

Motivational Interviewing Skill Code (MISC) 2.5

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The MISC 2.5 incorporates features from two previous coding systems: the MISC 2.1 (<http://casaa.unm.edu/download/misc2.pdf>) and the SCOPE (<http://casaa.unm.edu/download/scope.pdf>). Elements from both have been combined in order to capture more accurately the subtleties of counselor and client language. Changes made from the MISC 2.1 include the introduction of a Direction global rating, the transition from a 7-point Likert-type rating scale to a 5-point scale for all global measures, and the elimination of strength ratings from client behavior counts. Changes made from the SCOPE include folding the permission-seeking category into emphasize control, the inclusion of additional examples to disambiguate confusing codes, a revision to double-sided reflections to capture the sequential nature of this behavior, and clarification on the computation of summary scores.

General coding procedures

Coding for the MISC 2.5 is performed in three separate passes. In the first pass, a coder listens non-stop to the entire recording and completes a set of seven Likert-type global ratings. In the second pass, the recording is parsed into utterances (i.e., thought units). It is possible for experienced coders to code globals and parse within a single pass, but this is not recommended for beginning coders. In the third pass, the coder applies behavioral codes to each counselor and client utterance. The MISC 2.5 is a true sequential coding system that can preserve temporal order of behaviors.

First Pass: Global Ratings

In this first coding pass, the coder listens non-stop to the entire recording. Each global rating requires the coder to assign a single integer from a five-point scale to characterize the *entire* interaction. The first pass of the MISC 2.5 includes counselor ratings on six dimensions: Acceptance, Empathy, Direction, Autonomy Support, Collaboration, and Evocation. There is also one client global rating, Self-Exploration.

Counselor global ratings

The counselor global ratings are intended to capture the coder's overall impression of the counselor's performance during the interview. While this may be accomplished by combining a variety of elements, the coder's gestalt or all-at-once judgment is paramount. The global scores should reflect a holistic evaluation of the counselor, one that cannot necessarily be separated into individual elements. Counselor global ratings are given on a 5-point Likert scale, with the coder assuming a beginning score of "3" and moving up or down from there.

Specific Guidelines:

- All ratings are on a 5-point Likert scale.
- Ratings should be based primarily on the counselor's behavior during the observed session.
- Select only one number for each item, and do not leave any item blank. Do not make ratings that fall between the whole numbers.
- These global ratings are based on the *entire* interview or sample. Thus, for example, a rating of empathy is given for the whole interview, which might combine longer periods of high empathy and a few periods of low empathy.

- It is helpful to note examples of Empathy, Acceptance, Direction, Autonomy Support, Collaboration, and Evocation as you listen to the session.
- Examples of counselor behaviors are provided under each global rating. It is not necessary for counselors to exhibit all (or any) behaviors in the examples to receive that particular score.

Acceptance

Synonyms include “positive regard,” “allowing,” and “steadiness.” This rating captures the extent to which the counselor communicates unconditional positive regard for the client. A rating should be made starting at 3, and moving toward either the high (5) or low (1) end of the scale, based on the following criteria:

High Acceptance. Counselors high on this scale consistently communicate acceptance and respect to the client. They may be perceived as warm and supportive, but the key attribute is to communicate unconditional positive regard for the client.

Low Acceptance. Counselors at the low end of this scale consistently communicate non-acceptance, disregard, or disapproval of the client. They may be perceived as judgmental, harsh, disrespectful, labeling, or condescending.

Differentiating Acceptance from other counselor characteristics. Acceptance is person-focused (unconditional positive regard) and should not be confused with agreeing with the client’s opinions or approving of the client’s behavior. A counselor may:

Respect a client’s opinions without agreeing with them (acceptance vs. agreement)

Accept a client’s choices without approving of them (acceptance vs. behavioral approval)

Support the client as a worthwhile human being without either condoning or condemning the client’s actions and views (acceptance vs. judgment)

Verbal Anchors

1. The clinician’s behavior shows obvious and explicit disregard or disrespect toward the client.

Examples:

- Expressing open hostility toward, judgment of, or disregard toward the client.
- Dismissing the client’s ideas or opinions out of hand.
- Remarking on the client’s weaknesses, or labeling the client

2. The clinician’s behavior or attitude implies mild judgment or disrespect, but without many clear instances of disregard. The clinician may exhibit a single mild expression of non-acceptance, but is not otherwise openly disrespectful or harsh.

Examples:

- Clinician shows impatience toward the client.
- Clinician initially expresses, but then backpedals from, an expression of judgment.
- Clinician appears insincere, with an overall demeanor that contradicts what the clinician says.

3. The clinician is not obviously disrespectful toward the client, but also does not exhibit any clear acceptance. The clinician may also alternate between unenthusiastic acceptance and implied acceptance.

Examples:

- Few or no clear expressions of positive regard
- Fluctuation between acceptance and non-acceptance
- Clinician displays average and unexceptional levels of acceptance

4. The clinician's behavior implies acceptance, although there may be relatively few clear and explicit expressions of respect.

Examples:

- Several clear expressions of respect and appreciation
- Abstaining from judgment when clients divulge sensitive or uncomplimentary information about themselves.

5. The clinician's behavior implies acceptance, and the clinician also makes clear and explicit expressions of positive regard for the client. There are no instances of disrespect or disregard toward the client.

Examples:

- Frequent expressions of appreciation toward or confidence in the client.
- An apparent sincerity, with a clear match between how the clinician behaves and what the clinician says to the client.

Empathy

Synonyms include "understanding" and "perspective." This rating is intended to capture the extent to which the counselor understands and/or makes an effort to accurately understand the client's perspective. A rating should be made starting at "3", and moving toward either the high ("5") or low ("1") end of the scale based on the following criteria:

High Empathy. Counselors high on this scale show an active interest in making sure they understand what the client is saying, including the client's perceptions, situation, meaning, and feelings. The counselor accurately follows or perceives a client's complex story or statement or probes gently to gain clarity. Reflective listening is an important part of empathy, but this global rating is intended to capture all efforts by the counselor to understand accurately the client's perspective and convey that understanding back to the client. Nevertheless, a high rating on Empathy requires more than question-asking, and reflects skillful use of reflective listening.

Low Empathy. Counselors at the low end of this scale show little interest in the client's own perspective and experiences. There is little effort to gain a deeper understanding of complex events and emotions. Counselors low in empathy may probe for factual information or to pursue an agenda, but they do not do so for the sole purpose of understanding their client's perspective. Reflective listening is noticeably absent.

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. Clinician's 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

Differentiating empathy from other counselor characteristics. Empathy is not to be confused with warmth, acceptance, genuineness or client advocacy. These characteristics are independent of the empathy rating. It is possible for a counselor to:

Work very hard to understand the client's perspective but not be especially warm or friendly while doing so. (empathy vs. warmth)

Understand fully without accepting the client's perspective. (empathy vs. acceptance)

Be fully present and authentic, but not make efforts to understand the client's perspective. (genuineness vs. empathy)

Be invested in helping the client or gaining services for them without a particular effort to understand the client's perspective (client advocacy vs. empathy)

Direction

Synonyms include "focus" and "aim." This rating encompasses 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.

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.

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 tangential themes, 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.

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

Autonomy Support

A synonym is "client 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.

Autonomy-supportive counselors accept that clients can choose not to change. They may be invested in specific behavior changes, but do not push for an immediate commitment at the expense of "taking the long view" about the option of change in the future. They emphasize the client's freedom of choice, and

convey an understanding that the critical variables for change are within the client and cannot be imposed by others.

Low Autonomy counselors communicate a lack of acceptance that clients might choose to avoid or delay change. They convey a sense of urgency about the need for change, and may use imperative language, telling clients what they “must” or “have to” do. Little emphasis or acknowledgment is given to the client’s freedom of choice and self-determination.

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

Collaboration

Synonyms include “power sharing,” “working with,” “coming alongside,” and “client expertise.” 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.

High collaboration is apparent when counselors negotiate with the client and avoid an authoritarian stance. Counselors show respect for a variety of ideas about how change can occur and can accept differences between their ideal plan and what clients are willing to endorse. They avoid persuasion and instead focus on supporting and exploring the client's own concerns and ideas. These counselors minimize power differentials and interact with their clients as partners.

Low Collaboration is evident when counselors confront clients with their point of view. An authoritarian and rigid stance is apparent and little effort is made to include the client's ideas about how change might be accomplished. Low collaboration counselors attempt to persuade clients about the need for change. These counselors seem to view their clients as deficient in some manner and attempt to provide what is missing, often using an “expert” stance to do so. These counselors convey a sense of having expertise the client needs in order to make a change.

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

Evocation

A synonym is "drawing out." 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.

High evocation is apparent when counselors draw out the client's perspectives rather than "installing" the counselor's knowledge, insights and advice. They do not educate or give opinions without permission. They are curious and patient. They give the client the benefit of the doubt about wanting to change and show a focused intent to draw out the client's own desire and reasons for changing. Counselors high in evocation show an active interest in helping clients say to themselves the reasons that change can and should happen.

Low Evocation is evident when the counselor shows little or no interest in exploring the client's own reasons for change. They may convey an attitude of suspicion or cynicism about the client's desire to change. They may focus on giving information and advice, educating the client or giving logical reasons for changing. These occur at the expense of arranging conversations so that the client talks himself or herself into changing.

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 with interest to change talk when it occurs.
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

Differentiating counselor global ratings from other characteristics. The counselor global ratings are not to be confused with sympathy, expertise, education, skill-building, uncovering unconscious motivations, or spiritual guidance. A counselor might:

- Feel sad that the client has so many burdens, without conveying a sense that the counselor can solve them. (sympathy vs. autonomy support)
- Be able to give excellent advice to the client about how to solve problems, but fail to ask the client what he or she has already thought of. (expertise vs. evocation)
- Help clients replace irrational thoughts about the benefits of continuing in a maladaptive behavior, rather than explore the client's perceived benefits. (skill-building vs. evocation)
- Probe developmental antecedents of the client's need for a behavior, rather than asking about how this behavior is consistent or inconsistent with the client's current values and goals. (uncovering unconscious motivations vs. evocation)
- Help the client to contact or utilize spiritual resources to assist in changing, rather than using reflective listening and open questions to determine the client's strengths and successes (spiritual guidance vs. empathy)

The three global ratings of Evocation, Collaboration, and Autonomy Support replace the single MI Spirit global rating from the MISC 2.1. These ratings are not orthogonal; rather they may be related and influenced by each other. For comparison with past research, Evocation, Collaboration, and Autonomy Support may be averaged together to yield a Spirit global. It is recommended that you average this summary variable to two decimal points.

