustain Talk(FAQ #7)

Added FAQ to elaborate on how Softening Sustain Talk should be scored in decisional balance exercise (FAQ #8)

B. Change Talk

Added sentence to Cultivating Change Talk indicating that clinicians should not be penalized if clients do not offer change talk despite their efforts.

C. Seeking Collaboration

Added sentence to indicate that Seek Collaboration code need not be assigned when therapists are querying client's intellectual grasp of their statements (FAQ #9)

A. INTRODUCTION TO THE MITI

Purpose of the MITI

How well or poorly is a clinician 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 as a:

1) Treatment integrity measure for clinical trials of motivational interviewing.
2) Means of providing structured, formal feedback about ways to improve practice in non-research settings.
3) Component of selection criteria for training and hiring (for more information about this, see the FAQ section in Appendix B; in progress).

The MITI evaluates component processes within motivational interviewing, including engaging, focusing, evoking, and planning. Sessions without a specific change target or goal may not be appropriate for evaluation with the MITI (see Designating a Change Goal; Section C), although some of the elements may be useful for evaluating and giving feedback about engaging skills.

B. 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 an entire interaction. These scores are meant to capture the rater's global impression or overall judgment about the dimension, sometimes called the "gestalt". Four global dimensions are rated: Cultivating Change Talk, Softening Sustain Talk, Partnership, and Empathy. This means that each MITI review will contain four 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 overall quality of the event, as with global scores, but simply to count each instance of the behavior.

Typically, both the global scores and behavior counts are assessed within a single review of the audio recording. A random 20-minute segment is the recommended duration for a coding sample. Shorter or longer segments may be used, but caution is warranted in assigning and interpreting global scores for longer or shorter samples. Careful attention should be paid to ensure that the sampling of the segments is truly random, especially within clinical trials, so that proper inferences about the overall integrity of the MI intervention can be drawn.

The recording may be stopped as needed, but excessive stopping and restarting during 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 recording until they are proficient in using the coding system. In that case, the first pass should be used for the global scores and the second for the behavior counts.

C. DESIGNATING A CHANGE GOAL

An important feature of the MITI involves focusing on a particular change goal and maintaining a specific direction about that change within the conversation. Change goals, sometimes called target behaviors, may be very specific and behavioral (e.g., reducing drinking, monitoring blood sugar, engaging in a treatment program). *Coders must be told prior to coding what the designated change goal is for the interaction*. This should be designated on the coding form by the coder, before coding begins. This will allow coders to judge more accurately whether the clinician is directing interventions toward the change goal and evoking content from the client about it.

D. GLOBAL SCORES

Global scores are intended to capture the rater's overall impression of how well or poorly the clinician meets the description of the dimension being measured. Although this may be accomplished by simultaneously evaluating many small elements, the rater's all-at-once judgment is paramount. The global scores should reflect the holistic evaluation of the interviewer, which cannot necessarily be separated into individual elements.

Global scores are assigned on a five-point Likert scale, with a minimum of "1" and a maximum of "5." The coder assumes a default score of "3" and moves up or down as indicated. A "3" may also reflect mixed practice. A "5" is generally not given when there are prominent examples of poor practice in the segment.

Cultivating Change Talk				
Low				High
1	2	3	4	5
Clinician shows no explicit attention to, or preference for, the client's language in favor of changing	Clinician sporadically attends to client language in favor of change – frequently misses opportunities to encourage change talk	Clinician often attends to the client's language in favor of change, but misses some opportunities to encourage change talk	Clinician consistently attends to the client's language about change and makes efforts to encourage it	Clinician shows a marked and consistent effort to increase the depth, strength, or momentum of the client's language in favor of change

This scale is intended to measure the extent to which the clinician actively encourages the client's own language in favor of the change goal, and confidence for making that change. To achieve higher ratings on the Cultivating Change Talk scale, the change goal must be obvious in the session and the conversation must be largely focused on change, with the clinician actively cultivating change talk when possible. Low scores on this scale occur when the clinician is inattentive to the client's language about change, either by failing to recognize and follow up on it, or by prioritizing other aspects of the interaction (such as history-taking, assessment or non-directive listening). Interactions low in Cultivating Change Talk may still be highly empathic and clinically appropriate.

Care should be taken not to penalize clinicians if clients do not offer change talk or do not respond to efforts to evoke it.

Verbal Anchors

1. Clinician shows no explicit attention to, or preference for, the client's language in favor of changing.

Examples:

- Asks only for a history of the problem
- Structures the conversation to focus only on the problems the client is experiencing
- Shows no interest or concern for client values, strengths, hopes or past successes
- Provides education as only interaction with the client
- Supplies reasons for change rather than encouraging them from the client
- Ignores change talk when it is offered

2. Clinician sporadically attends to client language in favor of change – frequently misses opportunities to encourage change talk.

Examples:

- Superficial attention to client language about the change goal
- Fails to ask about potential benefits of change
- Lack of curiosity or minimal interest in client's values, strengths and past successes

3. Clinician often attends to the client's language in favor of change, but misses some opportunities to encourage change talk.

Examples:

- Misses opportunities to encourage client language in favor of change
- May give equal time and attention to sustain talk and change talk, for example using decisional balance after momentum for change is emerging

4. Clinician consistently attends to the client's language about change and makes efforts to encourage it.

Examples:

- More often than not, acknowledges client reasons for change and explores when they are offered
- Often responds to change talk with reflections that do not encourage deeper exploration from the client
- Expresses curiosity when clients offer change talk
- May explore client's values, strengths, hopes and past successes related to target goal

5. Clinician shows a *marked and consistent* effort to increase the depth, strength, or momentum of the client's language in favor of change.

Examples:

- Over a series of exchanges, the clinician shapes the client's language in favor of change
- Uses structured therapeutic tasks as a way of eliciting and reinforcing change talk
- Does not usually miss opportunities to explore more deeply when client offers change talk
- Strategically elicits change talk and consistently responds to it when offered
- Rarely misses opportunities to build momentum of change talk

Softening Sustain Talk				
Low				High
1	2	3	4	5
Clinician consistently responds to the client's language in a manner that facilitates the frequency or depth of arguments in favor of the status quo.	Clinician usually chooses to explore, focus on, or respond to the client's language in favor of the status quo.	Clinician gives preference to the client's language in favor of the status quo, but may show some instances of shifting the focus away from sustain talk.	Clinician typically avoids an emphasis on client language favoring the status quo.	Clinician shows a marked and consistent effort to decrease the depth, strength, or momentum of the clients language in favor of the status quo.

This scale is intended to measure the extent that the clinician avoids a focus on the reasons against changing or for maintaining the status quo. To achieve high scores, clinicians should avoid lingering in discussions concerning the difficulty or undesirability of change. Although therapists will sometimes choose to attend to sustain talk to build rapport, in general they should spend only as much time as needed to bring the discussion into more favorable territory for building motivation. High scores may also be achieved in the *absence* of sustain talk during a session, if the clinician does not engage in behaviors to evoke it. Low scores in Softening Sustain Talk are appropriate when clinicians focus considerable attention to the barriers of change, even when using MI-consistent techniques (e.g., asking open questions, offers reflections, affirmations and other MI Adherent techniques) to evoke and reflect sustain talk throughout the session.

1. Clinician consistently responds to the client's language in a manner that facilitates the frequency or depth of arguments in favor of the status quo.

