

MI Spirit Development

Deep Dive Modules · Clinical Strength

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Part 1 · Overview

Clinical Development Intensive

MI Spirit Development

A comprehensive self-directed intensive for SUD clinicians and staff — exploring the PACE framework of Partnership, Acceptance, Compassion, and Evocation through reading, self-assessment, and guided practice exercises.

For SUD Clinicians PACE Framework Reflective Practice MI Skill Development

The PACE Framework

P

Partnership

Genuine collaboration

A

Acceptance

Non-judgmental regard

C

Compassion

Authentic care

E

Evocation

Drawing out wisdom

↕

MI Spirit → Authentic Therapeutic Alliance → Sustainable Client Motivation

Reading Sections

What Is MI Spirit? The Foundation of Motivational Interviewing

Self-Assessment

Worksheets & Exercises

Part 2 · What Is MI Spirit? The Foundation of Motivational Interviewing

What Is MI Spirit? The Foundation of Motivational Interviewing

Motivational Interviewing is often misunderstood as a set of techniques — a collection of open-ended questions, reflective statements, and affirmations that clinicians learn to deploy strategically. While these technical skills are real and important, they are the surface expression of something far deeper: a fundamental orientation toward human beings and the change process that MI researchers call "spirit." Without the spirit, the techniques become manipulation. With the spirit, even imperfect technique produces genuine therapeutic connection.

MI spirit is not a performance. It cannot be faked reliably, and attempts to fake it are quickly detected by clients who have spent their lives reading people for signs of authentic care versus professional obligation. The spirit of MI is an actual set of internal attitudes — genuine beliefs about human nature, change, and the therapeutic relationship — that inform how a clinician shows up in every moment of every session. When MI spirit is present, clients feel it. When it is absent, clients feel that too, even if they cannot articulate why.

The four core components of MI spirit are Partnership, Acceptance, Compassion, and Evocation — sometimes remembered through the acronym PACE. Each component describes not just a behavior but an entire way of being in relationship with clients. Partnership means genuinely believing that the client is the expert on their own experience. Acceptance means holding unconditional positive regard for the person while maintaining honest concern about harmful patterns. Compassion means genuinely caring about the client's welfare in a way that prioritizes their wellbeing over our professional comfort. Evocation means trusting that the motivation and wisdom needed for change already exists within the client — our job is to draw it out, not to install it.

For clinicians working with substance use disorders, developing MI spirit is not a technical upgrade — it is a fundamental recalibration of the power dynamics that have historically defined addiction treatment. Traditional addiction treatment often positioned the clinician as the authority who knew what the client needed, confronted denial, broke down defenses, and directed the client toward prescribed change. Decades of research demonstrated that this approach — however well-intentioned — was often counterproductive. Confrontational approaches increased defensiveness, decreased treatment engagement, and produced worse outcomes. MI emerged from the recognition that change is not something we do to clients — it is something that happens within them when the conditions are right. Our job is to create those conditions.

Developing authentic MI spirit is the work of a career. It requires consistent reflection on our own assumptions, biases, and reactions. It requires honest examination of the moments when we slip from collaboration into direction, from acceptance into judgment, from evocation into persuasion. It requires the humility to recognize that our expertise, while real and valuable, is different from — and not superior to — the client's expertise on their own life. And it requires building the self-awareness to notice, in real time, when our internal attitude is drifting away from the spirit

that makes MI effective.

Reflection Questions

1. Before learning about PACE, how would you have described your therapeutic orientation? How has your approach to clients been shaped by your training and experience?

2. Reflect honestly: when you think about a challenging client, do you feel genuine curiosity and care — or frustration, judgment, or a desire to fix them? What does this tell you about your current MI spirit?

3. Have you ever caught yourself using MI techniques without genuine MI spirit — reflections that felt like strategic moves rather than authentic listening? What was happening internally in those moments?

4. What is one assumption you currently hold about clients in addiction recovery that might be interfering with genuine Partnership, Acceptance, Compassion, or Evocation?

