The Motivational Interviewing Treatment Integrity (MITI) Code: Version 2.0

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Author Note: The Motivational Interviewing Treatment Integrity (MITI) Code is an instrument-in-development. We are making it available now for use in research and scholastic endeavors, and we expect that many improvements will be needed before this coding system is complete. If you find errors, inconsistencies or have suggestions for improvement or other feedback, please contact us. We look forward to improving the MITI, with your help.

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

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

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

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

A. COMPONENTS OF THE MITI

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

A global score requires the coder to assign a single number from a seven-point scale to characterize the entire interaction. These scores are meant to capture the rater's global impression or overall judgment about the dimension, sometimes called the "gestalt". Two global dimensions are rated: empathy and MI spirit. This means that each MITI review will contain two global scores.

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

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

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

B. DESIGNATING A TARGET BEHAVIOR

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

C. GLOBAL SCORES

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

Global scores are intended to capture the rater's overall impression of how well or poorly the interviewer meets the intent of the scale. While this may be accomplished by simultaneously evaluating a variety of elements, the rater's gestalt or all-at-once judgment is paramount. The global scores should reflect the holistic evaluation of the interviewer, one that cannot necessarily be separated into individual elements. Global scores are given on a 7 point Likert scale, with the coder assuming a beginning score of 4 and moving up or down from there.

1. **Empathy**

This scale is intended to capture the extent to which the therapist understands and/or makes an effort to grasp the client's perspective.

What does it look like? Examples of high and low empathy clinicians

Ideal Adherence
Empathy is evident when providers show an active interest in making sure they understand what the client is saying. It can also be apparent when the therapist accurately follows or perceives a complex story or statement by the client or probes gently to gain clarity. Reflective listening is an important part of this characteristic, but this global rating is intended to capture all efforts that the therapist makes to understand the client's perspective and convey that understanding to the client.
Poor Adherence
Empathy is lacking when clinicians show little interest in the client's perspective and experiences. There is little effort to gain a deeper understanding of complex events and emotions. Clinicians 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 the client's perspective.

Differentiating empathy from other 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 clinician 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 agreeing with 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)

2. **Motivational Interviewing Spirit**

This rating is intended to capture the overall competence of the clinician in using motivational interviewing. It explicitly focuses on the three characteristics of **evocation**, **collaboration** and **autonomy**. These dimensions often overlap, or blend into one another, hence the global nature of this scale. The rater should consider all three characteristics when assigning a value for this scale and low scores in any of these dimensions should be reflected in a lower overall spirit score. Nevertheless, the global rating is intended to capture the "whole" or "gestalt" of the clinician's adherence to this spirit, without too much "picking apart" of the components of the scale.

What does it look like? Examples of high and low spirit clinicians

Ideal Adherence

Collaboration is apparent when clinicians negotiate with the client and avoid an authoritarian stance. Clinicians high in collaboration show a 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 concerns and ideas. These clinicians minimize power-differentials and view their clients as partners.

Evocation is evident when clinicians emphasize drawing out the client's ideas rather than educating clients or giving opinions without being asked. Clinicians high in evocation 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. Clinicians high in evocation show a special interest in helping clients to say to themselves the reasons that changing the target behavior can or should happen.

Autonomy-supportive clinicians can accept that clients may choose not to change. High autonomy clinicians are 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 convey an understanding that the critical variables for change are within the client and cannot be imposed by others.

Poor Adherence

Low collaboration is evident when clinicians 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 clinicians attempt to persuade clients about the need for change. These clinicians view their clients as deficient in some manner and attempt to provide what is missing, often using an expert stance to do so.

Low evocation is evident when the clinician neglects the critical task of eliciting the client's verbalizations about the need for change. Clinicians may convey an attitude of suspicion or cynicism about the client's desire to change. They may focus on giving information, educating the client or giving logical reasons for changing, at the expense of arranging conversations so the client talks himself or herself into changing.

Low autonomy clinicians have difficulty accepting that clients might choose to avoid or delay change, or may decide to proceed with change in an unconventional manner. They convey a sense of urgency about the need for change.

Differentiating spirit from other characteristics

MI Spirit is not to be confused with sympathy, expertise, education, skills-building, uncovering unconscious motivations or spiritual guidance. Therefore, a clinician might:

> Feel sad that the client has so many burdens but not convey a sense that he or she can solve them. (sympathy vs. motivational interviewing)

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. motivational interviewing)

Help clients replace irrational thoughts about the benefits of continuing in a maladaptive behavior rather than explore the perceived rewards. (skills-building vs. motivational interviewing)

Probe the developmental contributions to the client's need for a behavior rather than asking about how this behavior is consistent, or not, with the client's current values and goals. (uncovering unconscious motivations vs. motivational interviewing)

Help the client to contact or recognize spiritual forces to assist in changing rather than using reflective listening and open questions to determine what strengths and successes the client already has. (spiritual guidance vs. motivational interviewing)

D. BEHAVIOR COUNTS

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

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

Parsing Interviewer Speech to Assign Behavior Codes

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

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

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

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

Consider the following interviewer statement:

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

This statement is parsed in the following way:

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

What about this interviewer statement?

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

We've parsed it like this:

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

Behavior Codes

1. **Giving Information**

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

1a. *Providing Feedback from assessment instruments*

> You indicated during the assessment that you typically drink about 18 standard drinks per week. This places you in the 96th percentile for American men your age. (Giving Information)
>
> * Note that this is not a reflection. Reviewing information contained on assessment instruments does not typically qualify as a reflection, although the reflection code MAY be given if the interviewer skillfully emphasizes or enriches the material the client has given.