Examples:

- Explicitly asks for arguments against change, queries difficulties
- Actively seeks elaboration when sustain talk is offered through questions, reflections, or affirmations
- Preferential attention and reinforcement of sustain talk when it occurs alongside change talk
- Sustained curiosity and focus about reasons not change

2. Usually chooses to explore, focus on, or respond to client's reasons to maintain the status quo.

Examples:

- Often deepens discussion of barriers or difficulties of change when client mentions them
- Asks about barriers to change on more than one occasion during the interview, even if the client does not bring up
- Often reflects benefits of the status quo

3. Clinician gives preference to the client's language in favor of the status quo, but may show some instances of shifting the focus away from sustain talk.

Examples:

- Some missed opportunities to shift focus away from sustain talk
- Attends to benefits of status quo even when client offers change talk

4. Clinician typically avoids an emphasis on client language favoring the status quo.

Examples:

- Does not explicitly ask for reasons not to change
- Minimal attention to sustain talk when it occurs
- Does not seek elaboration of sustain talk
- Lack of curiosity and focus on client's reasons to maintain the status quo
- Does not linger in discussions about barriers to change

5. Clinician shows a *marked and consistent* effort to decrease the depth, strength, or momentum of the client's language in favor of the status quo.

Examples:

- uses structured therapeutic task(s) to shift the focus of sustain talk toward the target change goal
- may use double-sided reflections (ending with a reflection of change talk) to move the conversation away from sustain talk

Partnership				
Low				High
1	2	3	4	5
Clinician actively assumes the expert role for the majority of the interaction with the client. Collaboration or partnership is absent.	Clinician superficially responds to opportunities to collaborate.	Clinician incorporates client's contributions but does so in a lukewarm or erratic fashion.	Clinician fosters collaboration and power sharing so that client's contributions 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 contributions substantially influence the nature of the session.

This scale is intended to measure the extent to which the clinician conveys an understanding that expertise and wisdom about change reside mostly within the client. Clinicians high on this scale behave as if the interview is occurring between two equal partners, both of whom have knowledge that might be useful in solving the change under consideration. Clinicians low on the scale assume the expert role for a majority of the interaction and have a high degree of influence in the nature of the interaction.

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

Examples:
- Explicitly takes the expert role by defining the problem, prescribing the goals, or laying out the plan of action
- Clinician actively forces a particular agenda for the majority of the interaction with the client
- Denies or minimizes client ideas
- Dominates conversation
- Argues when client offers alternative approach
- Often exhibits the righting reflex

2. Clinician superficially responds to opportunities to collaborate.

Examples:
- Clinician rarely surrenders the expert role
- Minimal or superficial querying of client input
- Often sacrifices opportunities for mutual problem solving in favor of supplying knowledge or expertise
- Minimal or superficial responses to client's potential agenda items, knowledge, idea, and /or concerns

- Occasionally may correct the client or refutes what the client has said

3. Clinician incorporates client's contributions but does so in a lukewarm or erratic fashion.

Examples:
- May take advantage of opportunities to collaborate, but does not structure interaction to solicit this
- Misses some opportunities to collaborate when initiated by the client
- The righting reflex is largely absent
- Sacrifices some opportunities for mutual problem solving in favor of supplying knowledge or advice
- Seems to be in a stand-off with the client; not wrestling and not dancing

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

Examples:
- Some structuring of session to ensure client input
- Searches for agreement on problem definition, agenda setting, and goal setting
- Solicits client views in more than a perfunctory fashion
- Engages client in problem solving or brainstorming
- Does not attempt to educate or direct if client "pushes back" with sustain talk
- 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 contributions substantially influence the nature of the session.

Examples:
- Genuinely negotiates the agenda and goals for the session
- Indicates curiosity about client ideas through querying and listening
- Facilitates client evaluation of options and planning
- Explicitly identifies client as the expert and decision maker
- Tempers advice giving and expertise depending on client input
- Clinician favors discussion of client's strengths and resources rather than probing for deficits

Empathy				
Low				High
1	2	3	4	5
Clinician gives little or no attention to the client's perspective.	Clinician makes sporadic efforts to explore the client's perspective. Clinician's 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 makes active and repeated efforts to understand the client's point of view. Shows evidence of accurate understanding of the client's worldview, although 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 experience (i.e., how much the clinician attempts to "try on" what the client feels or thinks). Empathy should not be confused with sympathy, warmth, acceptance, genuineness, support, 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.

Clinicians high on the Empathy scale show evidence of understanding the client's worldview in a variety of ways including complex reflections that seem to anticipate what clients mean but have not said, insightful questions based on previous listening and accurate appreciation for the client's emotional state. Clinicians low on the Empathy scale do not appear interested in the client's viewpoint.

Verbal Anchors
1. Clinician gives little or no attention to the client's perspective.

Examples:
- Asking only information-seeking questions
- Probing for factual information with no attempt to understand the client's perspective

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

Examples:
- Offers reflections but they often misinterpret what the client had said
- Displays shallow attempts to understand the client

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

Examples:

- May offer a few accurate reflections, but may miss the client's point
- Makes an attempt to grasp the client's meaning throughout the session

4. Clinician makes active and repeated efforts to understand the client's point of view. Shows evidence of accurate understanding of the client's worldview, although mostly limited to explicit content.

Examples:

- Conveys interest in the client's perspective or situation
- Offers accurate reflections of what the *client has said already*
- Effectively communicates understanding of the client's viewpoint
- Expresses that the client's concerns or experiences are normal or similar to others'

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:

- Effectively communicates an understanding of the client *beyond* what the client says in session
- Shows great interest in client's perspective or situation
- Attempts to "put self in client's shoes"
- Often encourages client to elaborate, beyond what is necessary to merely follow the story
- Uses many accurate complex reflections

E. BEHAVIOR COUNTS

Behavior counts are intended to capture specific behaviors without regard to how they fit into the overall impression of the clinician's use of MI. Unlike global ratings, behavior counts will generally be determined as a result of categorization and decision rules, rather than attempting to grasp an overall impression. Coders should avoid relying on inference to determine a behavior count whenever possible.

E.1. Parsing Interviewer Speech. The session segment can be broken down into volleys, which are defined as uninterrupted segments of clinician speech. A volley begins when the clincian begins speaking and is terminated by client speech (other than facilitive comments such as "yeah, right, good"). It is the equivalent of turn-taking in a conversation.

E.1.a. Parsing Rules. Clinician volleys are comprised of a single or multiple clinician utterances. An utterance is defined as a complete thought or a thought unit (Gottman, Markman, & Notarius, 1977; Weiss, Hops, & Patterson, 1973). Behavior codes are assigned to clinician utterances, although not all utterances will receive a behavior code (see F. Statements that Are Not Coded in the MITI).

Each utterance may receive only one behavior code and each volley earns each code only once. For example, "You are worried about your drinking" is an utterance that is assigned one code. Whereas, "You are worried about your drinking; has this been a problem before?" is parsed into two utterances, that each receive a separate code. Thus, in the course of a relatively long reply, if a clinician reflects, confronts, gives information, then asks a question, these could each qualify for a distinct behavior code. Similarly, if a clinician offers Emphasizing Autonomy and an Affirm in the same volley, both codes would be given. (**Note that this parsing rule for MI-Adherent and MI Non-Adherent utterances is different than previous versions of the MITI).