5. On a scale of 1 to 10, how would you rate your current embodiment of each PACE component? What would moving the lowest score up by two points require?

Part 3 · Partnership: The Collaborative Foundation

Partnership: The Collaborative Foundation

Partnership in MI is not simply a pleasant interpersonal style — it is a fundamental repositioning of the therapeutic relationship away from hierarchy and toward genuine collaboration. In a hierarchical model, the clinician is the expert who knows what the client needs and works to help the client understand this. In a partnership model, both parties bring expertise to the work: the clinician brings knowledge of addiction, change processes, and therapeutic methods; the client brings knowledge of their own history, values, experiences, relationships, and reasons for change. Neither expertise is sufficient alone. Both are necessary.

The concept of partnership challenges a deep assumption embedded in many clinicians' professional identity: that our job is to know what is best for our clients and help them get there. This assumption is understandable — we went through years of training, we have worked with hundreds of people in recovery, we have studied the research, and we genuinely want our clients to succeed. But this expert orientation, however well-intentioned, can subtly undermine the client's own agency and motivation. When we position ourselves as the authority who knows what the client needs to do, we inadvertently communicate that they do not know what they need — that their judgment cannot be trusted, that their own knowledge of themselves is less valid than our clinical assessment. For clients who are already struggling with shame, distrust, and diminished self-efficacy, this communication — even when it is unspoken — can be devastating.

Partnership does not mean abandoning professional expertise. It means offering that expertise in a collaborative rather than prescriptive way. It means asking before telling. It means exploring before explaining. It means recognizing that the same information delivered as "here's what you should do" lands very differently than "here's something I've seen work — what do you think might apply to your situation?" The content may be identical. The relational experience is fundamentally different.

Genuine partnership also requires holding appropriate professional responsibility. There are clinical situations — acute safety concerns, imminent risk, situations requiring immediate intervention — where the collaborative stance must accommodate the professional's duty to act. MI does not require clinicians to be passive or to withhold critical information. It requires that we be intentional about how and when we exercise our authority, and that we remain anchored in the collaborative orientation even when direct action is necessary.

Building genuine partnership requires confronting the clinical "righting reflex" — the almost instinctive urge to correct, advise, and steer clients toward what we believe is the right path. This reflex is not evidence of poor clinical judgment; it is evidence that we care. But caring can express itself in ways that undermine the very goal we are trying to support. When a client says "I don't think my drinking is really that bad," our righting reflex says "Let me help you see how serious this actually is." Our partnership orientation asks instead: "What leads you to see it that way? Help me understand your perspective." One approach wins an argument. The other begins a conversation.

Reflection Questions

1. Think of a recent session where you felt most like a genuine partner with your client. What specific behaviors and internal attitudes made that partnership possible?

2. When does your "righting reflex" most commonly activate? What specific client statements or behaviors tend to trigger your instinct to correct, advise, or persuade?

3. How has your professional training shaped your beliefs about the distribution of expertise in the therapeutic relationship? What aspects of that training support genuine partnership, and what aspects make it harder?

4. Describe a time when offering advice or direction created resistance in a client. What might a pure partnership response have looked like in that moment?

5. What would it mean for your work if you genuinely believed that every client you see already possesses the core knowledge and motivation they need for change? How would your sessions look different?

Part 4 · Acceptance: Non-Judgment as Professional Practice

Acceptance: Non-Judgment as Professional Practice

Acceptance in MI is one of the most misunderstood and most frequently confused concepts in the entire motivational interviewing framework. It does not mean approving of harmful behavior. It does not mean withholding honest professional concern. It does not mean pretending that a client's drug use, dangerous decisions, or self-destructive patterns are acceptable or inconsequential. What it means is far more radical, and far more demanding: it means separating your evaluation of the behavior from your regard for the person.

Carl Rogers, whose person-centered therapy provided much of MI's philosophical foundation, called this "unconditional positive regard." The word "unconditional" is the operative one. Not positive regard contingent on the client making the changes we recommend. Not positive regard dependent on the client acknowledging their problem. Not positive regard that we feel toward clients who are engaged, motivated, and progressing — and withdraw from those who are resistant, ambivalent, or struggling. Unconditional. Available regardless of what the client does, decides, or feels.