Client Global Rating: Self-Exploration

The MISC 2.5 uses a single global rating of client Self-Exploration within a treatment session. This rating parallels the construct of "experiencing" used by Truax and Carkhuff in the study of client-centered therapy, except that the definition of "personally relevant material" is not limited to the expression of emotion. The rating should reflect a period (more than momentary) of the client's *high point* of self-exploration during the session. Because the client's behavior often changes markedly over the course of a session, this is not meant to be an average across the entire session. Self-exploration need not be related to changing the target behavior.

Specific Guidelines:

- The rating is made on a 5-point Likert scale. Unlike the counselor global ratings, the client global rating assumes a starting point of "1" (not "3") and requests a rating of the *high point* of the session (not an average across the entire session). The rating should be based primarily on the client's behavior during the observed session.
- Select one and only one number, and do not leave this item blank. Do not make a rating that falls between the numbers.
- It is helpful to note examples of self-exploration and personally relevant material on as you listen to the session.

Verbal Anchors

1. No personally relevant material is revealed or discussed by the client during the session. If the clinician brings up personally relevant material, the client dismisses it or responds only minimally.

Examples:

- Client actively avoids talking about personally relevant material
 - Client changes the subject if the clinician brings up personally relevant material
 - Client expresses disinterest in examination of the problem at hand
2. The client may respond to and elaborate on personally relevant material that is brought up by the counselor, but does not add significant material or volunteers information in a mechanical manner or without demonstration of emotional feeling.

Examples:

- Client discussion of personally relevant material seems almost rehearsed
 - Client refers to the problem in a superficial manner
 - Client is simply reporting historical facts about the problem
3. The client does volunteer or elaborate on some personally relevant material beyond that directly asked for by the counselor, but does not readily explore it further.

Examples:

- Client maintains superficial treatment of problem even if prompted for depth
 - Client talks about significant personal issues with a sense of emotional distance
 - Clinician attempts to elicit active problem solving are resisted by the client
4. The client readily volunteers or elaborates on personally relevant material beyond that directly asked for by the counselor, evidencing some active thinking, feeling, and/or problem solving. The client may discover some new feelings, perspectives, or personal meanings.

Examples:

- Client is actively trying to explore the problem even if fearful or tentative
 - Client demonstrates a sense of searching for new meaning or understanding
 - Client speech is present as future focused as opposed to reporting of history
5. The client engages in active intrapersonal exploration, openly exploring values, problems, feelings, relationships, fears, turmoil, life-choices, and perceptions. Clients may experience a shift in *self-perception*.

Examples:

- Client speech provides a connected chain of thoughts when referencing the problem and potential solution
- Client relates new insights into his/her own thought processes or actions
- Client may express emotion such as excitement or distress at a new self-perception
- Client shows a marked shift from prior defensiveness to open exploration of a problem and its possible solutions

Defining “Personally Relevant Material” in Coding Self-Exploration

Personally relevant material may include expression or exploration of the following:

- Personal problems
- Self-descriptions that reveal the self to the counselor, expressions of the internal world

- Personally private material which when revealed tends to make the client more vulnerable or could be personally damaging
- Personal values, life choices
- Expression of feelings
- Personal roles, perception of one's relationship to others
- Perception of self worth

Second Pass: Parsing

The basic unit of behavior coding is the *utterance*. An utterance is a complete thought, or a thought unit (Gottman, Markman, & Notarius, 1977; Weiss, Hops, & Patterson, 1973). Two or more utterances often run together without interruption. If two consecutive sentences or phrases merit different codes (e.g., a reflection followed by a question), they are by definition separate utterances. Sequences of Follow/Neutral or Giving Information can be combined into single, long utterances, even if the topic changes. Instances of client change language should be parsed into separate utterances, even if the client emits consecutive utterances from the same change talk (or sustain talk) category. Client speech that refers explicitly to the distant past and has not been directly linked to their current behavior should be treated as Follow Neutral, even if it otherwise sounds like change language. When this is unclear, parse the speech as if it was change talk.

T: (Thank you for coming in.) (What brings you to see us today?)

C: (Well, I really want to quit drinking.) (There's nothing I want more than to quit this habit.)

T: (Why would you like to quit drinking?)

C: (Because I'd like to go to work without a hangover,) (I want to have a liver left by the time I retire,) (I want my grandkids to be proud of me,) and (I want to take my wife out to dinner without having too much wine and making a scene.) (**four R+**)

C: (In my younger days, I used to work downtown, I used to stop by that bar on First Street—I forget the name—and then take the bus home afterward. Those were some good times. Do you know the one I mean?) **FN**

T: (No, I don't remember the name either. I'll bet you're thinking of the one on the corner, with the red roof. In any case, I'd like to get back to the assessment results.) **GI**

C: (When I first did treatment three years ago, I was so ready to change. I wanted to do it for my health, my family, and my job, but I never quite succeeded.) **FN** (distant "past" CT)

A client utterance always terminates a counselor utterance, and the next counselor utterance becomes a new response. When coding transcribed sessions, utterances should be enclosed by the parser in parentheses to indicate exactly which words are considered a part of each utterance. In cases where both parties speak at the same time, the volley may be parsed and linked to form separate coherent utterances.

T: (I think it's fantastic that you

C: (Yeah it was

T: ...were able to do that.)

C: ...hard for me).

These utterances would be nonsensical and uncodeable if each terminated when the other speaker began, but in this way they can be parsed in such a way as to form coherent utterances.

T: (I think it's fantastic that you)
C: (Yeah it was)
T: {...were able to do that.)
C: [...hard for me).

Because each utterance is defined by the available behavior codes, the persons selected to parse must be well-trained and experienced with language coding. The same individual may both parse and code on the same project, but generally should not code the sessions they have parsed.

Third pass: Behavior coding

During the coding pass, the recording may be stopped as often as necessary. The coder must decide in which of the main behavior categories each utterance belongs. If using transcripts, write the abbreviation for the appropriate behavior code (see page 16 for a list) next to the utterance number in the margin of the transcript, and then proceed to the next utterance. The same utterance may never be given two different codes. If the parser has included two or more complete utterances (or volleys) within one parse (i.e., because of judgment error, mechanical error, or basic disagreement), code the *last* utterance present. If two consecutive utterances both merit the same code (e.g., two questions in a row, on two different topics), then code them as such.

Examples:

T: (Why haven't you quit smoking – are you ever gonna quit?)	single utterance
T: (How long since your last drink?) (Do you feel ok?)	two utterances
C: (I can't quit.) (I just can't do it.) (I don't have what it takes.) (I just cannot stop.)	four utterances.
C: (I don't want to go to the bars every day.) (I don't want my kids to see that. I want my kids to have a better life than that.)	two utterances.

A *volley* is an uninterrupted utterance or sequence of utterances by one party, before another party speaks. The same code may be assigned multiple times within a volley, but any given utterance within a volley must be assigned only one code.

No Code:

Portions of a treatment session might be uncodeable, due to factors like poor audio quality, incomplete utterances, erroneous parsing, intrusions by third parties, interruptions, or in-session exercises. In these cases, coders will assign "No Code" to these client or clinician utterances. Although this code is rare, to ensure good inter-rater reliability it is important to use NC when warranted.

Examples:

- Values Card Sort (e.g., flipping of cards, silence, or client mumbling to self)
- Role play (e.g., counselor asks client to practice a skill or play someone else)
- Client or clinician accepting or placing a phone call
- A third person speaking during the session (e.g., client's child or partner, additional counselor)
- A pause in the session (e.g., nurse enters hospital room to check vital signs, fire alarm sounds)
- Incomplete utterances: Occasionally, one party begins a thought but does not complete it. Sometimes, it is clear from the partial utterance what was meant, in which case it should be coded. At other times, it is not clear what was meant, and in these cases the incomplete statement should be ignored and marked as uncodeable.

Examples:

C: I don't know what would happen to me if I went back to drinking.

T: You know, I... (not coded, because meaning is not clear)

C: I mean, I might lose my job.

T: So you're really drinking to excess.

C: No, I don't think... (coded as sustain talk)

T: I mean you're in the top two percent.

Facilitative language: Facilitative language, which indicates that the client or counselor is listening or insinuates that the speaker should “keep going” (e.g., uh huh, yeah, mm hmm) but does not indicate significant meaning, may be ignored and left unparsed and uncoded. This is especially relevant when parsing and coding by computer, because parsing out very brief facilitative statements would interrupt important codes (e.g., reflections, change talk). Contrast facilitative statements with client or counselor *agreement*, which might be coded as (borrowed) change talk or a MICO code.

Examples:

C: I don't know ...

T: uh huh (Facilitate)

C: ... what would happen ...

T: yeah (Facilitate)

C: ... to me if I went back to drinking.

T: So you're done for good.

C: Yeah (agreement; do not code as Facilitate)

Multiple Codes Parsed Together:

Sometimes, through parser error, technical difficulties (e.g., lag when parsing electronically), or differences in opinion, coders might believe that multiple utterances have been parsed together. When two or more utterances appear to be parsed together, the coder should assign a code based upon the *last complete utterance*.

