Exhibit 3.2 presents common misconceptions about MI and provides clarification of MI's underlying theoretical assumptions and counseling approach, which are described in the rest of this chapter.

EXHIBIT 3.2. Misconceptions and Clarifications About MI

MISCONCEPTION	CLARIFICATION
MI is a form of nondirective, Rogerian therapy.	MI shares many principles of the humanistic, person-centered approach pioneered by Rogers, but it is not Rogerian therapy. Characteristics that differentiate MI from Rogerian therapy include clearly identified target behaviors and change goals and differential evoking and strengthening of clients' motivation for changing target behavior. Unlike Rogerian therapy, MI has a strategic component that emphasizes helping clients move toward a specific behavioral change goal.
MI is a counseling technique.	Although there are specific MI counseling strategies, MI is not a counseling technique. It is a style of being with people that uses specific clinical skills to foster motivation to change.
MI is a "school" of counseling or psychotherapy.	Some psychological theories underlie the spirit and style of MI, but it was not meant to be a theory of change with a comprehensive set of associated clinical skills.
MI and the SOC approach are the same.	MI and the SOC were developed around the same time, and people confuse the two approaches. MI is not the SOC. MI is not an essential part of the SOC and vice versa. They are compatible and complementary. MI is also compatible with counseling approaches like cognitive–behavioral therapy (CBT).
MI always uses assessment feedback.	Assessment feedback delivered in the MI style was an adaptation of MI that became motivational enhancement therapy (MET). Although personalized feedback may be helpful to enhance motivation with clients who are on the lower end of the readiness to change spectrum, it is not a necessary part of MI.
Counselors can motivate clients to change.	You cannot manufacture motivation that is not already in clients. MI does not motive clients to change or to move toward a predetermined treatment goal. It is a collaborative partnership between you and clients to discover their motivation to change. It respects client autonomy and self-determination about goals for behavior change.

Sources: Miller & Rollnick, 2013, 2014; Moyers, 2014.

Ambivalence

A key concept in MI is ambivalence. It is normal for people to feels two ways about making an important change in their lives. **Frequently, client ambivalence is a roadblock to change, not a lack of knowledge or skills about how to change** (Forman & Moyers, 2019). Individuals with SUDs are often aware of the risks associated with their substance use but continue to use substances anyway. They may need to stop using substances, but they continue to use. The tension between these feelings is ambivalence.

Ambivalence about changing substance use behaviors is natural. As clients move from Precontemplation to Contemplation, their feelings of conflict about change increase. This

tension may help move people toward change, but often the tension of ambivalence leads people to avoid thinking about the problem. They may tell themselves things aren't so bad (Miller & Rollnick, 2013). **View ambivalence not as denial or resistance, but as a normal experience in the change process.** If you interpret ambivalence as denial or resistance, you are likely to evoke discord between you and clients, which is counterproductive.

In MI, your main goal is to evoke change talk and minimize evoking or reinforcing sustain talk in counseling sessions.

Sustain Talk and Change Talk

Recognizing sustain talk and change talk in clients will help you better explore and address their ambivalence. Sustain talk consists of client statements that support not changing a health-risk behavior, like substance misuse. Change talk consists of client statements that favor change (Miller & Rollnick, 2013). Sustain talk and change talk are expressions of both sides of ambivalence about change. Over time, MI has evolved in its understanding of what keeps clients stuck in ambivalence about change and what supports clients to move in the direction of changing substance use behaviors. Client stuck in ambivalence will engage in a lot of sustain talk, whereas clients who are more ready to change will engage in more change talk with stronger statements supporting change.

Greater frequency of client sustain talk in sessions is linked to poorer substance use treatment outcomes (Lindqvist, Forsberg, Enebrink, Andersson, & Rosendahl, 2017; Magill et al., 2014; Rodriguez, Walters, Houck, Ortiz, & Taxman, 2017). Conversely, MI-consistent counselor behavior focused on eliciting and reflecting change talk, more client change talk compared with sustain talk, and stronger commitment change talk are linked to better substance use outcomes (Barnett, Moyers, et al., 2014; Borsari et al., 2018; Houck, Manuel, & Moyers, 2018; Magill et al., 2014, 2018; Romano & Peters, 2016). Counselor empathy is also linked to eliciting client change talk (Pace et al., 2017).