This is extraordinarily difficult work. Every clinician comes to the therapeutic relationship with values, beliefs, histories, and reactions. When a client returns to use for the fifth time. When a client chooses to return to a partner who has been abusive. When a client dismisses our concern with the same phrases we have heard a hundred times. When a client prioritizes substances over their children, their health, their relationships. In these moments, maintaining non-judgmental acceptance requires not the suppression of our clinical reactions — it requires the processing of them, so that they do not leak out through tone, body language, the carefully chosen word that carries just enough edge to communicate disappointment.

Acceptance operates on four levels in MI practice. First, absolute worth — the belief that every human being has inherent value and dignity regardless of what they have done. Second, accurate empathy — the genuine effort to understand the client's experience from the inside, to see the world as they see it. Third, autonomy support — the recognition that clients have the fundamental right to make their own decisions, including decisions we disagree with. And fourth, affirmation — the active search for and acknowledgment of the client's strengths, efforts, and capacities, even when progress is slow or absent.

Building genuine acceptance requires regular examination of our own clinical biases. Most clinicians have client presentations that activate more judgment: the person who seems not to be trying, the person who is resistant to every intervention, the person whose values differ sharply from our own. These reactions are human. They become clinical problems only when we fail to examine them — when we allow our unexplored biases to shape our therapeutic relationships in ways we are not aware of. Acceptance is not a destination; it is a practice, requiring ongoing honest self-assessment and the willingness to recognize when our regard has become conditional.

Reflection Questions

1. Identify a client population or presentation that activates the most judgment in you. What specifically triggers the judgment, and where do you believe that reaction comes from?

2. Reflect on the four levels of acceptance: absolute worth, accurate empathy, autonomy support, and affirmation. Which of these four comes most naturally to you? Which requires the most intentional effort?

3. Have you ever caught yourself withholding warmth or engagement from a resistant or challenging client? What were the signs — in your tone, your body language, your word choices — that your acceptance had become conditional?

4. How do you hold genuine concern about a client's harmful behavior while simultaneously maintaining non-judgmental acceptance of the person? Where is the line between appropriate professional concern and judgment?

5. What personal history, values, or beliefs make unconditional positive regard most difficult for you? What would it take to work with that difficulty rather than around it?

Part 5 • Compassion: Authentic Care Without Rescue

Compassion: Authentic Care Without Rescue

Compassion in the MI framework has a specific and carefully defined meaning that distinguishes it from several adjacent states that clinicians commonly confuse with it. Compassion is not sympathy, which positions us as observers of suffering from a comfortable distance. It is not pity, which contains an element of condescension — the idea that we are fortunate enough not to be in the client's position. It is not emotional over-involvement, which leads us to take on the client's pain as our own and ultimately undermines both our effectiveness and our wellbeing. And it is not the rescuer orientation — the belief that it is our job to fix the client's pain — which, however kindly intended, can reinforce helplessness and undermine agency.

Authentic compassion in MI means genuinely prioritizing the client's wellbeing while maintaining the professional boundaries and self-awareness that allow us to be sustainably effective. It means asking ourselves, in every clinical decision: am I doing this because it serves the client's long-term wellbeing, or am I doing this because it relieves my discomfort? These are not always the same thing. Sometimes the compassionate response is to allow a client to sit with ambivalence rather than rushing to resolve it. Sometimes compassion looks like holding silence while the client confronts something painful, rather than immediately offering comfort. Sometimes the most compassionate thing we can do is to explore a client's argument for staying the same with genuine curiosity, rather than marshaling counter-arguments.

Compassion fatigue — the erosion of our capacity for genuine empathic engagement through cumulative exposure to client suffering — is one of the most significant challenges facing clinicians in substance use disorder treatment settings. It is not a character flaw or a sign of inadequate commitment. It is an occupational hazard of work that requires sustained emotional engagement with people in pain. When compassion fatigue is active, our responses to clients may become mechanical, our regard may become perfunctory, and our genuine curiosity about clients' experience may be replaced by procedural engagement. Maintaining authentic compassion requires attending to our own wellbeing — supervision, consultation, self-care, and honest acknowledgment of when we are depleted.