Reflections are handled differently. There is only one reflection code given per volley, regardless of the combination of simple and complex reflections in that volley. If any of the reflections are complex, then the Complex Reflection (CR) code is used. Otherwise, the reflection code is Simple Reflection (SR). For instance, if a clinician offers a simple reflection, asks a closed question, and then offers a complex reflection, the volley would receive two codes: complex reflection and question.

Finally, for questions, only one per volley is coded with the MITI 4.0. If multiple questions are offered within the same volley, the clinician will only receive a single Question behavior code.

The maximum possible number of codes per volley is 8. Only one of each of the following codes may be assigned per volley:

Giving Information (GI)
Persuade (Persuade or Persuade with)
Question (Q)
Reflection Simple (SR) or Complex (CR)
Affirm (AF)
Seeking Collaboration (Seek)
Emphasizing Autonomy (Emphasize)

Confront (Confront)

DECISION RULE: If the coder is not sure whether to parse or not, the default should be to decide in favor of *fewer parses*.

E.2. Parsing Examples:

E.2.a. 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— (Complex Reflection)
>
> Utterance Two: What would you like to do with the time you spend here? What would be helpful for you? (Seek)

E.2.b. What about this interviewer statement?

> What you say is absolutely true, that it is up to you. No one makes 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. 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. (Emphasizing Autonomy)
>
> 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?" (Complex Reflection)

E.2.c. What about this interviewer statement?

> To answer your question, it is recommended that people eat at least 5 servings of fruit and vegetables each day. Of course, you are the only one who can determine what works for you in this regard. How many more a day would that be? I mean, can you do it?

We've parsed it like this:

> Utterance One: To answer your question, it is recommended that people eat at least 5 servings of fruit and vegetables each day. (Giving Information)
>
> Utterance Two: Of course, you are the only one who can determine what works for you in this regard. (Emphasizing Autonomy)
>
> Utterance Three: How many more a day would that be? I mean, can you do it? (Question)

E.2.d. What about this interviewer statement?

> You sound exhausted. I know that I was when I had to deal with that problem. You want to find resolution and you are working really hard for it!

We've parsed it like this:

> Utterance One: You sound exhausted. (Reflection, could be simple or complex)
>
> Utterance Two: I know that I was when I had to deal with that problem. (Self-disclosure, not coded)
>
> Utterance Three: You want to find resolution and you are working really hard for it! (Affirm)

E.3. When to Parse. Client statements such as "yeah" or "right" that do not interrupt the interviewer sequence are considered facilitative statements, and should not interrupt the interviewer volley when coding. However, the volley might be parsed if the client's facilitative statement serves as an answer to the clinician's direct question or reflection. Remember, the default is to choose fewer parses.

For example, if the clinician says:

> Let me see if I've got this straight. You're not happy about being here today but you are willing to consider making a few changes. You realize your drinking has been causing you some problems and you think it might be time to make a change.

If the client responds "yeah" throughout the previous utterance as a way of conveying acknowledgment of the therapist, the utterance should not be parsed by the client's interruption. Compare that to this clinician example:

> You are really worried about your drinking and ready to make some changes. Do you think it's time to talk about treatment?

Here, if the client responds with "Yeah" in agreement that it is time for treatment, the client statement would interrupt the utterance and a new volley would begin with the clinician's next utterance.

When attempting to "keep up" with fast moving clinician/client interactions that contain multiple instances of facilitative speech, the coders is advised to remember the decision rule to parse fewer, rather than more, utterances.

E.4.Behavior Codes

E.4.a. Giving Information

This category is used when the interviewer gives information, educates, provides feedback, or expresses a professional opinion without persuading, advising, or warning. Typically, the tone of the information is neutral, and the language used to convey general information does not imply that it is specifically relevant to the client or that the client must act on it. No subcodes are assigned for Giving Information.

For example:

> From my professional experience, I think that going to cardiac rehab is the best choice for most people in your situation.
>
> The guidelines state that women should not drink more than seven drinks per week.

E.4.a.1. Structuring statements are not coded as Giving Information. These include statements that indicate what is going to happen during the session, instructions for an exercise during the session, set-up of another appointment, or discussion about the number and timing of sessions for a research protocol.

Examples of structuring statements:

> I would like for you to take a look at this list of strengths and pick two or three that apply to you.
>
> Now perhaps we'll take a look at your treatment plan and see what needs changing.
>
> We only have two more sessions after this one so we should plan for that.

E.4.a.2. Differentiating Giving Information from other Behavior counts.
Giving information should not be confused with persuading, confronting, or persuading with permission.

> From my professional experience, I think that going to cardiac rehab is the best choice for you. (Persuade)

From my professional experience, I think that going to cardiac rehab would be the best thing for you. What do you think about this as an option? (Persuade with permission; Seek)

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

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. (Persuade)

I would recommend that you always wear a bike helmet. It will really protect you in the event of a crash. (Persuade)

Today we're going to talk about some things that have worked for others. (Not coded – structuring statement)

The choice is yours, but in my opinion, staying in treatment would be a good thing for you. (Emphasize Autonomy; Persuade with Permission)

Continuing to drink at these levels can really harm your liver. (Persuade)

E.4.b. Persuade

The clinician makes overt attempts to change the client's opinions, attitudes, or behavior using tools such as logic, compelling arguments, self-disclosure, or facts (and the explicit linking of these tools with an overt message to change). Persuasion is also coded if the clinician gives biased information, advice, suggestions, tips, opinions, or solutions to problems *without* an explicit statement or strong contextual cue emphasizing the client's autonomy in receiving the recommendation.

Note that if the therapist is giving information in a neutral manner, without an explicit focus on influencing or convincing the client, the Giving Information code should be used.

Decision Rule: If the coder cannot decide between the Persuasion and the Giving Information code, the Giving Information code should be used. This decision rule is intended to set a relatively high bar for the Persuasion code.

You can't get five fruits and vegetables in your diet every day unless you put some fruit in your breakfast. (Persuade)

I used to be overweight but I decided to take my life into my own hands. You would be better off if you did the same thing. (Persuade)

You just don't know how good your life can be if you quit drinking altogether. (Persuade)

Well, your own father was a heavy drinker so it's very likely you are too. (Persuade)

Well, we know that sons of alcoholics carry an increased risk of problem drinking. (Giving Information)

I have some information about your risk of problem drinking and I wonder if I can share it with you. (Seek)

All of these things added together tell me that you will have a lot of trouble managing your blood sugar levels without some medication to help. I wouldn't tell you this unless I really thought it was the best thing for you. My job is to help you feel better, and I take that very seriously. (Persuade)

If you use a condom every time you have sex, then you never have to worry about whether you might have contracted a sexually transmitted infection. Wouldn't that be great? (Persuade)

We used to think that having kids in daycare was not good for them, but now the evidence indicates that it actually helps them have better social skills than kids who never attend. (Giving Information)

With everything going on in your life right now, how could it hurt to have your kids in daycare a couple of days a week? (Persuade)

E.4.c. Persuade with Permission

Persuade with Permission is assigned when the interviewer includes an emphasis on collaboration or autonomy support while persuading. The condition of permission may be present when

1. The client asks directly for the clinician's opinion on what to do or how to proceed.
2. The clinician asks the client directly for permission to provide advice, make suggestions, give opinion, offer feedback, express concerns, making recommendations, or discuss a particular topic.
3. The clinician uses autonomy supportive language to preface or qualify the advice such that the client may chose to discount, ignore, or personally evaluate that advice.