Examples:

[T: “I’m not sure if I’m ready to quit yet.” C: “It’s important to you to choose the right time.”] **CR- (not R-, CR-)**

[“I want to change, and I know that I really need to change, but I’m not feeling at all confident about actually doing it.”] **A- (not D+, N+, A-)**

[“So I was at my girlfriend’s place when the cops showed up. The house was full of underage drunk people, and there was a keg in the kitchen. Everyone ran, but I didn’t make it out in time. I know now that it was a stupid decision to drink that night, because it landed me in here.”] **O+ (not FN, O+)**

[C: “...at the mall.” T: “That’s where you met.”] **SR⁰ (not FN, SR⁰)**

Counselor behavior categories

There are 17 basic categories of counselor behavior in MISC 2.5, each of which has a unique two-letter code. Four categories require differentiation between two subcategories. These four categories must include the subcategory designation. The Counselor Behavior categories are:

AD	Advise	With Permission (ADP) or Without Permission (ADW)
AF	Affirm	
CO	Confront	
DI	Direct	
EC	Emphasize Control	
FA	Facilitate	
FI	Filler	
GI	Giving Information	
OQ	Open question	
CQ	Closed question	
RC	Raise Concern	With Permission (RCP) or Without Permission (RCW)
SR	Simple Reflection	Requires valence +/-/0/±
CR	Complex Reflection	Requires valence +/-/0/±
RF	Reframe	
SU	Support	
ST	Structure	
WA	Warn	

Advise (with or without permission) (ADP/ADW)

The counselor **gives advice, makes a suggestion, or offers a solution or possible action.** Instances will usually contain language that indicates that advice is being given: should, why don't you, consider, try, suggest, advise, you could, etc.

Advise requires sub classification for whether the advice was given **with or without permission** from the client. Prior permission can be in the form of a request from the client, or in the counselor asking the client's permission to offer it. In this way, permission serves as an “escape clause”, which allows the client *not* to choose an option suggested by the counselor. These permission-seeking utterances are coded as a separate utterance of Emphasize Control. Permission-seeking for asking a question or giving information is also coded as Emphasize Control.

Indirect forms of permission asking may also occur, such as a counselor statement that gives the client permission to disregard the advice ("This may or may not make sense to you"). A client may also implicitly give permission by requesting the counselor's advice. In this case the ADP utterance would be coded without a preceding EC utterance.

(ADP) Advise with permission:

“Would it be all right if I suggested something?”

“Do you mind if I tell you how alcohol works in the body?”

“Can I ask you a question about that?”

“We could try brainstorming to come up with ideas about quitting if you like.”

“This may or may not work for you, but some people chew gum instead of smoke cigarettes.”

“I'd like to get your thoughts, but switching medications could be a possibility.”

(ADW) Advise without permission:

“Consider buying more fruits and vegetables when you shop.”
“You could ask your friends not to drink at your house.”
“You should really keep doing what you’re doing.”
“Double trouble would be a better AA meeting for you.”
“After this session, you should write all these things down.”
“I recommend that you attend 90 meetings in 90 days.”
“Just going ‘cold turkey’ is the best way to give up smoking.”

Differentiating Advise from other categories

Advise should not be confused with other codes.

“Don’t let your friends drink at your house.”	Direct due to the imperative “ <i>Don’t</i> ”
“Could you ask your friends not to drink at your house?”	Closed Question.
“What could you ask your friends to do to help you?”	Open Question.
“It’s your choice whether to do this or not.”	Emphasize Control

Affirm. (AF)

The counselor says something **positive or complimentary** to the client. It may be in the form of expressed **appreciation, confidence, or reinforcement of client achievements**. The counselor comments on the client’s **strengths or efforts**.

It is not necessary to subclassify Affirm responses.

Appreciation. The counselor compliments the client on a **trait, attribute, or strength**.

The reference can be to a "stable, internal" characteristic of the client, something positive that refers to an aspect of the client that would endure across time or situations (smart, resourceful, patient, strong, etc.). It may also be for **effort**.

“You’re a very resourceful person.”
“Thank you for coming today.”
“You’ve made a huge cut in your smoking.”
“I’ve enjoyed talking with you today.”

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

Client: “I don’t think I can do it.”

Counselor: “*You’ve succeeded through some difficult changes in the past*”

Reinforcement. These are general **encouraging** or "applause" statements even if they do not directly comment on a client's nature, and do not speak directly to self-efficacy. They tend to be short.

“That’s a good idea.”
“Good for you.”
“That’s good.”

Differentiating Affirm from other categories

Affirm should not be confused with Support or Emphasize Control.

Support takes on a **sympathetic** or **agreeing** quality, while affirm comments favorably on a client **characteristic**, bespeaks **confidence**, **congratulates**, or **encourages**. Support is a “hug,” whereas Affirm is a “pat on the back.”

Emphasize Control takes precedence over Affirm when a counselor response could be interpreted as both.

“That must have been difficult.”	Support (sympathetic not appreciative)
“You’ve accomplished a difficult task.”	Affirm (effort/reinforcement)
“It was your decision to come here today.”	Emphasize Control
“Thank you for coming today.”	Affirm (appreciation)

The Affirm code is only applied to information about the *client*. Positive feedback related to the client’s SO or other important individuals in the client’s life should be coded as Support.

C: The Mets won the World Series!	Follow/neutral
T: That’s great!	Filler
C: I didn’t drink at all at the victory party.	Follow/neutral
T: That’s great!	Affirm
C: My daughter got into Harvard!	Follow/neutral
T: That’s great!	Support

Confront. (CO)

These are the expert-like responses that have a **negative-parent quality** – an uneven power relationship accompanied by disapproval, disagreement, or negativity. There is a sense of “expert over-ride” of what the client says.

The counselor **directly disagrees, argues, corrects, shames, blames, seeks to persuade, criticizes, judges, labels, moralizes, ridicules, or questions the client's honesty.**

Included here are utterances that have the form of questions or reflections, but through their content or **emphatic voice tone** clearly constitute a roadblock or confrontation.

If you are in **doubt** as to whether a behavior is a Confront or some other code, do *not* code it as Confront. **Re-emphasizing negative consequences** that are already known by the client constitutes a Confront, except in the context of a Reflection. The Reflection restates information presented by the client and is merely reflected back to the client without disapproval or negativity.

Client: "I can't believe they took my license away."
Counselor: "You knew you'd lose your license and you drove anyway." **Confront**
(criticizes)

Or

Counselor: "You lost your license because of your DUI." **Reflection**

Client: "I looked for a job this week."
Counselor: "Sure you did. Right." (Disbelieving, sarcastic voice tone) **Confront**

Client: "I thought when I got pregnant I'd quit smoking for the baby, but I haven't"
Counselor: "You're willing to jeopardize the baby's health just for cigarettes." **Confront**
(judgmental, shaming, re-emphasizes consequences not voiced by the client)

An utterance may express direct disagreement without expressing negativity and still be coded as confront.

C: "I'm an awful mother."
T: "No you're not, you're a great mother." **Confront** (disagrees)

C: I just don't feel like I can do this right now.
T: Sure you can! **Confront** (disagrees)

Differentiating Confront from other categories

Do not confuse Confront with Reflect or Question or Facilitate.

Confront should be unmistakably confrontational. Subtle inference is not sufficient reason to code a counselor's behavior as Confront; conceptually, the bar for coding an utterance as a Confront is quite high, and coding sub-threshold statements as Confronts can lead to poor inter-rater reliability.

If a question has a sarcastic tone, code as Confront as referenced above.

Client: "I don't really have a problem with alcohol."

or
Counselor: "Drinking really hasn't caused problems for you." **Reflection**
Counselor: "So YOU think that you don't have any problems AT ALL!" **Confront** (conveyed by
sarcastic tone in vocal emphasis)

Client: "I can't believe I missed work and blew a good job just to party."

or
Counselor: "It seems like a high price to pay for a good time."
Counselor: "Well, surprise, surprise! Imagine that!" **Reflection**
Confront (sarcasm)

Client: "I don't care if I lose my job because I drink too much."

or
Counselor: "Losing your job is a pretty high price to pay for having a good time." **Confront**
(disagrees)
Counselor: It really doesn't matter to you. **Reflection**

Client: "I feel kind of run down."

- Counselor: "Don't you understand what drinking is doing to your health?"* **Confront**
or *Counselor: "Do you think alcohol is affecting your health?"* **Closed Question** (not sarcastic
in tone)
or *Counselor: "D'ya think that alcohol might be responsible, maybe?"* **Confront** (sarcastic tone)

Client: "I didn't drink all weekend."

- Counselor: "So you say. Tell me another one."* **Confront**
or *Counselor: "Uh huh."* **Facilitate**

Occasionally, a Confront can masquerade as an Affirm. This often will sound like "cheerleading," in which the counselor persists in pushing the client in the direction of change, despite indications that the client is ambivalent or unready.

Client: I went for five days without drinking this week.

- Counselor: "I told you you could do it!"* **Confront** (Expert, paternal quality)
or *Counselor: "Good for you!"* **Affirm**

Client: I'm doing a little better, I guess, but I feel like it's pretty hopeless.

- Counselor: "But look how much progress you've made!"* **Confront** (disagreement)
or *Counselor: You can see some progress, but mostly you're discouraged.* **Reflection**

Direct. (DI)

The counselor gives an **order, command, or direction**. The language is imperative.

- "Don't say that!" **Direct**
"Get out there and find a job." **Direct**
"Just finish treatment so you can get back on track with your life!" **Direct**
"Put your family first." **Direct**

Phrases with the effect of the imperative tone include

- "You need to___." **Direct**
"I want you to___." **Direct**
"You have to___." **Direct**
"You must___." **Direct**
"You can't___." **Direct**

Examples:

- "I want you to watch this video." **Direct**
"You've got to stop drinking." **Direct**

“You must have more respect for yourself.”	Direct
“You can’t keep smoking pot.”	Direct
“Try out the meeting--see if you like it.”	Direct
“Just keep doing what you’ve been doing.”	Direct

Differentiating Direct from other categories

Direct should not be confused with Affirm, Advise, Warn, or Confront.

“You could try looking for a job this week.”	Advise
“I want you to try to find a job.”	Direct
“There’s no reason for you not to be working.”	Confront
“You should be proud of yourself for finding a job.”	Affirm
“Now get out there and get a job!”	Direct
“If you don’t find a job, your kids will starve.”	Warn

Generally speaking, the Direct code will applied primarily to contexts *outside* the session.

“Please have a seat.”	Filler
“Now, go ahead and blow into the Breathalyzer.”	Structure
“I’d like you to fill out this questionnaire.”	Structure
“Tell me what brings you here today.”	Open Question

Emphasize Control. (EC)

The counselor directly acknowledges, honors, or emphasizes the client's **freedom of choice, autonomy, personal responsibility**, etc. This may also be stated in the negative, as in "Nobody can make you change." There is no tone of blaming or fault-finding. Permission seeking utterances (e.g., “... if it’s OK with you”) are also coded as Emphasize Control. When this occurs in relation to an Advise with permission or a Raise concern with permission, the permission-seeking utterance should be coded as Emphasize Control, and the Advise or Raise Concern utterance should be coded as either ADP or RCP.