The distinction between compassion and the rescuer orientation deserves particular attention in addiction treatment. Many clinicians enter this field because of a deeply personal connection to addiction — their own recovery, a family member's struggle, a professional calling rooted in genuine care. This personal motivation is often a strength, bringing authenticity, lived experience, and genuine investment to the work. It can also create vulnerability to the rescuer orientation: the belief that if we just care enough, work hard enough, and find the right approach, we can save this person. When this belief is operating, the client's failure to change becomes a narcissistic injury as much as a clinical disappointment. Authentic compassion requires releasing the belief that the client's recovery is our accomplishment or our responsibility — and holding instead the belief that our job is to create conditions in which recovery becomes possible, while recognizing that the actual work of change belongs entirely to the client.

Reflection Questions

1. Reflect honestly on your current level of compassion fatigue. On a scale of 1 to 10, how depleted is your capacity for genuine empathic engagement right now? What are the signs in your clinical work?

2. Distinguish between a recent moment of authentic compassion in your work and a moment of pity or sympathy. What was different about your internal experience and your behavioral response in each case?

3. Have you noticed the rescuer orientation operating in your work? When a client does not progress or returns to use, do you experience it primarily as clinical concern — or as personal failure? What does your answer reveal?

4. How do you currently attend to your own wellbeing in a way that sustains your capacity for genuine compassion? What additional practices or supports might be necessary?

5. Think about a client you find it hardest to feel genuine compassion for. What is getting in the way? What would you need to understand about this person to be able to access authentic compassion?

Part 6 · Evocation: Drawing Out What Is Already There

Evocation: Drawing Out What Is Already There

Evocation is perhaps the most counter-intuitive component of MI spirit for clinicians trained in traditional helping models. The evocation principle holds that the resources, motivations, and wisdom needed for change already exist within the client — that our job is not to install these from the outside but to draw them out from within. This is not a polite fiction or a therapeutic technique; it is a fundamental belief about human nature and the architecture of change.

The conventional clinical assumption operates in the opposite direction. If a client does not appear to be motivated, we assume they need more motivation — and that we are responsible for providing it through information, persuasion, confrontation, consequences, or incentives. If a client does not seem to know what they need to do, we assume they need education — and that our expertise in addiction and recovery qualifies us to provide the answers they lack. These assumptions are understandable, but they have a consistent empirical problem: they don't work nearly as well as we expect them to. Lectures increase resistance. Advice-giving frequently produces the opposite of what was intended. Confronting denial strengthens it. The harder we push, the harder clients push back.

Evocative practice begins with a different question. Instead of asking "What does this client need to understand?" we ask "What does this client already know that could support change?" Instead of asking "How can I motivate this person?" we ask "What motivation is already present that I haven't yet found a way to evoke?" Instead of preparing our most persuasive argument for why the client should change, we prepare our most skillful questions to help the client discover their own reasons for change — reasons that will be far more motivating than anything we could provide because they belong to the client.

The technical expressions of evocation — open-ended questions, elaborating change talk, rolling with ambivalence, exploring the client's own values and hopes — are the behavioral manifestations of a genuine internal belief that the client possesses what they need. When evocation is performed as technique without genuine belief, clients detect the inauthenticity. When it is expressed from genuine curiosity about what exists within this particular human being, it creates conditions in which clients hear themselves articulating their own reasons for change — often to their own surprise.

Sustaining evocative practice requires ongoing examination of one of our deepest clinical habits: the assumption that our experience and expertise gives us better judgment than our clients about what they need to do. This assumption is sometimes correct in narrow clinical ways — we may know more about withdrawal timelines, medication options, or relapse warning signs than the client does. But it is almost always incorrect in the broader sense. We do not know the client's deepest values, their most important relationships, their most painful experiences, or the precise contours of what recovery could mean for their particular life. Only they know these things. Evocation is the practice of treating that knowledge as the most important expertise in the room.