The clinician could seek a general sense of permission (How about we start today talking about your probation requirements?) or permission specific to a topic, condition, or action item (If it is alright with you, I'll share some strategies that have been used by others to keep their blood sugar in check.).

Permission may be obtained before, during or after persuasion is used, but must occur close to persuasion in time. If Persuade with Permission is accompanied by an explicit Seeking Collaboration or Emphasizing Autonomy, both the Persuade with Permission and the Seeking Collaboration or/Emphasizing Autonomy code should be assigned.

If a clinician has asked for more general permission, it does not need to be repeated for every statement or suggestion. There is a "condition of permission" that may last for several minutes.

If the clinician changes the topic, becomes more directive, starts adding significant content (becomes the expert), or starts prescribing a plan without again asking permission, it is possible that the clinician would then receive a Persuade code.

Note that if the interviewer is providing information or advice in a neutral manner, the Giving Information code should be used instead. If the coder is uncertain, the GI code should be preferred.

> Well, your father was a problem drinker so you definitely have an increased risk according to the numbers. But everyone is unique. What are your own thoughts about that? (Persuade with Permission; Seek)
>
> For some of my clients, daycare can turn out to be a real lifesaver especially when life gets as demanding as yours is right now. But I know you've mentioned your concerns about that, so maybe it is not for you no matter what. (Persuade with Permission; Seek)
>
> I have some ideas about getting your kids to help more. I got my own child to clean his room by using a star chart. He got a star for every day he cleaned his room and after he earned seven stars, he got to choose the movie for Saturday night. (Persuade)

Moving to Insulin

> Your A1C level has been over 12 the last 3 times we've checked it. In general, this puts people at risk for complications (Giving Information)
>
> Looking at your A1C level, it is apparent that you've been having some trouble controlling your blood sugar levels, despite your best efforts. My best advice at this point is for you is to switch to injectable insulin and give up the oral medication. But I don't know if that is something you are willing to consider. I'd welcome your thoughts. (Persuade with Permission; Seek)

Clinician: I've reviewed your lab results and I wonder if I might share some thoughts about how you can improve your control of your blood sugar levels. (Seek)

Client: Sure, I'm curious what you think.

Clinician: Looking at your A1C level, it is apparent that you've been having some trouble controlling your blood sugar levels, despite your best efforts. My best advice at this point is for you is to switch to injectable insulin and give up the oral medication. But I don't know if that is something you are willing to consider. I'd welcome your thoughts. (Persuade with Permission; Seek)

Parenting Self Disclosure

Clinician: Well, I have a story about my own child that might fit in here. I wonder if you'd be interested in hearing about my experiences. (Seek)

Client: Anything that would help.

Clinician: I got my own child to clean his room by using a star chart. He got a star for every day he cleaned his room and after he earned seven stars, he got to choose the movie for Saturday night. (Persuade with Permission)

Smoking Cessation

Clinician: I wonder if it would be ok if I provide some information with you about ways to quit smoking? (Seek)

Client: Yes.

Clinician: I've had good luck with clients using the nicotine gum. (Persuade with Permission)

E.4.c.1 Decision Rule for Persuade and Persuade with Permission

Decision Rule: When both Persuade AND Persuade with Permission occur in the same utterance, the coder should only assign the Persuade with Permission code. This may result in uncoded Persuasion statements in the exchanges. To the extent that the coder judges that these uncoded persuasion statements impinge on the collaboration between the pair, this should be captured on the Partnership global rating.

E.4.d. Questions

All questions from clinicians (open, closed, evocative, fact-finding, etc.) receive the Question code but only one question per volley is coded. Thus, if a clinician asked four separate questions in a single volley, only one question would be tallied. Closed and open questions are not differentiated in the MITI 4.0. Instead, coders attend to the nature of the clinician's questions with the global ratings in mind. For example, many fact-finding questions within an interview *might* result in a lower rating on the Partnership global and reduce opportunities to Sidestep Sustain Talk.

E.4.e. Reflections

This category is meant to capture reflective listening statements made by the clinician *in response to* client statements. Reflections may introduce new meaning or material, but they essentially capture and return to clients something about what they have just said. Reflections may be either Simple or Complex.

E.4.e.1. 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 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.

E.4.e.2. 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 directional 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. (Simple Reflection)

or

Interviewer: This is the last straw for you. (Complex Reflection)

Controlling Blood Sugar

Interviewer: What have you already been told about managing your blood sugar levels? (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. (Simple Reflection)

or

Interviewer: You don't know why you're sabotaging yourself. (Complex Reflection)

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)

or

Interviewer: You're having a hard time figuring out what your mother really wants. (Complex Reflection)

or

Interviewer: Are you having a hard time figuring out what your mother really wants? (Question)

or

Interviewer: What do you think your mother really wants? (Question)

Smoking

Client: I'm so tired of being told what to do. No one understands how difficult this is for me.

Interviewer: Is this overwhelming you? (Question)

or

Interviewer: You are angry and frustrated. (Complex Reflection)

or

Interviewer: It's hard for people around you to get it. (Complex Reflection)

DECISION RULE: When a coder cannot distinguish between a simple and complex reflection (including for summaries), the default is to code a Simple Reflection..

E.4.e.3. Series of Reflections

When a clinician offers a series of simple and complex reflections *in the same volley*, only one Complex Reflection should be coded. Reflections often occur in sequence, and over-parsing can lead to difficulties in obtaining reliability or take away from the intent of the volley. Therefore, if a clinician offers a Simple Reflection, followed by an Emphasizing Autonomy statement, and then a Complex Reflection, only the codes of Complex Reflection and Emphasize would be given.

Diet Failure

Client: I keep failing in this diet. I do okay for a while, but then I find myself eating an entire pan of brownies, and ruining all my progress. Do you know how many calories there are in a pan of brownies? Never mind the ice cream I eat with them. I never realized it would be so hard.

Clinician: It's two steps forward and then one step back. That kind of progress just doesn't seem enough. And what's hard is that something that is so normal for you, like a pan of brownies, is so terrible for your weight. If you knew this would be so hard, you might not have even tried to lose weight. (Complex Reflection)

Client: No, I have to do this. Even if I have to accept that I will never eat another brownie the rest of my damn life, I still have to stop killing myself with my weight.

Clinician: You want to lose weight so much that you would even give up brownies if you really had to. (Complex Reflection, added value for Cultivating Change Talk)

or

Clinician: Actually, you don't have to give up any food forever. Research shows that when you try to restrict yourself from foods you love, you will just eat more of them. The best goal is to eat them in moderation. (Persuade)

E.4.e.4. Reflection and Question in Sequence

Sometimes the interviewer begins with a reflection, but adds a question to "check" the reliability of the reflection. Both elements should be coded.

> *Client:* I just can't keep using like this.
>
> *Clinician*: You're certain you don't ever want to use heroin again. Is that right? (Complex Reflection, Question)
>
> *Client*: My boss said I'm on probation now. No overtime, no bonuses. Nothing.
>
> *Clinician*: Your boss said you can't work overtime anymore because of this incident. What do you make of that? (Simple Reflection, Question)

E.4.e.5 Structuring Statements posing as reflections

Sometimes the interviewer will ask a question, but will precede the question with information designed to cue the listener about the context for it. Essentially this functions as a way of saying; "Remember that other thing you said? Well, now I want to ask you this about it". These types of structuring statements that occur prior to questions should *not* be coded as separate reflections. Instead they should be considered structuring statements to provide context for a question and therefore not coded. The intent of this rule is to avoid giving credit for reflections when the interviewer is merely cueing the client about the topic.