Statements acknowledging the client’s autonomy in an accomplishment are coded as Emphasize Control rather than Affirm.

Client: “I went for five days this week without drinking.”

Counselor: “You made that choice.” **Emphasize Control**

Or Counselor: Good for you! **Affirm**

Emphasize Control takes precedence over Affirm, Reflect, or Giving Information when a counselor response could be interpreted as both.

- | | |
|---|--------------------------|
| “It is totally up to you whether you quit or cut down.” | Emphasize Control |
| “It’s your decision.” | Emphasize Control |
| “You know what’s best for you.” (No sarcasm) | Emphasize Control |
| “This isn’t a decision that I would ever want to make for you.” | Emphasize Control |
| “Is it OK if I ask you a few questions about that?” | Emphasize Control |

Differentiating Emphasizing control from other categories

Emphasize Control should not be confused with Affirm, or Confront, or Reflect.

When one utterance can clearly be coded as Emphasize Control, Affirm, or Reflect, Emphasize Control takes precedence.

- | | |
|---|--|
| “It’s great that you’re doing this for yourself.” | Affirm (reinforcement) |
| “It’s your decision whether you quit or not.” | Emphasize Control (freedom of choice) |
| Client: “ I’m finding this difficult.” | |
| Counselor: “ <i>You’re the one who has to change.</i> ” | Confront (negative quality) |
| Client: “I need to make up my mind about drugs.” | |
| Counselor: “ <i>You’re ready to make a decision.</i> ” | Reflection |
| Client: “Since I’m quitting, I won’t allow smoking in the house.” | |
| Counselor: “ <i>You’re setting your own goals and boundaries.</i> ” | Emphasize Control (not Reflection) |

Facilitate. (FA)

These are simple utterances that function as **keep-going** acknowledgments (e.g., “Mm Hmm,” “Yep,” “OK,” “Right,” “Got it, “I see,” “Good” [when not an Affirmation]).

- | | |
|--|-----------|
| C: “I’m thinking about joining the gym down the street.” | FN |
| T: “Okay.” | FA |
| C: “Yeah, I think it could help with my recovery.” | O+ |

C: "Here's that form from my PO."	FN
T: "Good."	FA
C: "She said you'd want it."	FN
T: "Right."	FA
C: "I didn't have many people who believed in me, growing up."	FN
T: "Uh huh."	FA
C: "My parents both died when I was young."	FN
T: "Oh."	FA

Responses to client questions are typically coded as Giving Information, even if they are brief.

Example:

C: "Do I have to go to all the groups while I'm here?"	FN
T: "Yup."	GI

Facilitate responses are **standalone** utterances. They do not usually occur with other counselor responses in the same volley. Do not code as Facilitate if the vocal sound is a preface to some other counselor response like a Question or a Reflect. In these combinations, code only the second response. No Facilitate would be coded for:

"OK, well let's get started with these questionnaires, then." **Structure (ST)**

C: "I went the whole weekend without having a cigarette."	TS+
T: "Wow!"	SU

"That's right. Alcohol is a depressant." **GI**

Do not code as Facilitate if the vocal sound serves as a **time holder** (uh . . .) that serves to delay the client's response, rather than having the "go ahead" function. These are treated as part of a single utterance.

"Uhhhhhh, I think it's about four standard drinks." **Giving Information**

"Well...I think we should move on to your step work now." **Structure (ST)**

Similarly, a counselor's utterance might serve the function of **agreeing** with the client, rather than just furthering the interaction (e.g., "Exactly!" "Yes!" "You've got it!"). This speech is likely to be a Support, Affirm, Emphasize Control, or other MI-consistent statement.

Special cases

In video coding, do not code a head-nod or other nonverbal acknowledgment as Facilitate, unless it is accompanied by an audible utterance. When parsing and coding without a transcript, such as via computer software, facilitative utterances may be ignored for the purpose of improving the understandability of the parsed recording.

Differentiating Facilitate from other categories

Do not confuse Facilitate with Question or Confront. A counselor may make an utterance that sounds like a Facilitate but has a **negative or sarcastic quality**. It must unambiguously disagree, question the client's honesty, express sarcasm, etc. These have a "Hah!" or "Aha!" or cynical "Yeah, right!" quality. If a

Facilitate has a sarcastic or cynical quality it is coded as a Confront. When in doubt, however, code as Facilitate rather than Confront.

Some brief utterances sound like other categories, but function as Facilitates: “Oh, did you?” “Really!” If voice tone *clearly* implies skepticism (“Oh you did, did you?”) it would be coded as **Confront**.

A counselor’s speech pattern may include Facilitates that have some features in common with other categories. Some common examples include “Really?” and “You know?” These should be counted in the Facilitate category unless it is clear from the context that the counselor is seeking additional information about the client’s statement.

C: I think my brother has a drinking problem, and his wife is a pain. **Follow/Neutral**

T: Right. **Facilitate**
Although siding with the client typically would be coded as Support, the counselor here is most likely telling the client to “go on,” rather than agreeing with the client’s assessment.

C: I’d like to talk about what happened this weekend. My wife... **Follow/Neutral**

T: Go on. **Facilitate**
Although phrased in the imperative, the use here is clearly facilitative, so it is not coded as Structure.

C: I had a fantastic weekend! **Follow/Neutral**
T: Really. **Facilitate**

Although phrased in the interrogative, here again the use is clearly facilitative.

Filler. (FI)

This is a code for the few responses that are not codeable elsewhere (**pleasantries**, etc.). It should not be used often. If these exceed 5% of Counselor responses, they probably are being over-coded.

“Good Morning, John.” **FI**

“I assume you found a parking space OK.” **FI**

“Nice weather today!” **FI**

“I see that you’ve met the new receptionist.” **FI**

Giving Information. (GI)

The counselor provides **information** to the client, **explains something, educates** or **provides feedback**, or **discloses personal information**. When the counselor gives an opinion but does not advise, this category would be used.

It is no longer necessary to distinguish among types of Giving Information. If a Counselor response fits any of the following example types, code it as Giving Information.

Some example types of Giving Information include providing feedback from assessment instruments, explaining ideas or concepts relevant to the intervention, or educating about a topic.

Providing feedback from assessment

“You indicated during the assessment that you typically drink about 18 standard drinks per week. This places you in the 96th percentile for men your age.”

Giving Information

“Your blood pressure was elevated when the nurse took it this morning.”

Giving Information

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

“You had mentioned last time that you were thinking about moving out.”

Structure

“I see from your chart that you’re here because of a DWI.”

Giving Information

Explaining ideas or concepts relevant to the intervention

“This homework assignment to keep a diary of your urges to drink is important because an urge is like a warning bell, telling you to wake up and do something different.” **Giving Information**

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**

Differentiating Giving Information from other categories

Giving Information should not be confused with **Warn, Direct, Confront, Advise Reflect**, or **Question**.

Reviewing information contained on assessment instruments does not typically qualify as a Reflection.

“From what I see here it seems like you’ve experienced a lot of interpersonal consequences.”

Giving Information

Informing can become a Warn if there is a tone of threat or “if...then.”

“If you do tell me that you’ve used drugs, I am required to disclose that to your probation officer.”

Giving Information

“If you tell me that you’ve been using drugs, I’m going to tell your probation officer.” **Warn**

Giving Information can be combined with other responses that go beyond the simple provision of information:

“[You indicated during the assessment that you typically drink about 48 standard drinks per week.] [That much drinking is bound to damage your health sooner or later.]”

Giving Information/ Warn

“Here is a diary that you can use to keep track of urges.”

Giving Information

“Keep track of your urges this week using this diary, 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 think you are eating five. It can be easy to deceive yourself.”

Confront

“[AA 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.]” **Giving Information, Confront, Advise without Permission**

“I’m wondering what brings you here today.”

Open Question

“I think it’s so great that you were able to make it all week without smoking.” **Affirm**

“[This score tells me that your answers were inconsistent], [which means that you didn’t answer the items truthfully].”

Giving Information, Confront

Question. (OQ/CQ)

The counselor asks a question in order to gather information, understand, or elicit the client's story. Generally, these begin with a question marker word: Who, What, Why, When, How, Where, etc. The question may also be phrased in the imperative or opinion statement. Statements that end with an upward inflection are typically coded as questions, even if they are formed as reflections; however, questions need not have an upward inflection at the end (e.g., “Tell me more about your use.”)

“Tell me about your family.”

Open Question

“Tell me more.”

Open Question

“Tell me how old you are.”

Closed Question

“I’d like to know more about...” **Open Question**

“I wonder why you feel that.” **Open Question**

QUESTION responses require subclassification as:

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

What do you want to do about your drug use?	Open Question
What do you want to do about your drug use? Anything?	Closed Question
Tell me about your drinking.	Open Question
[Tell me about your drinking.] [How old were you when you had your first drink?]	Open question/Closed Question
“You’re saying that your alcohol use hasn’t changed that much?”	Closed Question (spoiled reflection)
“You really want to change, but don’t know how?”	Closed Question (spoiled reflection)
“For you, this has been really...costly?”	Closed Question (spoiled reflection)

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

What county do you live in? Washington? Multnomah?	Closed Question
What do you want to do about your drinking?	Open Question
What do you want to do about your drinking: quit or cut down?	Closed Question
Do you mostly use alcohol, or marijuana?	Closed Question

Closed questions may also be expressed to gather specific information about a past event with only one specific, concrete answer possible:

What did your parole officer tell you when he found out?	Closed Question
How often did you go to that bar?	Closed Question
Who referred you to our agency?	Closed Question
What was your BAC at the time of the accident?	Closed Question

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

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

Differentiating Open and Closed Questions:

Questions must reach a threshold of openness to be coded as open questions. This is similar to complex reflections, which must reach a threshold of complexity to be coded as complex reflections. If a question does not reach a threshold of openness, code as **closed question**.