Reflection Questions

1. Think of a recent session where you found yourself providing a great deal of advice, information, or persuasion. What internal assumption was operating that led you toward information-giving rather than evocation?

2. Recall a moment when a client surprised you with their own insight, wisdom, or motivation. What created the conditions for that to emerge? How had you made space for it?

3. What is the most common form your righting reflex takes — advice-giving, information-providing, confronting, or something else? How might this habit be interfering with evoking the client's own motivation?

4. Practice shifting one advice-giving statement to an evocative question. For example: "I think you should consider what triggers your use" becomes "What have you noticed about the situations where the urge to use gets strongest?" Generate three more examples from your own clinical vocabulary.

5. What would your clinical sessions look like if you genuinely trusted that every client already carries within them everything they need to change — that your job is only to help them access it?

Part 7 · Resistance Navigation: Ambivalence as Normal and Information

Resistance Navigation: Ambivalence as Normal and Information

The MI framework offers one of the most important reframes in all of clinical practice: resistance is not the problem — it is information. Traditional addiction treatment often positioned client resistance as pathological denial that needed to be broken down through confrontation, consequences, and persuasion. Research by Miller and Rollnick and their colleagues demonstrated something startling: the harder clinicians pushed against resistance, the stronger it became. And when clinicians rolled with resistance — expressed curiosity about it, reflected it without judgment, explored both sides of the ambivalence it contained — resistance frequently dissolved and motivation began to emerge.

Ambivalence is not a symptom of inadequate motivation or insufficient insight into the severity of one's problem. It is the normal human experience of contemplating significant change. Every person who has ever seriously considered changing a major behavior — leaving a relationship, changing careers, modifying a lifelong pattern — has experienced ambivalence. The simultaneous pull toward change and the pull toward the familiar, the known, the comfortable, even when the familiar is causing harm. Treating this normal human experience as pathology — something to be overcome, argued away, or confronted out of existence — has been one of addiction treatment's most costly errors.

When a client says "I don't think I really have a problem," the confrontational reflex says: show them the evidence that they do. The MI-consistent response begins by exploring what leads them to see it that way — genuinely, curiously, without the hidden agenda of convincing them they're wrong. This exploration frequently reveals something important: the statement "I don't think I have a problem" is rarely a simple factual claim. It is often an expression of ambivalence, a defense against shame, a negotiation about identity, or a test of whether the clinician can be trusted to be honest without being punishing. When we respond with genuine curiosity rather than strategic confrontation, we find out which of these it is — and we gain access to the actual work.

The practical expression of resistance navigation involves several key skills. Reflecting resistance without amplifying it — acknowledging the client's position without either agreeing with it or arguing against it. Exploring both sides of ambivalence with equal curiosity, giving full expression to the reasons to stay the same as well as the reasons to change, because the ambivalence is real and both sides need to be understood. Shifting focus when forward movement is blocked — moving to a different topic or dimension of the work rather than pushing against the wall. And recognizing that resistance frequently signals a mismatch between the clinician's approach and what the client actually needs in that moment — not a failure of the client, but information about what needs to change in our approach.

Perhaps the most important clinical implication of the MI stance on resistance is this: when a client is highly resistant, the most useful question is not "What is wrong with this client?" but "What might I be doing that is increasing rather than decreasing this client's defensiveness?" This

is a radical act of professional humility that changes everything about how we approach difficult sessions.

Reflection Questions

1. Think of a client you have experienced as "highly resistant." If you reframed that resistance as important clinical information, what might it be telling you? What might this person be protecting, negotiating, or communicating through their resistance?

2. Recall a session where you pushed against client resistance and the resistance intensified. What were you doing? What did the client do in response? How might a different approach have produced a different outcome?

3. How do you currently respond when a client challenges your assessment, minimizes the severity of their use, or argues against the value of treatment? Be honest about your internal reaction, not just your professional response.