If the interviewer makes a clear distinction or stop between the "set up" statement and the question, a separate reflection may be coded. For this to be the case, the client should have an opportunity to respond in some way before the question occurs.

> *Interviewer*: You were describing that you haven't returned to that store where you stole the candy. Do you feel you are avoiding it? (Question)

or

> *Interviewer*: You haven't returned to the store where you stole the candy. (Simple Reflection)
>
> *Client*: Right.
>
> *Interviewer*: Do you feel you are avoiding it? (Question)

When the coder determines that the purpose of the reflection is to provide a foundation or a cue for a question, it should not be coded.

E.4.f. MI-Adherent (MIA) Behaviors

It is important to note that often examples of good MI practice will not earn an MIA code. One common mistake for novice coders (and expert practitioners of MI) is to spot example of good MI practice that they try to "fit" into one of the MIA codes. Take care to assign only the MIA codes that are available here, and only when the example "rings the bell" as a clear example of the code.

When in doubt, or when you are working too hard to make the example fit, select another code instead. Remember that adjusting a global rating can help compensate for elements of excellent MI practice that are not easily captured with a behavior count.
**Unlike previous versions of the MITI, each subtype of MI Adherent (MIA) behavior is now coded and tallied separately.

E.4.f.1 What happens when a statement might fit more than one MIA Category?

"Trump" (origin 1580's)
verb: to surpass or beat
noun: playing card of a suit that ranks above the others

Most of the time, coders will be able to assign a MIA code with certainty. Sometimes, though, coders will encounter single utterances that could fit into more than one MIA category. As with all other MITI codes, uncertainty about MIA is resolved by using a decision rules. These are sometimes called trumping rules, because they tell the rater which codes should prevail when the decision is unclear.

The following hierarchy should be used to determine which code should be assigned for MIA (see Figure 1). If the coder is unsure which code is more appropriate, the lower code should be used (i.e., it should be the default). For example, if the coder is uncertain whether to assign Emphasize Autonomy or Seek, the Seek code should be used. Lower codes on the pyramid are given *when the coder is uncertain*. To assign the highest code on the pyramid, the coder should have a reasonable degree of confidence that the code is a true example of that category. When there is less certainty, the coder defaults to the lower codes. The intent of this trumping pyramid is to "protect" codes having high importance in motivational interviewing from being assigned too easily. Affirmations, for example, are relatively "inexpensive" for the interviewer, whereas emphasizing autonomy is both more challenging to achieve and has greater theoretical interest. Therefore the bar is intentionally set higher for the Emphasize Autonomy code.

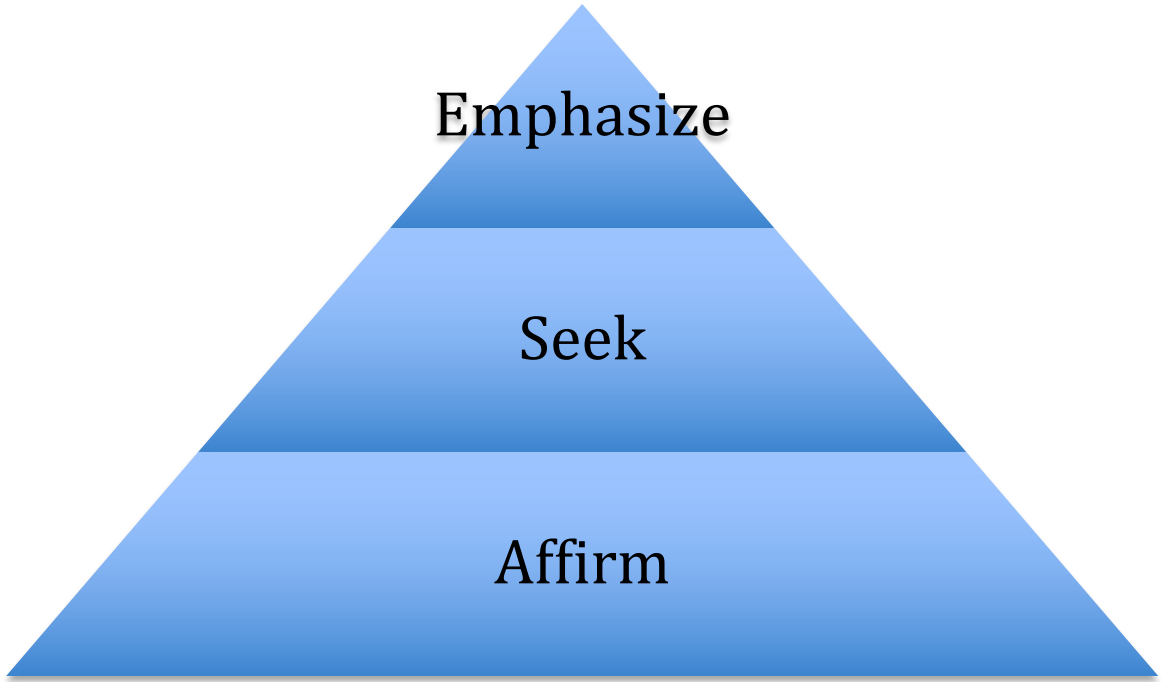

Figure 1: Decision rules for MIA codes

E.4.f.1.a. What if the coder is not sure whether the code should be a MIA or some other code (such as a Question or a Reflection)?

When in doubt, the coder should *not* code MIA. Thus, if a statement could be coded as MIA or some other code, MIA should be assigned only if falls clearly within that category. When uncertain, the coder selects the other code.

E.4.f.2. Affirm (AF)

An affirmation (AF) is a clinician utterance that accentuates something positive about the client. To be considered an Affirm, the utterance must be about client's strengths, efforts, intentions, or worth. The utterance must be given in a genuine manner and reflect something genuine about the client. It does not have to be focused on the change goal and could reflect a "prizing" of the client for a specific trait, behavior, accomplishment, skill, or strength. Affirms are often complex reflections, and when this occurs, the Affirm code should be preferred.

Affirm should not be coded automatically for the clinician's agreeing with, approval of, cheerleading for, or non-specific praising of the client. They must be explicitly linked to client behaviors or specific characteristics. The utterance must seem genuine and not merely facilitative.

> **Note that this definition of Affirm is more stringent than that both what is used in *Motivational Interviewing* (Miller & Rollnick, 2013) and in previous versions of the MITI. Specifically, statements of support ("It's always hard when you are getting started") are no longer coded in the MITI.

If the coder is not certain whether the statement is specific or strong enough to merit the Affirm code, *it should not be assigned*.9.9

> You came up with a lot of great ideas on how to reduce your drinking. Great job brainstorming today. (Affirm)
>
> It's important to you to be a good parent, just like your folks were for you. (Affirm)
>
> I am really proud of you. (Not coded; not specific).
>
> You have been able to avoid sweets throughout the holiday and you're proud of your accomplishment. It has paid off! (Affirm; trumps Reflection)
>
> You are the kind of person who takes her responsibilities seriously, wanting to do the right thing. (Affirm)
>
> With the parking problems and the rain coming down, it hasn't been easy to get here. I appreciate that you continue to come. (Affirm)
>
> I know it's really hard to stop smoking. (Support; not coded)
>
> You did great! (Not coded)
>
> Way to go! (Not coded)
>
> You've been working so hard at being a good parent. I'm so impressed with your willingness to stay in there even when the going gets tough! (Affirm)
>
> Given what you have told me about your previous success with losing weight, I am confident that you will be successful again when you are ready. (Affirm)
>
> You're feeling pretty discouraged about the fast foods. You had hoped to not hit the drive thru at all this past two weeks. It strikes me though that, even if you went for fast food twice during that time, that is considerably less than when you were going every day. That seems like a big change! (Affirm)

E.4.f.2.a. Three strikes rule for Affirmations

Clinicians can overuse affirmations by repeating them many times during the conversation. In general, the first two or three times, the statement may be credible and coded as an Affirm if the coder is confident that the utterance still clearly falls into the Affirm category. After that, they are typically not coded.