Do you want to change?	Closed Question
So change is important to you?	Closed Question
What do you want to do: change or not change?	Closed Question
On a scale of 1 to 10, how much do you want to change?	Closed Question
What did your parole officer say that you'd need to change?	Closed Question
Could you tell me what you think about change?	Closed Question
How much do you want to change?	Open Question
Tell me what you think about change.	Open Question
What do you think about change?	Open Question
How might you go about change?	Open Question
I'm wondering what you might do to change.	Open Question
What would have to happen for you to consider change?	Open Question

In cases where a question is ambiguous and could reasonably be interpreted both as having a fixed set of responses (closed question) or any number of responses (open question), code as **closed question**.

“How ready are you to start working on changing?” **Closed Question** (can be interpreted as fixed response or open response, thus go with closed question)

“What did the committee say you needed to do to keep your scholarship?” **Closed Question** (information gathering, i.e., what the committee said is the only realistic answer)

“Where did you go to high school?” **Closed Question** (any high school could be a possible answer, but really the high school the client went to is the only realistic answer)

Some questions function as open questions, but are structured as closed questions. In these cases, go with **Closed Question**.

“Could you tell me what brings you here?” **Closed Question** (formatted as yes/no, despite functioning as open question)

“Can you tell me a little more about what you're turned off by?” **Closed Question** (formatted as yes/no)

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

Now remind me here - why is it again that you're on probation?	Confront
Why should I trust you this time?	Confront
Are you feeling angry with your mother?	Closed Question

Questions are sometimes strung together in a series. In this case, if each question addresses a different topic, then **each question** is coded. If each question **belongs to the same category** and **addresses the same thought**, then the **entire series** of questions is coded as a single question.

“What about your mother? What does she think of all this?”	OQ
“What about your family? And has your doctor discussed this with you?”	OQ, CQ
“Tell me about your drug use. Do you use marijuana?”	OQ, CQ
“ Was it cocaine or benzos that were giving you the most trouble? Do you prefer uppers or downers? ”	CQ
“Do you prefer uppers or downers? Tell me about your drug use.”	CQ, OQ
“How old are you? Do you want to lose weight? Where did you get that pen?”	CQ, CQ, CQ

A statement that serves to provide context for a subsequent question should be parsed and coded part of that question, in a single utterance. However, if the counselor gives a reflection and a separate question (e.g., by pausing after the reflection to allow the client to respond or by giving a reflection that is not merely for providing context to the question), parse and code both units of speech.

Examples:

(You said that you started going to AA meetings, so how is that going?)	Single utterance
You want to go to AA meetings.) (What else would help you change?)	Two utterances
(You said you started going to AA meetings.) [pause] (How is that going?)	Two utterances

Question statements may also have other types of speech intertwined within the question. If such speech primarily serves the purpose of adding contextual information, do not parse and code as separate units of speech; instead code as a single question.

Example:

(What helped you get through that? Because a lot of people have a hard time, so what helped you through that?)	Single utterance of OQ
--	------------------------

Raise Concern (With or Without Permission). (RCP/ RCW)

The counselor points out a **possible problem** with a client's goal, plan, or intention. It always contains language that marks it as the **counselor's concern** (rather than fact).

Raise Concern always requires sub classification as to whether the concern was raised **with or without permission**.

Prior permission can be in the form of a request from the client or in the counselor asking the client's permission to offer it. These permission-seeking utterances are coded as separate utterances of Emphasize Control.

Indirect forms of permission asking may also occur, such as a counselor's statement that gives the client permission to disregard the counselor's concern. A client may also implicitly give permission by requesting the counselor's input. In these cases the RCP utterance would be coded without a preceding EC utterance.

Raise Concern may include elements of **possible negative consequences** as long as these are expressed as the **counselor's own concern**.

Examples: Raise Concern with Permission (RCP)

T: “This may not seem important to you, but I’m worried about your plan to move back to your old neighborhood”. **EC, RCP**

T: “Is it OK if I tell you a concern that I have about that? I wonder if it puts you in a situation where it might be easy to start using again. **EC, RCP**

C: “What do you think of that idea?”T: “Well, frankly it worries me.” **FN, RCP**

T: “This might not be your top priority today, but I admit that I’m a little worried that you’re drinking more frequently.” **EC**

Examples: Raise Concern without Permission (RCW)

T: “I’m worried that you may have trouble when you’re around your old friends.”

T: “I think you may wind up using again with your old friends.”

T: “That doesn’t seem like the safest plan.”

Differentiating Raise Concern from other categories

Do not confuse Raise Concern with Advise, Support, Question, Giving Information, Confront, or Warn.

Advise is coded when the counselor is suggesting a form of action. Raise Concern does not advise a course of action, but rather points to a potential problem or issue for the client's consideration.

Support includes statements of compassion that can appear similar in language. The difference is that Raise Concern points to a **particular** issue, problem, or risk.

If concern is raised in the form of a question, code as *Question*, **unless** the counselor is asking permission to raise a concern in the form of a question.

In *Giving Information* the counselor provides factual information that is not identified as a concern.

Confront involves direct disagreement, argument, criticism, shame, blame, judgment, moralization, disapproval, etc. Confront has a particular negative-parent quality that acts as a roadblock or confrontation. Confront contains language that implies the concern as “fact” rather than opinion or concern. Raise Concern contains language that identifies it as the counselor’s concern only.

Warn always threatens or implies negative consequences without identifying them as the counselor’s concern.

“I’m worried that you’ll use drugs when you’re bored.” **RCW** (no advice given)

“You could ride your bike when you get bored.” **Advise** (makes a suggestion)

“I’ve been concerned about you this week.”	Support (sympathetic, no specific issue)
“Could I tell you what concerns me about your plan?”	RCP (not coded as Question)
“Boredom is a common trigger for drug use.”	Giving Information (if the context does not imply Warn)
“How will you keep on track when you go back home?”	Open Question (not RCW or Confront)
“There’s no way your plan will work if you’re around your old friends.”	Confront (factual statement)
“I’m concerned that you are an alcoholic.”	Confront (labeling)
“If you get bored you’ll use drugs.”	Warn (negative consequences, not concern, fact)

Reflection. (SR/CR)

A reflection is a reflective listening statement made by the counselor **in response to** a client statement. The counselor makes a statement that reflects back content or meaning previously offered by the client, usually (but not always) in the client's immediately preceding utterance. Never code questions (Who, Why, What, etc.) as **Reflection**. If a counselor response includes both a **Reflection** and another codeable response (such as a **Reflection** followed by a **Question**), code *both* behaviors separately, **as long as the reflection stands alone as an utterance and does not merely provide context to the question**. However, do not sub-divide a reflection, even if it includes a great deal of information. If a reflection is interrupted by another category of behavior, such as reflect-confront-reflect, then both all three utterances would be coded. Utterances referring to the content of previous sessions are coded as **Structure**.

Reflections **capture and return** to the client something that the client has said in the current session.

- Reflections can simply **repeat** or **rephrase** what the client has said or may **introduce new meaning** or **material**.
- Reflections can **summarize** part or all of the current session.
- Counselor utterances that reflect upon information that was provided by the client in a **questionnaire** or on an **intake form** may be coded as **Reflect** as long as that information was **previously available to the client** (otherwise code as Giving Information).
- Reflections require **subclassification** as either Simple or Complex.

Simple Reflection: These reflections add **little or no meaning** or **emphasis** to what the client has said. They often **restate** or **slightly rephrase** what the client has already said. Simple reflections **merely convey understanding** or facilitate client-counselor exchanges. They may identify very important or intense client **emotions** but do not go far beyond the original overt content of the client’s statement. These reflections may be lengthy, but they do not change substantially the client’s intended meaning. Generally counselors are **following the client’s statements** relatively closely.

Complex Reflection: These reflections **add significant meaning** or **emphasis** to what the client has said. They convey a **deeper or richer** picture of the client's statement. The counselor may add either **subtle or obvious** content or meaning to the client's words.

This may be accomplished in a variety of ways, but the essential feature of a complex reflection is the counselor's injection of emphasis or content to make the client's statement **more** than it was. Here are some examples of how reflections can become complex:

- **Amplified reflection:** Content offered by the client is exaggerated, increased in intensity, overstated, or otherwise reflected in a manner that amplifies it. Likewise, content offered by a client may be understated or the intensity may be depreciated.
- **Double-sided reflection:** Both sides of ambivalence are contained in a counselor's response. Note that for **sequential coding**, each aspect of ambivalence should be parsed and coded into separate simple reflections whenever possible (e.g., **SR+**, **SR-**). These sequential utterances can then be captured as double-sided reflections during data analysis.
- **Continuing the paragraph:** The counselor anticipates the *next* statement that has not yet been expressed by the client.
- **Use of analogy, metaphor, or simile:** When not previously stated by the client.
- **Reflection of emotion/feeling:** Where the affect was not directly verbalized previously by the client.
- **Contrasting:** Across time or situations, often to create or intensify discrepancy.
- **Summaries:** These might be coded as Complex Reflections if they add significant content or meaning to client statements and are not merely collections of utterances.
- **Distillation of meaning:** Where the clinician extracts deeper meaning from a statement or collection of loosely related statements.

Note that each of these types of reflection **might or might not** be complex, and when coders come across them, they should carefully evaluate whether the statement adds **sufficient** meaning or emphasis to what the client has said. For example, a double-sided reflection may be a repetition or restatement of what the client has said. In this case, it is still a simple reflection:

Client: "I want to, but I don't want to."

Counselor: "You want to change, but you don't want to."

Simple Reflection (SR+/-)

Counselor: "You want to change, but the comfort of old habits also has a strong pull."

(CR+/-)

Complex Reflection

C: "I wouldn't mind coming here for treatment but I don't want to go to one of those places where everyone sits around crying and complaining all day."

Counselor: "You don't want to do that."

Counselor: "So you're kind of wondering what it would be like here."