4. Practice writing a "rolling with resistance" response to each of these statements: (a) "I don't think AA is for me." (b) "My drinking isn't as bad as other people here." (c) "I've tried this before and it doesn't work." What does each response attempt to accomplish without argument or persuasion?

5. When you notice yourself pushing against client resistance, what is the internal signal — the thought, feeling, or physical sensation — that you are no longer rolling but pushing? What would help you catch that signal earlier?

Part 8 · MI Spirit Self-Assessment

MI Spirit Self-Assessment

Rate each statement: 1 (Not at all like me) to 5 (Very much like me)

I genuinely believe that clients are the experts on their own experience and lives

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I regularly ask for client input before offering clinical recommendations or information

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I catch myself wanting to steer clients toward outcomes I've already decided are best for them

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I maintain a collaborative stance even with clients who are highly resistant or challenging

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I feel most effective when I am directing clients toward appropriate treatment goals

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I explore the client's perspective fully before offering my professional assessment

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I experience discomfort when clients make decisions that differ from my clinical recommendations

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

My clients would describe our relationship as genuinely collaborative rather than directed by me

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can maintain genuine warmth and regard for clients who repeatedly return to use

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I notice when my unconditional positive regard becomes conditional based on client behavior

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

There are specific client presentations or populations that activate significant judgment in me

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I separate my evaluation of client behavior from my fundamental regard for the client as a person

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I support clients' right to make decisions I believe are harmful to them

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

My clinical language (even internally) remains non-pathologizing and strengths-focused

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can genuinely celebrate client strengths even when clients are not making the changes I recommend

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I regularly examine my own biases that might be influencing my acceptance of specific clients

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I experience genuine empathy for client struggle rather than sympathy, pity, or frustration

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I notice when compassion fatigue is affecting my capacity for authentic engagement

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I take care of my own emotional wellbeing in ways that sustain my clinical effectiveness

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can feel the client's experience from their perspective without taking it on as my own

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

When clients do not progress, I experience this primarily as clinical concern rather than personal failure

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I am able to be present with client pain without rushing to relieve it or fix it

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I prioritize the client's long-term wellbeing over my own discomfort in every clinical decision

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can distinguish between genuine compassion and the rescuer orientation in my own clinical work

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I genuinely believe that the motivation and wisdom for change already exists within each client

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

My default response to a client who seems unmotivated is to explore their perspective, not to provide motivation

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I catch myself giving advice when a well-crafted question would be more effective

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I use open-ended questions more frequently than closed questions or informational statements

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can listen to a client's argument for not changing with genuine curiosity rather than strategic patience

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I regularly create space for clients to articulate their own reasons for change

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

My sessions involve more client talking than clinician talking

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I trust the evocation process even when it feels slower than direct advice-giving would be

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

When a client is resistant, my first question is "What am I doing that might be increasing this resistance?"

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can explore a client's argument against change with genuine curiosity rather than strategic reframing

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I experience client resistance as clinical information rather than client pathology

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can reflect ambivalence without pushing toward the change-side of the argument

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

When progress is blocked, I shift focus rather than pushing harder against the same wall

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can hold space for a client's reasons to stay the same as equally valid as their reasons to change

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I catch myself engaging in subtle confrontation masked as reflection or summarizing

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can maintain equanimity when clients challenge my clinical assessment or minimize their problems

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I maintain MI spirit consistently across client presentations, not just with motivated clients

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can identify in real time when I have slipped from MI spirit into a more directive stance

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

My MI spirit remains stable under therapeutic stress (client crisis, confrontation, stagnation)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I integrate PACE authentically rather than performing it strategically

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I actively pursue feedback, supervision, or consultation to develop my MI practice

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I am able to sustain genuine therapeutic alliance even through extended periods of ambivalence

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

My colleagues would recognize genuine MI spirit in my interactions with clients and with them

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I understand my own specific MI spirit development edges and am actively working on them

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

1. Which PACE domain scored highest? What experiences and practices have developed this particular strength?

Your reflection...

2. Which domain represents your most significant development edge? What clinical patterns might be connected to this gap?