E.4.f.3 Seeking Collaboration

This code is assigned when a clinician explicitly attempts to share power or acknowledge the expertise of the client. It can occur when the clinician genuinely seeks consensus with the client regarding tasks, goals or directions of the session. Seeking collaboration may be assigned when

the clinician asks what the client thinks about information provided. When permission to give information or advice is sought, Seeking Collaboration is typically assigned.

When a clinician asks about the client's knowledge or understanding of a particular topic, this is coded as a Question. It is not considered to be Seeking Collaboration.

> I have some information about how to reduce your risk of colon cancer and I wonder if I might discuss it with you. (Seeking Collaboration)
>
> What have you already been told about drinking during pregnancy? (Question)
>
> Would it be alright if we spend some discussing the standards for consuming alcohol during pregnancy (Seeking Collaboration)
>
> 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 two hours after lunch. (Seeking Collaboration, consider Persuade with Permission)
>
> How can I help you with this? (Seeking Collaboration)
>
> Would it be all right if we spent some time talking about smoking? I know you didn't come here to talk about that. (Seeking Collaboration)
>
> I have your assessment results. Are you interested in going over those? (Seeking Collaboration)

E.4.f.3.a Note: Elicit–Provide–Elicit (E–P–E) exchanges may *or may not* be an example of seeking collaboration. Each item is typically coded separately.

Elicit-Provide-Elicit without Seeking Collaboration

> Clinician: What do you already know about drinking during pregnancy (Question)?
>
> Client: I know it's better if I don't drink.
>
> Clinician: Yes. It's recommended that women abstain from alcohol during pregnancy. (GI)

Elicit-Provide-Elicit with Seek Collaboration

> Clinician: What do you already know about drinking during pregnancy (Question)?
>
> Client: I know it's better if I don't drink.
>
> Clinician: What do you make of this information? How does it fit in with your approach to drinking? (Seeking Collaboration)

In contrast to:

Clinician: What do you already know about possible ways of quitting smoking? (Question)

Client: I know that the patch is supposed to be the most effective for quitting. How long can I be on the patch? Is it only supposed to be used for a week or two?

Clinician: The patch is one way to quit smoking. It is an effective method and is typically used for about four to six months (GI).

E.4.f.4. Emphasizing Autonomy (Emphasize)

These are utterances that clearly focus the responsibility with the client for decisions about and actions pertaining to change. They highlight clients' sense of control, freedom of choice, personal autonomy, or ability or obligation to decide about their attitudes and actions. These are *not* statements that specifically emphasize the client's sense of self-efficacy, confidence, or ability to perform a specific action.

Yes, you're right. No one can force you stop drinking. (Emphasizing Autonomy)

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

The number of fruits and vegetables you choose to eat is really up to you. (Emphasizing Autonomy)

This is really your life and your path. You are the only one who can decide which direction you will go. Where do you think you would like to go from here with your exercise? (Emphasizing Autonomy)

You are in a tough spot. Being in jail leaves you feeling like you have no control over your life. And you are being asked to consider engaging in a treatment program that might give you some control back if you decide to do that. You are not sure what to choose at this point. (Emphasizing Autonomy)

This is both an opportunity and a challenge as you see it. You are weighing the options and figuring out what will work best for you. (Emphasizing Autonomy)

Quit drinking

Client: I'm pretty sure I can quit drinking for good.

Clinician: You feel confident you can quit drinking because you have done it before. (Reflection; Added value for Cultivating Change Talk)

Clinician: There's a choice in front of you and you feel pretty sure which way you want to go (Emphasizing Autonomy)

Clinician: You feel pretty sure about which way you want to go (Reflection; Added value for Cultivating Change Talk)

Clinician: You're ready to stop (Reflection; Added value for Cultivating Change Talk)

Checking Blood Sugar Levels

Client: I'm not ready to check my blood sugar every day, but I could do it once a week or so.

Clinician: In the end, it's really up to you how often you check your blood sugar. (Emphasizing Autonomy)

Clinician: One change you're considering is checking weekly. (Simple Reflection; Added value for Cultivating Change Talk)

Clinician: It's really hard to get that test in every day (Complex Reflection; Decreased value for Softening Sustain Talk)

HIV test

Client: Last week I talked to the Advice Nurse about a home test. She said I could buy one at the drugstore and get the results back right away.

Clinician: You have already taken some steps to find the answer you need. (Reflection; Added value for Cultivating Change Talk)

Clinician: Now you have to make the decision about what is the best choice for you. (Emphasizing Autonomy)

Clinician: You feel two ways about finding out (Complex Reflection)

Clinician: I have some information about the home testing kits. I wonder if I could share it with you. (Seeking Collaboration)

Clinician: Yahoo! You made it to your goal! (Affirm)

Clinician: You've got what it takes. (Affirm)

E.4.g. MI Non-Adherent (MINA) Behaviors

There are only two MINA codes: Persuade and Confront.

E.4.g 1. Persuade (see Section E.4.b.)

E.4.g.2. Confront.

This code is used when the clinician confronts the client by directly and unambiguously disagreeing, arguing, correcting, shaming, blaming, criticizing, labeling, warning, 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 Confronts can be correctly categorized by careful attention to voice tone and context.

Decision Rule: In the relatively unusual circumstance where the coder is not certain whether to code an utterance as a Confrontation or Reflection, *no code should be assigned.*

You were taking Antabuse but you drank anyway? (Confront)

You think that is any way to treat people you love? (Confront)

Yes, you are an alcoholic. You might not think so, but you are. (Confront)

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

Think of your kids, for crying out loud. (Confront)

You have no concerns whatsoever about your drinking? (Confront; Question code not assigned since Confront trumps Question)

Most people who drink as much as you do cannot ever drink normally again. (Confront)

I have a concern about your plan to drink moderately and I wonder if I can share it with you. (Seeking Collaboration)

Disciplining your child with punishment is a slippery slope. It seems alright in the beginning but then one thing leads to another. (Confront)

Remember you said that your cholesterol level was a threat to your life. If you can't get your diet under control, you are risking a stroke or a heart attack. (Confront)

Well, kids who are not supervised closely by their parents are at higher risk for substance abuse. I wonder what you think about your own parenting skills in that regard. (Probably Confront—listen for tone)

If you choose to continue to drink, there's nothing we can do to help you. (Probably Confront—listen for tone).

When clinicians use confrontation to emphasize a client strength, virtue or positive achievement, the Affirm code should be considered. A Confront is not mandatory when the clinician is clearly attempting to affirm or support the client.

Terrible Mother

Client: I'm a terrible mother.

Clinician: No you are *not*. You are having some troubles, but you are still a great mother. (Affirm)

Cholesterol Improvement

Client: I improved this month. I ate at least three servings of fruits or vegetables every single day.