Another development in MI is the delineation of different kinds of change talk. The acronym for change talk in MI is DARN-CAT (Miller & Rollnick, 2013):

- **D**esire to change: This is expressed in statements about wanting something different—"I want to find an Alcoholics Anonymous (AA) meeting" or "I hope to start going to AA."
- **A**bility to change: This is expressed in statements about self-perception of capability—"I could start going to AA."
- **R**easons to change: This is expressed as arguments for change—"I'd probably learn more about recovery if I went to AA" or "Going to AA would help me feel more supported."
- **N**eed to change: This is expressed in client statements about importance or urgency—"I have to stop drinking" or "I need to find a way to get my drinking under control."
- **C**ommitment: This is expressed as a promise to change—"I swear I will go to an AA meeting this year" or "I guarantee that I will start AA by next month."
- **A**ctivation: This is expressed in statements showing movement toward action—"I'm ready to go to my first AA meeting."
- **T**aking steps: This is expressed in statements indicating that the client has already done something to change—"I went to an AA meeting" or "I avoided a party where friends would be doing drugs."

Exhibit 3.3 depicts examples of change talk and sustain talk that correspond to DARN-CAT.

EXHIBIT 3.3. Examples of Change Talk and Sustain Talk

TYPE OF STATEMENT	EXAMPLES OF CHANGE TALK	EXAMPLES OF SUSTAIN TALK
Desire	"I want to cut down on my drinking."	"I love how cocaine makes me feel."
Ability	"I could cut back to 1 drink with dinner on weekends."	"I can manage my life just fine without giving up the drug."
Reasons	"I'll miss less time at work if I cut down."	"Getting high helps me feel energized."
Need	"I have to cut down. My doctor told me that the amount I am drinking puts my health at risk."	"I need to get high to keep me going every day."
Commitment	"I promise to cut back this weekend."	"I am going to keep snorting cocaine."
Activation	"I am ready to do something about the drinking."	"I am not ready to give up the cocaine."
Taking steps	"I only had one drink with dinner on Saturday."	"I am still snorting cocaine every day."

Source: Miller & Rollnick, 2013.

To make the best use of clients' change talk and sustain talk that arise in sessions, remember to:

- Recognize client expressions of change talk but don't worry about differentiating various kinds of change talk during a counseling session.
- Use reflective listening to reinforce and help clients elaborate on change talk.
- Use DARN-CAT in conversations with clients.
- Recognize sustain talk and use MI strategies to lessen the impact of sustain talk on clients' readiness to change (see discussion of responding to change talk and sustain talk in the next section).
- Be aware that both sides of ambivalence (change talk and sustain talk) will be present in your conversations with clients.

A New Look at Resistance

Understanding the role of resistance and how to respond to it can help you maintain good counselor-client rapport. Resistance in SUD treatment has historically been considered a problem centered in the client. As MI has developed over the years, its understanding of resistance has changed. Instead of emphasizing resistance as a pathological defense mechanism, MI views resistance as a normal part of ambivalence and a client's reaction to the counselor's approach in the moment (Miller & Rollnick, 2013).

A client may express resistance in sustain talk that favors the "no change" side of ambivalence. The way you respond to sustain talk can contribute to the client becoming firmly planted in the status quo or help the client move toward contemplating change. For example, the client's show of ambivalence about change and your arguments for change can create discord in your therapeutic relationship.

Client sustain talk is often evoked by discord in the counseling relationship (Miller & Rollnick, 2013). **Resistance is a two-way street. If discord arises in conversation, change direction or listen more carefully.** This is an opportunity to respond in a new, perhaps surprising, way and to take advantage of the situation without being confrontational. This new way of looking at resistance is consistent with the principles of person-centered counseling described at the beginning of the chapter.