(CR⁰)

Simple Reflection (SR⁰)

Complex Reflection

Client: "The court sent me here."
 Counselor: "That's why you're here."
 Counselor: "That's the *only* reason you're here."
 , by amplification)

Simple Reflection (SR⁰)
Complex Reflection (CR-

Client: "At one time I was pretty much anti anything but marijuana."
 Counselor: "Marijuana was OK."
 Counselor: "That's where you drew the line."
 (CR⁰)

Simple Reflection (SR⁰)
Complex Reflection

Client: "Everyone's getting on me about my drinking."
 Counselor: "Kind of like a bunch of crows pecking at you."
) (simile)

Complex Reflection (CR-

Client: "I'm not sure I can finish treatment."
 Counselor: "You're not confident that you can do it."
 Counselor: "Committing to this program seems terrifying."
Complex Reflection (adding emotion)

Simple Reflection (restatement)

Client: "I drank a couple of times this week when I was with my brother."
 Counselor: "Staying sober is pretty easy for you most of the time, but you find it more difficult not to drink when he's around."
Complex Reflection (contrasting)

Client: "I don't like what smoking does to my health, but it really reduces my stress."
 Counselor: "On one hand you're concerned about your health, on the other you need the relief."
Complex Reflection (double-sided) (CR+/-)
 Counselor: "You don't like what smoking does to your health, but it's a stress-reducer."
Simple Reflection (adds nothing to what the client just said) (SR+/-)

Client: "I'm a little upset with my daughter."
 Counselor: "You're really angry at her."
Complex Reflection (overstates)

Counselor: [looking at questionnaire] "So you said you eat about five fruits and vegetables a day, and that is the usual recommended daily level."
Simple Reflection/Giving Information

Decision rule: If it is unclear whether a reflection is simple or complex, code it as **SR** to improve inter-rater reliability.

Reflections require further sub-classification as reflecting commitment to change (change talk), commitment to maintain the status quo (sustain talk), both, or neither (see client behavior codes below for a discussion of change talk). Denote which type of reflection with a superscripted +, -, +/-, or **0** as illustrated below.

Client: "I want to quit so badly, but I don't think I can do it."
 Counselor: "You're really concerned about whether you can do this or not."
 Counselor: "You've got a really strong desire to quit drinking."
 Counselor: ("You have a strong desire to quit,)(but you're not sure you have the ability.)"

SR⁻
SR⁺
SR^{+/-}

Reframe. (RF)

The counselor suggests a **different meaning** for an experience expressed by the client, placing it in a new light. These utterances generally have the quality of **changing the emotional valence** of meaning from negative to positive or from positive to negative.

Reframes generally **meet the criteria for Complex Reflections**, but go further than adding meaning or emphasis by actually **changing the valence** of meaning and not just the depth.

Reframing can involve giving the client **new information** in order to see their situation from a different perspective. In this case the information is a vehicle for reframing, and the default is **Reframe**.

Examples:

Client: "My husband is always nagging me about taking my medication."

Counselor: "Sounds like he's pretty concerned about you." **Reframe** ("nagging" as "concern")

Client: "My wife and kids know I've cut down a lot, but every time I do smoke they make a remark."

Counselor: "Their efforts to help feel like pressure to quit." **Reframe** ("pressure" as "help")

Differentiating Reframe from other characteristics

Reframe needs to be differentiated from **Reflection, Affirm, Giving Information, and Confront**

The above examples certainly reflect counselor understanding, but they also change the valence or emotional charge of a client statement.

Client: "I don't know if I can do it. I've tried so many times, and then something else comes up that I have to deal with first."

Counselor: "Something always gets in the way." **Complex Reflection**

Or Counselor: "You have clear priorities." **Reframe**

Reframe may make a positive attribution about the person, but the difference from **Affirm** is that it is a direct restructuring of what the person has just said.

Client: "I don't think I can do it. I've tried so many times, and then something else comes up that I have to deal with first."

Counselor: "Oh, I don't know. You're a pretty strong person." **Affirm** (it is not obviously linked to the content of the client's preceding statement)

Counselor: "You have clear priorities." **Reframe**

The giving of information is only coded as a **Reframe** if it changes the valence of meaning of a client statement.

Client: "Do people who go through this program quit the first time?"

Counselor: "Some do, and sometimes it takes a few tries before they succeed." **Giving Information**

Client: I've tried to quit before and failed.

Counselor: “Each attempt is moving you closer to success.”

Reframe (“failure” as “step toward success”)

Finally, **Reframe** can border on **Confront** because it involves an indirect element of disagreement with the client. The distinctive difference is that **Confront** has a corrective, expert tone that implies that the client is mistaken.

Client: I don’t think I can do it. I’ve tried so many times, and then something else comes up that I have to deal with first.

Counselor: “Oh, I don’t know. You’re a pretty strong person.”

Affirm (it is not obviously linked to the content of the client’s preceding statement)

Counselor: “You have clear priorities.”

Reframe

Counselor: “Now look here. How can you sit there and tell me you can’t do it, when you know full well that you can?”

Confront

Structure. (ST)

The counselor gives information about what will happen directly to the client **throughout the course of treatment or within a study format, in this or subsequent sessions.**

Structure is also used **to make a transition** from one topic or part of a session to another.

Examples of **Structure**:

“What we normally do is start by asking you about your eating habits.”

“Now I’d like to talk with you about your motivation.”

“In this study I’ll meet with you twice a month and the sessions will be audio recorded.”

Differentiating Structure from other categories

Structure needs to be differentiated from Giving Information. If a counselor gives the client information about the study or treatment in general, code as **Giving Information**. When there is a clear purpose of preparing the client for what will happen, code as **Structure**.

“We’ll ask you about your smoking every week.”

Structure (directly pertains to client)

“We analyze all of the blood samples for nicotine levels.”

Giving Information

“Now I’d like to switch gears and talk about exercise.”

Structure

“In IOP, you’ll be attending group three times a week and seeing your individual counselor on Tuesdays.”

Structure

When a counselor recalls content from a previous session, the **Structure** category would be used, even if the statement has the sense of a reflection. This is because it is impossible for coders to evaluate the clinician's response to a client statement that has not been heard.

"You said last week that you started taking yoga." **Structure**

"It seemed like you were having a pretty hard time with this the last time we met. (**Structure**).
How are you doing with it now? (Open question)

Support. (SU)

These are generally **sympathetic, compassionate, or understanding** comments. They have the quality of **agreeing** or siding with the client.

Examples of Support:

"You've got a point there."	Agreement
"That must have been difficult."	Compassion
"I can see why you would feel that way."	Understanding
"I'm here to help you with this."	Compassion

Differentiating Support from other categories

Support needs to be differentiated from **Affirm, Reflect, or Confront**.

Affirm imparts appreciation, confidence, or reinforcement, whereas Support conveys understanding, compassion, or agreement. Affirm generally expresses compliment or praise for attributes or achievements of the client, whereas Support generally expresses compassion or understanding difficulties the client has experienced. Support is a hug, whereas Affirm is a pat on the back.

"That's a difficult thing to say."	Support (compassion)
"You've been through a lot."	Support (compassion)
"I wouldn't have been able to do what you did."	Support (understanding)
"You made a very brave decision."	Support (compassion)
"I appreciate you saying that."	Affirm (appreciation)
"You've accomplished a very difficult task."	Affirm (effort)
"Way to go."	Affirm (reinforcement)

Client: "It wasn't easy to do that."	
Counselor: "It was hard for you."	Simple Reflection

Client: "I don't have a car."

Counselor: "That must make it difficult for you to get here for appointments."

Counselor: "So that's your excuse for not keeping your appointments."

**Support
Confront**

Warn. (WA)

The counselor provides a **warning or threat, implying negative consequences** unless the client takes a certain action. It may be a threat that the counselor has the perceived power to carry out or simply the **prediction of a bad outcome** if the client takes a certain course.

"You're going to relapse if you don't get out of this relationship."

Warn

"You could go blind if you don't manage your blood sugar levels."

Warn

"If you don't come to our sessions I'll have to talk to your parole officer."

Warn

"You can lose the weight you'll put on if you quit, but you can't lose cancer."

Warn

"Taking too much of your pain meds can lead you down the wrong path."

Warn

"Not showing up for court will send you straight back to jail."

Warn

Differentiating Warn from other categories

Warn needs to be differentiated from **Advise, Confront, Direct, Inform, or Raise Concern**.

Warn should always be identified as **containing a threat or implied negative consequences**. The following examples *do not* imply negative consequences.

"You should consider leaving your partner."

Advise (suggestion)

"There's no reason for you to neglect your health."

Confront (shames)

"You have to come to our sessions."

Direct (lacks negative consequences)

"One of the health risks for diabetics is blindness."

Giving Information (all diabetics)

When a potential negative consequence is expressed as a concern of the counselor, **Raise Concern** takes precedence over **Warn**.

"I'm worried that you'll relapse if you stay with your partner." **Raise Concern** (counselor's concern)

Client Behavior Codes

Understanding the target behavior change

Before you begin coding a session, it is essential to have a clear understanding of the **Target Behavior Change (TBC)**, which typically is specified by the Principal Investigator (although it can be determined by the parser for projects in which the target behavior varies). Examples of clear TBCs are:

- Stopping smoking
- Stopping or reducing use of alcohol
- Increasing dietary intake of fruits and vegetables
- Taking blood pressure medication as prescribed

Note that a well-specified TBC includes both a target behavior (smoking, drinking, fruit/vegetable intake, taking medication) and a specified direction of change (stopping, increasing, adhering to prescription). In many substance abuse treatment settings, the TBC will be the reduction or cessation of substance use (e.g., quitting drinking, smoking less marijuana, drinking less often, adhering to methadone prescriptions, etc.).

Coders should not infer a link between actions being discussed by the client and the TBC, unless it is clear from the context that the purpose of the behavior is to move toward or away from the TBC goal. Sometimes the client will specify this link, and other times the counselor will make the relation more specific (e.g., via Questions or Reflections).

For example, if the TBC goal is to reduce cardiovascular risk, and the Principal Investigator has not specified specific target behaviors, “I wish I were less stressed” would not in itself indicate movement toward or away from the TBC goal. If, on the other hand, the client said, “Decreasing my stress at work would probably help my heart,” it would be coded as change talk. Similarly, if the counselor’s or client’s prior responses clearly provide a context for TBC, it is coded. For example, if the counselor asked, “What could you do to reduce your risk of having another heart attack?” and the client replies, “I could exercise more,” it would be coded as change talk – the counselor has provided the connection, even though the client has not directly stated it. If the counselor says, “One way that people can have a healthier heart is to stop smoking,” the client’s next response is likely to be relevant to TBC, whether positive or negative.