Your reflection...

3. Which specific items did you rate as 1 or 2? These are your most urgent MI spirit development priorities.

Your reflection...

4. Were any of your answers surprising? Did this assessment reveal patterns in your practice you had not consciously recognized?

Your reflection...

5. Looking across all six domains, what is the single most important internal shift that would most significantly improve your MI spirit?

Your reflection...

6. What would your clients say if asked how consistently you demonstrate genuine Partnership, Acceptance, Compassion, and Evocation toward them?

Your reflection...

Scoring guide

Reset all progress? This cannot be undone.

For Domains 1-5, higher scores in items about genuine spirit qualities indicate greater alignment with MI philosophy. For items that describe directive or judgmental tendencies (marked by phrasing like 'I feel most effective when directing'), lower scores indicate greater MI spirit. Domain 6 (Integrated MI Spirit Capacity) — higher scores indicate greater overall integration. Compare your scores across domains to identify your strongest MI spirit foundations and your most significant development edges.

Part 9 • Exercise 1: MI Spirit Self-Portrait

Exercise 1: MI Spirit Self-Portrait

An honest picture of who you are as a clinician — right now

Purpose

Before we can develop MI spirit, we need an honest portrait of where we are. This exercise is not about judgment — it is about clarity. Seeing ourselves accurately is the prerequisite for genuine growth.

1. How would you describe your natural, unguarded clinical style — the way you work when you are not consciously applying a particular model?

Write honestly and specifically...

2. What do your clients experience when they are with you? If you could hear a client describe their session with you to a friend, what would they say?

Write honestly and specifically...

3. What is your relationship with silence in sessions? With not knowing? With ambivalence that doesn't resolve?

Write honestly and specifically...

4. When are you most genuinely present with a client? When do you find yourself going through the motions?

Write honestly and specifically...

1. Which component of PACE — Partnership, Acceptance, Compassion, Evocation — feels most natural and authentic to you? Describe a specific example where you demonstrated this strength.

Write honestly and specifically...

2. What in your personal history, professional training, or life experience has most developed this strength?

Write honestly and specifically...

3. How do clients respond to you when this strength is fully present?

Write honestly and specifically...

4. What would it look like to amplify this natural strength intentionally across all your clinical interactions?

Write honestly and specifically...

1. Which PACE component is most difficult for you to embody consistently? Be specific about the situations where it breaks down.

Write honestly and specifically...

2. What internal state — feeling, thought, or physical sensation — is usually present when you drift away from MI spirit?

Write honestly and specifically...

3. What do you do when that happens? What does your clinical behavior look like when MI spirit is absent?

Write honestly and specifically...

4. What is the cost — to your clients, to the therapeutic relationship, to treatment outcomes — of those moments when spirit is absent?

Write honestly and specifically...

1. Describe what your ideal MI practice looks like — the clinician you are working to become. Be specific about how sessions feel, how clients respond, what you do when things get hard.

Write honestly and specifically...

2. What is the most significant internal shift (not skill acquisition — internal shift) that would move you from where you are to where you want to be?

Write honestly and specifically...

3. Who in your professional life most embodies genuine MI spirit? What specifically do they do or not do that reflects this?

Write honestly and specifically...

4. Write a one-paragraph commitment statement to your own MI spirit development — not what you will do, but who you commit to becoming as a clinician.

Write honestly and specifically...

Part 10 • Exercise 2: Partnership vs. Direction Audit

Exercise 2: Partnership vs. Direction Audit

Examining the balance between collaboration and control in your clinical work

The Core Question

In each clinical moment, you are operating somewhere on a spectrum from full partnership (the client's agenda, perspective, and expertise guiding the work) to full direction (your clinical assessment driving the session). Neither extreme is always appropriate. MI invites us to notice where we are on this spectrum at all times — and to have a reason for being there.

Scenario 1: A client says they are thinking about reducing use rather than abstaining

DIRECTIVE RESPONSE

Express concern and redirect toward abstinence as the evidence-based goal

PARTNERSHIP RESPONSE

Explore their thinking about reduction, what it would look like, and what they hope it would accomplish

What would your natural response actually be in this situation? Be honest.