Clinician: Yes, but your cholesterol level is still way too high. (Confront)

or

Clinician: You've made some real progress in your eating habits. What do you make of that in terms of your longer-term health goals? (Affirm; Seeking Collaboration)

E.4.g.3. Decision rules for MINA

Persuasion and confrontation sometimes overlap and can fit in more than one category. When this happens, the following hierarchy should be used (see Figure 2):

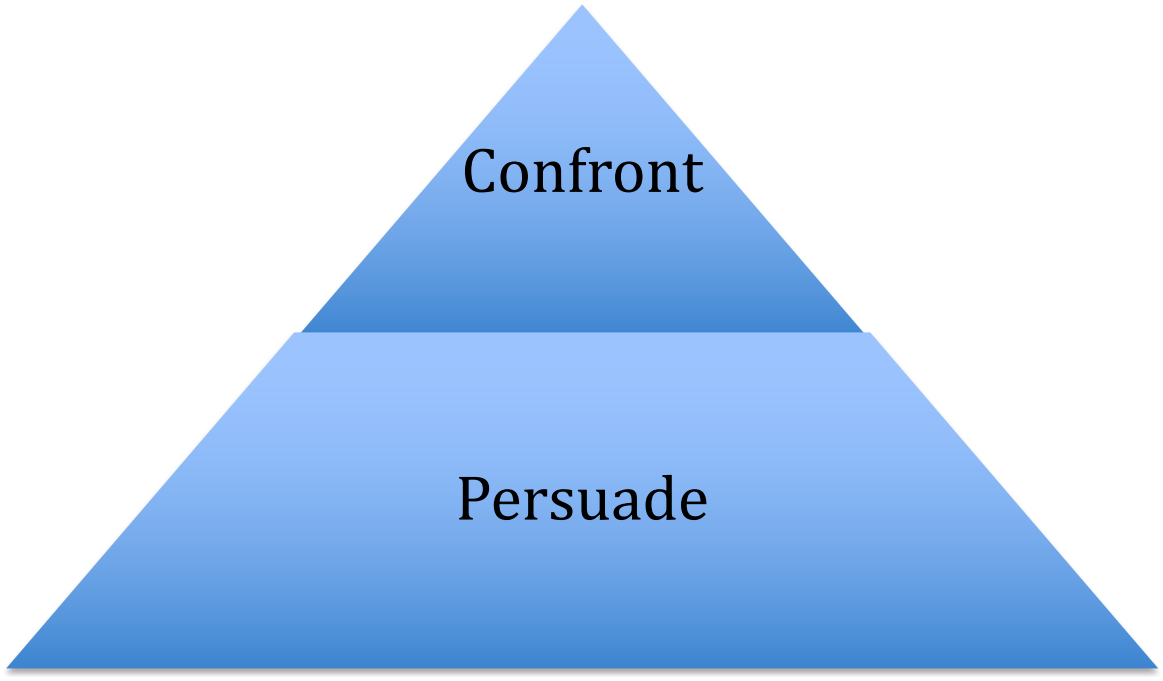

Figure 2: Decision rules for MINA codes

F. STATEMENTS THAT ARE NOT CODED IN THE MITI

The MITI is not an exhaustive coding system because some utterances may not receive a behavior code.

Examples of utterances that are not coded in the MITI.

Structure statements:	"Now we'll talk about the forms from last week."
Greetings:	"Hi Joe. Thanks for coming in today."
Facilitative statements:	"Okay, all right. Good."
Previous session content:	"Last week you mentioned you were really tired."
Incomplete thoughts:	"You mentioned…." (client interrupts)
Off-topic material:	"It's a bit cold in here."

G. CHOOSING THE LENGTH AND TYPE OF THE CODED SEGMENT

The development of the MITI was done using 20-minute segments of psychotherapy tapes. It may be possible to use the MITI for longer audio segments (e.g., the entire 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 audio recordings rather than video. The MITI can be used to code video, but should not be altered to gather visual information.

H. SUMMARY SCORES

Because critical indices of MI functioning are imperfectly captured by frequency counts, we have found that many applications of coding are better served with summary scores computed from code frequencies, 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.

- Technical Global (Technical)
  = (Cultivating Change Talk + Softening Sustain Talk) / 2

- Relational Global (Relational)
  = (Partnership + Empathy) / 2

- (% CR)

= CR / (SR + CR)

- Reflection-to-Question Ratio (R:Q)
  = Total reflections/ (Total Questions)

- Total MI-Adherent
  = Seeking Collaboration + Affirm + Emphasizing Autonomy

- Total MI Non-Adherent
  = Confront + Persuade

Note that these formulas will yield summary scores that are not comparable to previous versions of the MITI.

I. CLINICIAN BASIC COMPETENCE AND PROFICIENCY THRESHOLDS

Below are suggested MITI basic competence and proficiency thresholds for clinicians. Please note that these are based upon *expert opinion*, and currently lack normative or other validity data to support them. Until those data become available, these thresholds should be used in conjunction with other data to arrive at an assessment of clinician basic competence and proficiency in using MI.

	Fair	**Good**
Relational	3.5	4
Technical	3	4
% CR	40%	50%
R:Q	1:1	2:1
Total MIA	-	-
Total MINA	-	-

List of MITI Codes

GLOBAL RATINGS

Cultivating Change Talk	(Cultivate)
Softening Sustain Talk	(Sidestep)
Partnership	(Partner)
Empathy	(Empathy)

BEHAVIOR COUNTS

Giving Information	(GI)
Persuade	(Persuasion)
Persuade with Permission	(Persuasion with)
Question	(Q)
Simple Reflection	(SR)
Complex Reflection	(CR)
Affirm	(AF)
Seeking Collaboration	(Seek)
Emphasizing Autonomy	(Emphasize)
Confront	(Confront)

Appendix A:
Questions about Whether the MITI is Appropriate for Your Intervention

Motivational interviewing can often be used to address broader life changes and situations that do not involve a specific change goal, but the MITI will be of limited value for interventions of this type. For more abstract changes, it is difficult for coders to reliably evaluate client language about change and—more importantly—whether the interviewer is appropriately evoking and responding to it.

Without this critical evoking element of MI, the MITI is an impoverished tool for evaluating a clinician's ability to deliver MI. Low scores might also be earned in a number of important areas, even though the clinician appropriately chooses not to influence client language in any particular direction. Similarly, when the interview focuses entirely on the engaging or focusing processes, the MITI will reflect lower scores because the evoking element of MI is absent. The MITI is most appropriate when the full range of MI skills is intended in an interview.

The MITI is of limited value in the following situations:

- Change goal cannot be specified as a behavior (for example, making a decision)
- Clinician does not wish to influence the client toward any particular goal (equipoise)
- Clinician intentionally uses only engaging or focusing skills

J.1 What if there is more than one change goal?

It is sometimes the case that interventions have more than one target change (e.g., (1) medication compliance and (2) finding appropriate housing). As long as both target changes result in behaviors from the client (rather than internal events) the MITI can be used.