Client responses are classified into one of three overarching, mutually exclusive categories: Follow/Neutral/Ask, Change talk, and Sustain talk. Change language (either change talk or sustain talk) requires further subclassification as detailed below.

Follow/Neutral/Ask: The client's response follows along with the counselor, but does not deal with changing the target behavior. The statement is neither toward nor away from the direction of changing the target behavior. This category is also used when the client requests information, asks a question, or seeks the counselor's advice or opinion. This category can include reporting information about current or past behavior, story-telling, or asking questions of the counselor.

- “I have three daughters.” **FN** (unrelated to target behavior)
- “When I started smoking marijuana in high school, I thought it was the best thing ever.” **FN** (history)
- “I usually drink 4-5 days per week.” **FN** (reporting)
- “What do you think I should do about my drinking?” **FN** (question)
- “I’ve never used heroin.” **FN** (history/reporting)

“My parents don’t like me smoking.”	FN (unless client directly expresses desire to please parents)
“I’ve always had an addictive personality.”	FN (theoretical explanation, not about change)
“Do you know when the diabetes group meets?”	FN (asking counselor)
“I don’t use; I just deal.”	FN (reporting)
T: “On a scale from 0 to 10, how ready are you to quit?” C: “I’d say a 5.”	FN (no valence for/against change)

Change Language: These are client statements that deal with changing (**change talk**) or maintaining (**sustain talk**, AKA counter-change talk) the target behavior. Each utterance should be placed into one of the following categories by marking it with the appropriate letter and valence. Note the valence of the language with a + or – sign next to the letter (i.e., positive/ toward change as “+”, and negative/away from change as “-”).

Only client speech that indicates or reflects the client’s **present or future state of mind** is included as change language; speech related to the distant past is not included. For client speech in the past tense, coders must make a judgment about whether the speech refers to something that is related to the current treatment or occurred in the recent past that should be coded as change talk, (e.g., an ongoing action occurring within the past month [Taking Steps]; or a contrasting between past behavior and current insight [Other]), or something from clients’ distant past that does not reflect their current state of mind (Follow/Neutral). All client speech should be treated as if it is related the present treatment unless the client or therapist clearly places it in the distant past.

“I’ve always drank to handle my anger.”	Reason-
“When I was in high school I would smoke to help with stress.”	FN
“I quit once before.”	FN

Client language may have the quality of relating a disposition of the client that is no longer relevant or true, or occurred in the distant past. For example, reports of past successes or failures in changing the target behavior will often occur, and should typically be coded as Follow/Neutral. Reporting of current or recent drinking behavior that does not attach a valence about the drinking or suggest a change is also coded as Follow/Neutral. These utterances should be coded as change language **only if they are linked to the TBC and provide clear information** about the client’s **current intentions or state of mind**.

Note that clients occasionally speak about themselves in the second or third person. This may be common among certain groups, such as young adults. If it is clear that clients are doing this style to talk about themselves, either as individuals or as parts of a group, code this as change language.

For example:

“Sometimes it’s just late at night and you don’t feel like taking the bus home by yourself, so you drive a little tipsy—it’s no big deal.” **O –**

“A lot of times, we’ll designate a driver so no one gets hurt or arrested.” **O +**

A Note about Rulers:

Readiness, importance, and confidence rulers can be useful tools for evoking change talk. When coding numeric client responses, the 0–10 scale can be divided into change, sustain, and neutral responses. Scores of 0–4 are considered Sustain Talk, 5 is FN, and 6–10 are Change Talk. However, this should be adjusted for the scale offered by the clinician.

E.g.:

T: “On a scale of 0–10, with 0 being completely unimportant and 10 being completely important, how important is it to you to make a change in your smoking?”	
C: “I’d say about a 3.”	R-
or	
C: “I’d say about a 5.”	FN
or	
C: “I’d say about an 8.”	R+

Categories of Change Language

Commitment (C): a statement that explicitly states or implies that the client is making a commitment to changing/sustaining behavior, is considering currently realistic options, or is offering alternatives to the target behavior.

“I am going to stop smoking tomorrow.”	C +
“I’ll never drive the speed limit!”	C –
“I could start calling a cab instead of driving home after drinking.”	C +
“One thing I could try is not smoking on weekdays.”	C +
“I’ll probably buy some more weed after I get paid.”	C -
“If I can’t smoke pot, I guess I’ll just drink more instead.”	C -

Commitments may also be indirect. Some markers for indirect commitment include the implicit or explicit use of “if...then” sentence structures indicating that a commitment is in place the extent that the client has determined how they will react should a likely threatening situation arise. In other words, the client is indicating that they have a plan in place to reach or maintain a goal. Also, remarks about how clients intend to rearrange their lives, to maintain or change a behavior, are considered committing language:

“Back then I would do anything to get high.”	FN (reporting; past)
“I used to think I could just distract myself to avoid using.”	FN (past)
“I could try distracting myself to avoid using.”	C + (viable present alternative)
“I plan to stay with him so I can get my drugs.”	C -
“I’ve stayed with him so I can get my drugs.”	C -
“I could move away to make things better.”	C +
“I will go to AA every day this week to help me quit.”	C +

Another form of indirect commitment occurs when clients suggest alternatives to the target behavior. These statements may indicate intentions of what the client **could do** or **might do** to change the target behavior.

"I guess I could drive home another way that doesn't pass by the bar."	C +
"Maybe I could wait 10 more minutes whenever I have a craving."	C +
"I could drive home after drinking this week if I need to."	C -
"I will probably drink and drive again at some point."	C -
"I could chew gum instead of smoking."	C+

Differentiating Commitment from other codes

Commitment is easily confused with similar codes. To decide which code is most appropriate, consider the time (distant past, past week, present, future) and whether the idea is realistic (C) or hypothetical (O).

Examples:

“Back in college, I wanted to move out to get away from the drugs.”	FN (distant past)
vs.	
“I moved out over the weekend to get away from the drugs.”	TS+ (recent)
vs.	
“I’m moving out to get away from the drugs.”	C+ (realistic present)
vs.	
“I could move at the end of the month to get away from the drugs.”	C+ (realistic future)
vs.	
“I’d have to move out to get away from the drugs.”	O+ (hypothetical future)

Reason (R): Statements about reasons for changing or maintaining the target behavior. Included here are statements about the client’s emotional reaction to the target behavior.

“I’m killing myself.”	R +
“It bothers me when I can’t do things right.”	R +
“Drinking at the bars can get really expensive.”	R+
“I can’t be there for my daughter when I drink.”	R+
“Life will be better if I’m abstinent.”	R+
“I wouldn’t have to worry about getting pulled over anymore.”	R+
“(I get relaxed.) (My problems go away.)”	R-, R-
“I am terrified of being without the pills.”	R-
“Everyone drinks in college; it’s like the social norm.”	R-
“I don’t want to lose my friends because I got clean.”	R-
“Being high makes the day go easier.”	R-
“Football and fishing wouldn’t be the same without beer.”	R-
“It’s not like I’m having health problems because of cocaine.”	R-
“It’s a better choice for me than being anxious all the time.”	R-

It should be noted that Desires, Abilities, and Needs to change (or maintain) a behavior can be considered **Reasons**; consider these to be special classes of Reason that get their own code. *Generally speaking, if you can tell that an utterance is preparatory language, but aren’t sure whether it is a Desire, Ability, or Need, it should be coded as a Reason.*

Desire (D): a statement that expresses a desire to alter or maintain the target behavior.

“Well, I want to quit doing drugs.”	D +
“I don’t want to live like this anymore.”	D +
“I hate the way cigarettes smell.”	D +
“I want to be able to hang out with my family and not get high.”	D +

“I mean I want to, but I don’t want to [quit].”	D +, D -
“I want to keep getting high.”	D -
“I just like starting the day with a cigarette.”	D-
“I just love the way beer makes me feel.”	D -
“I would love to smoke a joint right now.”	D -
“I’m not sure yet what I want to do about alcohol.”	FN

T: “On a scale from 0 to 10, with 0 being not at all motivated, how motivated are you to quit?”	
C: “I’d say a 3.”	D -

Ability (A): a statement that assesses the client’s ability or capacity to alter the behavior. "Ability" here refers to capability, not to choice. Statements that use ability language (e.g., “could,” “can”), but through context appear to refer to a client's choice, are coded as Commitment or Other.

T: “On a scale from 0 to 10, with 0 being not at all confident, how confident are you that you can quit?”	
C: “I’d say a 6.”	A +
or	
C: “I’d say a 3.”	A-
or	
C: “I’d say a 5.”	FN

“I can do it...this is do-able.”	A +
"I can stop overeating."	A +
“My friends give me a lot of support to help me quit.”	A +
“I’d need more support from my friends to do it.”	O + (hypothetical)

“If I could get rid of these drugs.”	A -
“...okay well, I can do some [drugs] myself.”	A -
“I need help; I can’t do this on my own.”	A -
“I must get help [to be able to succeed].”	A -
“It will be hard [to stop] because my friends drink all the time.”	A -
“I just don’t think it’s realistic right now.”	A-
“Given my history of smoking, I’ll never be able to quit.”	A-

"I can eat popcorn instead of candy."	C +
“I’ve decided that I’m going to need to ask for help to do this.”	O+

Notice that the last statement may be taken to imply, "I have the ability to eat popcorn instead of candy" or "I have the choice of eating popcorn or candy, and it would be better if I chose popcorn." The latter interpretation is probably more reasonable in most contexts, and would refer to the person's choice. Few would doubt that most people are capable of eating popcorn, so it is unlikely that a person would comment on this capability. Such statements are frequent when clients suggest alternative behaviors for the target behavior.

Statements that are admissions of powerlessness over the target behavior (e.g., drinking) should be coded as problem recognition (O +) if the client insinuates recognition of a problem related to the target behavior. If it is unclear whether a statement is A- or O+, we recommend coding FN.