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

> Your doctor tells me you've been struggling with your glycemic control (Giving Information)
>
> I talked to your wife and she said she was really worried about your drinking (Giving Information)

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

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

1d. *Educating about a topic*

> Individuals who eat five fruits and vegetables each day reduce their cancer risk five fold. For certain kinds of cancer, like colon cancer, it's even more of a reduction. (Giving Information)
>
> If I do find that you've relapsed, I'll have to disclose that to your probation officer. (Giving Information) (Coder may consider MI Inconsistent instead)

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

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

> You indicated during the assessment that you typically drink about 18 standard drinks per week. This far exceeds social drinking. (MI Inconsistent)
>
> Keep track of your cravings, using this log, and bring it in next week to review with me. (Direct)
>
> Well, you are only eating two fruits per day according to this chart, even though you said you are eating five. It can be easy to deceive yourself. (Confront)
>
> It worked for me, and it will work for you if you give it a try. We need to find the right AA meeting for you. You just didn't find a good one. (Advice)

2. **Questions**

2a. *Closed Question*

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

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

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

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

2b. *Open Question*

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

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

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

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

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

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

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

3. **Reflection**

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

3a. *Simple Reflection*

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

3b. *Complex Reflection*

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

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

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

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

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

3d. *Reflection and Question in Sequence*

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

> So you don't ever want to use heroin again. Is that right? (Reflection, Closed Question)
>
> Your boss said you can't work overtime anymore. What do you make of that? (Reflection, Open Question)

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

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

4. **MI Adherent**

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

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

> I have some information about how to reduce your risk of colon cancer and I wonder if I might discuss it with you. (MI Adherent)
>
> What have you already been told about drinking during pregnancy? (MI Adherent)
>
> This may not be the right thing for you, but some of my clients have had good luck setting the alarm on their wristwatch to help them remember to check their blood sugars 2 hours after lunch. (MI Adherent)
>
> note: when permission is asked prior to advising, the MI Non-Adherent Code is *not* used for the subsequent advice. The entire volley is coded as MI Adherent.

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

> You are the kind of person that, once you make up your mind, you usually get the job done (MI Adherent)
>
> It's important to you to be a good parent, just like your folks were for you. (MI Adherent)

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

> Yes, you're right. No one can force you stop drinking. (MI Adherent)
>
> You're the one who knows yourself best here. What do you think ought to be on this treatment plan? (MI Adherent)
>
> The number of fruits and vegetables you choose to eat is really up to you. (MI Adherent)
>
> You've got a point there. (MI Adherent)

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

> With the parking problems and the rain coming down, it hasn't been easy to get here. (MI Adherent)
>
> I know it's really hard to stop drinking. (MI Adherent)
>
> Well, there is really a lot going on for you right now. (MI Adherent)

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

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

5. **MI Non-Adherent**

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

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

> What about trying to get a ride from a friend? (MI Non-Adherent)
>
> Checking your blood sugars five times a day is best in the beginning. (MI Non-Adherent)
>
> It might not be as bad as you think. People are usually civil if you give them a chance. (MI Non-Adherent)

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

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

> You were taking antabuse but you drank anyway? (MI Non-Adherent)
>
> You think that is any way to treat people you love? (MI Non-Adherent)
>
> Yes, you are an alcoholic. You might not think so, but you are (MI Non-Adherent)

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

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

"Don't do that!" (MI Non-Adherent)
"Bring this homework back next week." (MI Non-Adherent)
"You need to go to 90 meetings in 90 days" (MI Non-Adherent)

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

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

Tantrums

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

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

E. CHOOSING THE LENGTH AND TYPE OF THE CODED SEGMENT

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

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

F. SUMMARY SCORES FOR THE MITI

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

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

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

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

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

F. TRAINING STRATEGY FOR THE MITI

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

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

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

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

Below are recommended proficiency and competency thresholds for clinicians, based on the MITI coding system. Please note that these thresholds are based on EXPERT OPINION, and currently lack normative or other validity data to support them. We are in the process of gathering normative data for the MITI now (6/15/04). Until such normative data is available, these thresholds should be used in conjunction with other data to arrive at an assessment of clinician competency and proficiency in using MI.

Behavior Count or Summary Score Thresholds	**Beginning Proficiency**	**Competency**
Global Therapist Ratings	5	6
Reflection to Question Ratio (R:Q)	1	2
Percent Open Questions (%OC)	50%	70%
Percent Complex Reflections (%CR)	40%	50%
Percent MI-Adherent (% MIA)	90%	100%

Motivational Interviewing Treatment Integrity Code (MITI)
Coding Sheet rev 10/03

Tape #_____ Coder:_____ Time:_____

Global Ratings

Empathy/ Understanding		1 2 3 4 5 6 7 Low High
Spirit		1 2 3 4 5 6 7 Low High

Behavior Counts

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

First sentence:_____
Last sentence:_____

List of MITI Codes

EMPATHY	(Global rating of empathy)
SPIRIT	(Global rating of MI Spirit)
GI	(Giving Information)
MiA	(MI Adherent)
MiNa	(MI Non-adherent)
OQ	(Open Question)
CQ	(Closed Question)
Rs	(Reflection simple)
Rc	(Reflection complex)

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