J.2. Examples of Inappropriate Target Goals for MITI coding

J.2.a. "Making a Decision": Target change without obvious change talk

If the target goal is "making a decision," the content of the change talk will not be a side of the dilemma (as when a desirable change is specified), but instead language about the decision itself. For example, when the change goal is smoking cessation, the following statements would be change talk:

"I need to quit smoking"
"If I don't quit, I'm going to get cancer"
"I'd have so much more money"
"I want to be a good example for my children"

If the target goal is "*making a decision* about smoking," none of those statements would be change talk. Instead, the following statements would be:

"I need to make a decision"

"If I don't make a decision, I'll just keep going as I am"
"Settling this would be such a relief"
"I hate being so wishy-washy"

Although it is theoretically possible to code change talk for making a decision, it is a complex task that has not been evaluated psychometrically and we have elected not to include it in the MITI 4.0.

J.2.b. "Becoming a Better Person": Target Change That Is Not a Behavior

If the target change is a non-behavioral goal, defining change talk will be difficult. For example, would the following statements qualify as change talk if the person's goal is "to become a better person"?

"I need to express my anger more freely"
"If I want more friends I need think about the wishes of others instead of myself"
"I want to exercise more often and eat less"
"I can do that now without feeling any guilt at all!"
"I am going to get my chakras into better alignment"

Each of these examples depends entirely on the clinical context (and the mind of the interviewer) to determine whether they are change talk or something else. For example, a goal to exercise more often and eat less might be a good fit for a person who has just been told that their BMI is over 25 in a primary care setting, but not for a client with anorexia. Or it might be that none of these statements fit into being a better person. The point is that coders cannot reliably discern the change talk in such situations, and interrater reliability cannot be achieved. For this reason, the MITI 4.0 (as with previous versions) specifies a target behavior that is known in advance.

J.3. What if I only want to evaluate the engaging and focusing dimensions within an interview?

Even when interviews are not intended to evoke arguments for change, some of the subscales of the MITI might still be useful in evaluating the basic counseling skills of the interviewer. The Partnership and Empathy global ratings—as well as the behavior counts for Questions, Reflections, MI Adherent and MI Non-Adherent—will all yield useful information about nondirective approaches to interviewing. They may be used and adapted with appropriate citation.

Appendix B: Frequently Asked Questions

1. What if my session is less than 20 minutes long?
Global ratings may be more difficult to measure in sessions less than 10 minutes long. For extremely short sessions (2-5 minutes), it may be best to code only the behavior counts.

2) How is MI Spirit captured in the MITI 4.0?
MI Spirit is no longer measured in the MITI 4.0. Important dimensions of MI Spirit, such as partnership and evoking a client's reasons to change, are still measured in the MITI 4.0

3) What happened to the percentage of MIA and MINA summary scores?
The percentage of MIA and MINA behaviors were calculated in previous versions of the MITI: (Percentage of MIA = MIA/(MIA + MINA) and Percentage of MINA = MINA/(MIA + MINA). These percentages were not particularly informative, especially for sessions that had no MIA or MINA behaviors. . The percentage of MIA and MINA behaviors was misleading and uninformative and was therefore dropped from the MITI 4.0.

4) What are the threshold scores for the MITI 4.0?

Determining thresholds for the MITI 4.0 is not as straightforward as in previous versions. In some ways this is because our understanding of the practice of MI is more complex than in years past, so deciding what is "acceptable" can be a challenge. Further, almost all the ratings have been altered in the new version meaning they cannot be compared with previous versions. Finally, we lack empirical data to make some recommendations on many ratings, though we hope that will be coming before long.

A few things to note:

For the MITI 4.0, the recommended ratings for the Relational Element are higher than for the Technical Element at both the Fair and Good practice level. This reflects the current theoretical framework in MI emphasizing the engaging, relational skills as a foundation for the evoking, technical elements.

We have concluded that there is enough empirical evidence to retain the threshold scores for complex reflections and, in particular, the ratio of questions and reflections so they have been retained.

MIA and MINA recommendations have intentionally been left unspecified since we have no data yet to inform them. We encourage full reporting of all MITI 4.0 scores in clinical trials in which it is used to document treatment fidelity. When tied to clinical outcomes, this would allow for confident recommendations of MIA and MINA in a relatively short time.

5) What if I should technically assign the Persuade with Permission code, but the permission doesn't seem genuine or the information seems to be more of a Persuade?

The global measures, particularly Partnership, may be impacted by how the clinician gives information, obtains permission, or provides suggestions or opinions. The following are

situations that might warrant a lowering of the Partnership global, even when the Persuade with Permission behavior count is given.

1. The clinician asks for permission for virtually every comment
2. The tone of the permission asking is perfunctory or insincere
3. The clinician does not give time for the client to respond to the permission asking before providing the information
4. The clinician overstretches the boundaries of the permission (i.e. asking to provide information on drinking and then gives that and additional information on other lifestyle or behavioral issues)
5. The clinician asks for and receives permission for a general topic and then proceeds to "dump" too much information (may go on for several minutes)

6) When sustain talk does not occur in a session how should the Softening Sustain Talk Scale be scored?

We cannot tell why sustain talk does not occur in a session. It might be absent because the client genuinely did not have any to offer OR it might be absent because the clinician was skilled enough not to elicit it. Coders are not asked to guess about this.

Higher ratings on SST may be given even in the complete absence of sustain talk. Essentially, the clinician gets the "benefit of the doubt" when sustain talk does not appear, which can result in occasional dubiously high ratings on SST. This is an element of uncertainty in the SST code that is acceptable. SST ratings *should* be lowered when sustain talk is infrequent, but the clinician responds inappropriately when it does occur.

7) What happens when the clinician responds to sustain talk by reflecting it or giving it attention in order to convey empathy or build partnership? For example, the first 12 responses on the Rounder tape appear to be acknowledging sustain talk, which then increases. How can this clinician get a LOW score on SST?

It is frequently the case that there is a trade off between the relational and technical elements of MI. A therapist who attempts to soften sustain talk without building collaboration is often unsuccessful. The Rounder session shows several excellent examples of SST later in the session, once partnership has been established. It is the *session as a whole that is reflected in the global ratings*, *and the coder should consider the pattern and momentum of the client's language in assigning rating.*

8) How should SST be scored in a decisional balance exercise?

In a true decisional balance both sides of the change equation are explored equally. There is not an effort to soften sustain talk, but rather to draw it out fully. When this is the case, low SST ratings should be assigned assuming they are not "salvaged" later in the interview.

9) Can the Seeking Collaboration code be assigned for simply asking the client what they think about information that has been provided, for example in feedback about an assessment or in the E-P-E format?

The Seek code can be assigned any time the coder feels the clinician is making a genuine effort to collaborate and share power with client. The Seek code should be withheld if the coder does not perceive such an effort, for example if a clinician appears to be simply testing a client's understanding without explicitly attempting to share power. Rhetorical, rote or superficial questions to a client ("what do you think of that?") may not necessarily receive the Seek code. Raters are asked to defer the Seek code if they cannot decide whether it is merited.

Recording #:_____ Coder:_____ Date: ____/____/____

Global Ratings

Technical Components					
Cultivating Change Talk	1	2	3	4	5
Softening Sustain Talk	1	2	3	4	5
Relational Components					
Partnership	1	2	3	4	5
Empathy	1	2	3	4	5

Target Change:_____

Behavior Counts

		Total
Giving Information (GI)		
Persuade (Persuade)		
Persuade with Permission (Persuade with)		
Question (Q)		
Simple Reflection (SR)		
Complex Reflection (CR)		
Affirm (AF)		
Seeking Collaboration (Seek)		
Emphasizing Autonomy (Emphasize)		
Confront (Confront)		

Start time and sentence:_____

End time and sentence:_____