“I’m coming to realize that I’m the kind of drinker that has to have as many drinks in one night as I can, and suddenly you’re well beyond your limit.”	O+, (problem recognition)
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“I’ve realized that doing this alone is way too difficult.” FN

Statements that reflect pessimism about one’s ability to change should be coded as A-:

“I’m coming to realize that I don’t think I could stop drinking even if I tried.”

A- (pessimism about ability to change)

“I think the hardest part stopping would be that if I have just one drink, I wouldn’t be able to stop myself from having 10 more.”

A-(pessimism about ability to change)

Need (N): A statement about the client’s need to change (need for help is coded as ability -) or need for the target behavior.

“I need to stop.” N +

“I don’t need to stop.” N-

“I don’t need to turn to alcohol or anything.” N +

“Cause I need it everyday.” N –

“You need to smoke if you want to have fun.” N –

“I have to have it if I want to get to sleep at night” N-

“I really must get help if I’m going to stop.” N+

“I’m going to stop.” C+

Taking Steps (TS): a statement that refers to a recent behavioral change made by the client. “Recent” requires some judgment on the part of coders, but refers to the quality of being current (i.e., an ongoing action that has occurred or continued into the past week), not something the client did in the distant past. These latter statements will typically be coded as Follow Neutral.

“Last week I cut down to only two cigarettes a day.” TS +

“I decided to try every type of beer at the bar.” TS -

“When I was in college [10 years ago], I avoided parties so I wouldn’t drink.” FN

“I could stay away from the frat parties so I don’t smoke as much weed.” C +

Reporting information about previous behavior is not coded as TS unless it indicates behavior clearly related to the **target behavior change**, and not simply engaging or not engaging a behavior. Coders should refrain from making inferences about a client’s intentions when deciding whether to code TS vs. FN..

Last week I cut back my drinking and only drank on three days. TS +

This week I decided that abstinence wasn’t for me anymore, and I drank on three days. TS -

Last week I drank on Monday, Wednesday, and Friday. FN

Last week I drank on Monday, Wednesday, and Friday, instead of every day. TS +

Years ago, I used to drink on Mondays, Wednesdays, and Fridays. FN

I’ve started going to AA meetings to help me stop drinking. TS +

Since our last meeting, I’ve drunk every single day, all day. FN

I’ve started having four beers a night instead of six. TS +_

Mostly I use on the weekends; I don’t really do anything during the week. FN

I broke up with my girlfriend yesterday because she triggers my use. TS+

I’ve started taking walks in the park to get my mind off the cigarettes. TS+

I had a slip this weekend because I went to that party. R-

NOTE: Each of the above categories of commitment language (C, R, D, A, N, TS) must have as their subject or object the target behavior. However, sometimes statements occur that are related to changing or sustaining the target behavior change but do not refer directly to it. In these cases, code as Other, as detailed below.

Example:

“I sure want to get the most out of therapy.” **O +**

This is clearly a statement of desire but *not* a desire to change the target behavior, but rather a desire to fully participate in therapy for the target behavior. This is statement expresses movement toward change, but does not refer directly to the behavior that might be changed.

Coders should take care in applying the definitions of Desire, Ability and Need. Ability, for example, refers to the ability to engage in the target behavior or ability to stop engaging in the target behavior, not to any ability related to the target behavior. For example, consider the following statement:

“I can't stop checking the door, 50 times a night, unless I drink, and then it gives me the ability to overcome the urge to check whether the door is locked.” **R -**

This is a reason *to drink*, NOT an ability statement. The statement does not refer to the ability to drink (A -), inability to stop drinking (A -), an inability to drink (A +), or ability to stop drinking (A +). The ability statement refers to the ability to stop a compulsive behavior, but in reference to the target behavior (i.e., drinking), it is a Reason.

Here are examples concerning desire:

“I really want a beer right now.” **D -**

“I drink because I want to relax.” **R -**

Here again, the second statement includes desire language, but it relates to an *effect* of the target behavior instead of a desire for the **target behavior change** itself. This outcome (relaxation) is a reason for engaging in the target behavior.

Other (O): In the complexity of real therapy sessions, clients often express ideas related to change that are ambiguous at best. Statements which are about changing (or maintaining) the target behavior, but are not well categorized as D, A, R, N, TS, or C, are categorized as Other. These include indirect statements and hypotheticals.

If you recognize client as speech as clearly being change (or sustain) talk but cannot determine which category is most appropriate, code Other. Examples might include unconventional client ideas about how to change, or statements of optimism about change.

Example:

“Enlisting your family to help is key to making a change like this.” **O +**

“I know that my life is turning around now that I'm in treatment.” **O +**

Keep in mind that change talk and sustain talk are contextual, and that human coders must determine the most appropriate code based upon the facts that are **presented in the session**, using their personal judgment. With that in mind, coders should consider what in the current treatment session to assign the “best” code. For

example, whether a client is using a statement to report a lack of drug use (FN), minimize a problem (O-), or cite a reason for maintaining drug use (R-) will depend upon the content, tone, and placement within the session. Similarly, statements about self-help or mutual-help practices may be change talk, sustain talk, or neutral speech, depending upon context.

Common examples of Other are statements of problem recognition (O +) (i.e., the explicitly expressed knowledge that the target behavior is problematic in some way), or problem minimization (O -) (i.e., explicitly expressing the opinion that a target behavior change is problematic or negative in some way).

Also, statements about **hypothetical or unrealistic** things that would have to happen to implement or avoid the TBC are coded as Other. If a set of ideas seem likely within the client's current circumstances, then code C +.

“If I were to get pregnant, I would quit drinking.”	O +
“If I were to move back home, I don’t think I could make it.”	O –
“If you put me on a desert island without any cigarettes, then I’d stop smoking.”	O +
“If you could put me on a medication to help with cessation, then I’d stop smoking.”	C +
“Even if you put me on a medication to help with cessation, I’d keep smoking.”	C -
“I guess I might have another heart attack if you made me run a marathon at gunpoint.”	O –
“Even running a marathon at gunpoint wouldn’t give me a heart attack—I’m fit!”	A +
“I plan to keep eating bacon cheeseburgers, even if I’ll have another heart attack.”	C –

Note that an utterance can be coded as problem minimization (or recognition) if the utterance suggests movement toward maintaining the target behavior, even if there is not conclusive evidence that the client has a problem related to the target behavior. For example, the statement “I have never experienced a negative problem from my drug use, ever,” suggests movement toward maintaining drug use, even if the client’s statement is correct and drug use has never caused a problem.

Although the Other category is intended primarily for **unanticipated** statements, a few possible examples are listed below. These statements usually have the quality of referring to the target behavior, and will carry information (often only in the context of the surrounding utterances) about whether the client is arguing for or against change, but they will not be easily categorized as commitment, desire, ability, reason, need, or taking steps.

I know it takes a lot of willpower to quit. on context)	O (valence depends
I tell you, I sure don’t want to be here in therapy.	FN (resistance)
People just need to mind their own business.	FN (resistance)
“It’s not important to change.”	O –
“I’m a 1 out of 10 for importance,”	D -
I’ve never experienced a single negative consequence of my drug use, ever. minimization)	O - (problem
“I don’t think I’m someone who needs to see a therapist for my drinking.”	O -
“It’s not like I have blackouts.” (contextual) -	R- or O-
Counselor: Has alcohol ever caused any problems besides this DUI? Client: No.	O –
Counselor: What could you have done differently? Client: Nothing. Look, I don’t want to talk about it.	FN (resistance)

Counselor: "Tell me about your drinking.	
Client: It's absolutely none of your business.	FN (resistance)
"I've blacked out once or twice... it's not a regular thing for me."	FN (reporting)
"I guess my drinking is a little out of control." recognition)	O + (problem
"I sure want to get the most out of this therapy."	O +
"I shouldn't have driven my car when I was that drunk."	O +
"Starting on crack was a bad decision."	O +
"I need to decide when I'm drinking whether it's really worth it to have one or two more drinks."	O +
"This arrest has really been a reality check."	O +
"I'm fortunate the consequences weren't worse."	O +
"I screwed up big-time."	O +

MISC 2.5 Summary Scores

As with previous versions of the MISC, version 2.5 provides several summary scores based upon the second-pass behavior codes. These are recommended as provisional summary indicators.

Ratio of Reflections to Questions (R/Q)

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

Percentage Open Questions (%OQ)

%OQ is a percentage in which the numerator is the number of Open Questions asked and the denominator is the total number of Questions asked (Open + Closed).

Percentage Complex Reflections (%CR)

%CR is a ratio in which the numerator is the number complex reflections and the denominator is the total number of Reflections.

Percentage MI-Consistent Responses (%MIC)

%MIC is a ratio in which the numerator is the number of MICO responses, and the denominator is the total number of MICO plus MIIN responses.

MI-Consistent Responses (sMICO)

MICO responses are those directly prescribed (e.g., affirmation, emphasizing client control, support) in Motivational Interviewing (Miller & Rollnick 1991, 2002). The sMICO score is the sum of:

- Affirm
- Advise with permission
- Emphasize Control
- Raise concern with permission
- Support
- Open Questions
- Reflections

Sequential MI-Consistent Responses (MICO)

When presenting results from sequential coding, typically Reflections and Questions will be considered separately from other MICO behaviors. The sMICO score is simply the sum of the remaining MICO behaviors:

- Affirm
- Advise with permission
- Emphasize Control
- Raise concern with permission
- Support

MI-Inconsistent Responses (MIIN)

MIIN are those directly proscribed (e.g., giving advice without permission, confronting, directing, warning) in Motivational Interviewing. The MIIN score is the sum of:

- Advise without permission
- Confront
- Direct

Raise Concern without permission
Warn

MISC 2.5 also provides summary scores based on client behavior counts. These are particularly useful when the individual client language categories are relatively infrequent or demonstrate low reliabilities.

Change talk (CT)

Change talk is the sum of all positively-valenced client language:

Commit+
Desire+
Ability+
Reason+
Need+
Taking Steps+
Other +

Sustain talk (ST)

Sustain talk is the sum of all negatively-valenced client language:

Commit-
Desire-
Ability-
Reason-
Need-
Taking Steps-
Other -

Percentage Client Change Talk (%CT)

%CT is a percentage in which the numerator is the number of all client change talk (CT) utterances and the denominator is the sum of CT plus sustain talk (ST) utterances.