Understanding Your Coding Feedback

With specific feedback about your sessions, you can choose whether or how to change your performance to make your interviews more consistent with the spirit and methods of Motivational Interviewing. Those of us providing this feedback want to make it as helpful and user-friendly as possible.

Global Clinician Ratings

These numbers, ranging from 1 to 5, represent the rater's overall impressions of the session. The specific scales are as follow:

Evocation. This scale measures the extent to which the clinician actively evokes the client's own reasons for change and how that change should happen. Clinicians high on this scale actively elicit reasons for change and the means to go about implementing a change. While they might provide information or education, clinicians high in evocation do not rely on it as a means of helping clients to change. Clinicians low on this scale do not solicit the client's own ideas about change, rather they provide reasons for change in the form of information or education. In addition, clinicians low on this scale do not respond to client change talk nor do they intentionally try to elicit change talk from the client.

Collaboration. 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. Clinicians high on this scale actively foster an environment which encourages the client to express their own perspective and experience such that the client's ideas influence the session. Clinicians low on this scale often assume an expert role in the session.

Autonomy/Support. 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. Clinicians high on *Autonomy/Support* ensure, either directly or implicitly, that the topic of choice and control is raised in session. In addition, clinicians may explicitly acknowledge that the client has the choice to change or maintain the status quo. They may also express an optimism about the client's ability to change. Clinicians low on this scale view the client as incapable of moving in the direction of health without input from clinician. They may assume that the client will change their behavior in the direction that the clinician

Direction. This scale measures the degree to which clinicians maintain appropriate focus on a specific target behavior or concerns directly tied to it. Unlike the other global scales, clinicians high scores on this scale do not necessarily reflect better use of MI. Clinicians high on this scale exert influence on the session and do not miss opportunities to direct the client to discussion regarding the target behavior. Clinicians low on this scale do not

influence the session, rather they allow the topics of session to be entirely determined by the client.

Empathy (also called accurate understanding) The focus here is the extent to which the clinician *understands* the client's perspective, and not on warmth, acceptance, genuineness, or identification with the client. Clinicians high on this scale are able to attain and communicate an *accurate understanding* of the client's perceptions, situation, meaning, and feelings through high-quality reflective listening. Clinicians at the low end of this scale show little interest in or appreciation of the client's perspective, little overt understanding or reflection of what the client is experiencing. They evidence little effort at seeking a deeper understanding of the client's perspective. Clinicians low in empathy may ask many questions to gain factual information or pursue their agenda, but do not seek to understand the client=s own perspective.

Clinician Behavior Counts

General Information. The clinician gives information to the client, explains something, or provides feedback. This is not advice. This includes information about people in general, but not specifically about the client: hypotheticals, "Someone who..." "People who....." Personal feedback includes information about the client that was not already available to the client.

Motivational Interviewing Adherent Behaviors:

Advise with permission. Prior permission can be in the form of a request from the client, or in the clinician asking the client's permission to offer it. Indirect forms of permission-asking may also occur, such as a clinician statement that gives the client permission to disregard the advice ("This may or may not make sense to you").

Affirm. The clinician says something positive or complimentary to the client.

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

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

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

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

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

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

Motivational Interviewing Non-Adherent Behaviors:

Advise without permission: The clinician gives advice, makes a suggestion, offers a solution or possible action. These will usually contain language that indicates that advice is being given: Should, Why don't you, Consider, Try, Suggest, Advise, You could, etc. No prior permission is obtained from the client to give this information.

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

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

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

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

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

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

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

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

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

QUESTION responses are broken down into open versus closed questions:

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

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

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

Reflect. The clinician makes a statement that reflects back content or meaning previously offered by the client, usually in the client's immediately preceding utterance. REFLECT responses require subclassification regarding the level/type of reflection:

Simple: These reflections add nothing at all to what the client has said, but simply repeat or restate it using some or all of the same words. Some simple reflections slightly rephrase what the client has said or use different words to convey the client's ideas, but the definition of the simple reflection is one which does not change the essential meaning of what the client has said.

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

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

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

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

Metaphor and Simile in reflection

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

Overall Goals for Using Motivational Interviewing

Talk less than your client does

Your most common response to what a client says should be a reflection

On average, reflect twice for each question you ask

When you reflect, use complex reflections (paraphrase and summarize) over half the time

When you do ask questions, ask mostly open questions

Avoid getting ahead of your client's readiness level