Describe what you would actually say and do...

What internal state (thought, feeling, assumption) tends to pull you toward the directive end of the spectrum in moments like this?

What's happening inside you in this moment?

What would a fully MI-consistent partnership response look like — not just the words, but the internal attitude that would make it genuine?

Describe the response and the internal state behind it...

Scenario 2: A client misses their third appointment in two weeks

DIRECTIVE RESPONSE

Address the pattern directly and explain the impact on treatment progress

PARTNERSHIP RESPONSE

Explore with genuine curiosity what has been getting in the way, without assumption about motivation

What would your natural response actually be in this situation? Be honest.

Describe what you would actually say and do...

What internal state (thought, feeling, assumption) tends to pull you toward the directive end of the spectrum in moments like this?

What's happening inside you in this moment?

What would a fully MI-consistent partnership response look like — not just the words, but the internal attitude that would make it genuine?

Describe the response and the internal state behind it...

Scenario 3: A client shares a plan you believe is likely to lead to relapse

DIRECTIVE RESPONSE

Share your clinical concern clearly and recommend a different approach

PARTNERSHIP RESPONSE

Explore what the client is hoping the plan will accomplish and what concerns, if any, they have about it

What would your natural response actually be in this situation? Be honest.

Describe what you would actually say and do...

What internal state (thought, feeling, assumption) tends to pull you toward the directive end of the spectrum in moments like this?

What's happening inside you in this moment?

What would a fully MI-consistent partnership response look like — not just the words, but the internal attitude that would make it genuine?

Describe the response and the internal state behind it...

Scenario 4: A client is ambivalent about medication-assisted treatment

DIRECTIVE RESPONSE

Provide education about MAT effectiveness and address misconceptions

PARTNERSHIP RESPONSE

Explore both sides of the ambivalence with genuine curiosity about what is driving each side

What would your natural response actually be in this situation? Be honest.

Describe what you would actually say and do...

What internal state (thought, feeling, assumption) tends to pull you toward the directive end of the spectrum in moments like this?

What's happening inside you in this moment?

What would a fully MI-consistent partnership response look like — not just the words, but the internal attitude that would make it genuine?

Describe the response and the internal state behind it...

Scenario 5: A client says their recovery is going well but you see clinical warning signs

DIRECTIVE RESPONSE

Gently point out the warning signs you are observing and their potential significance

PARTNERSHIP RESPONSE

Ask the client to describe what "going well" means to them and what they are noticing themselves

What would your natural response actually be in this situation? Be honest.

Describe what you would actually say and do...

What internal state (thought, feeling, assumption) tends to pull you toward the directive end of the spectrum in moments like this?

What's happening inside you in this moment?

What would a fully MI-consistent partnership response look like — not just the words, but the internal attitude that would make it genuine?

Describe the response and the internal state behind it...

1. Looking across all five scenarios, where on the directive-to-partnership spectrum did your natural responses tend to fall? What pattern do you notice?

Synthesize your audit findings...

2. What specific clinical situations, client presentations, or emotional states most reliably pull you toward the directive end? What is driving this pull?

Synthesize your audit findings...

3. What is the cost — in terms of therapeutic alliance, client motivation, and treatment outcomes — of operating primarily from the directive end?

Synthesize your audit findings...

4. What is one concrete change to your clinical practice that would shift your default position toward genuine partnership? What would help you remember to make that shift in the moment?

Synthesize your audit findings...

Part 11 • Exercise 3: Acceptance Challenge Inventory

Exercise 3: Acceptance Challenge Inventory

Mapping the client presentations that strain your unconditional positive regard

Acceptance as Practice

Unconditional positive regard is easy with clients who are engaged, grateful, and progressing. The real measure of our acceptance is what happens when it is tested — by difficult presentations, repeated setbacks, and clients who challenge every aspect of our clinical confidence. This inventory maps where your acceptance most strains.

A client in long-term treatment who has relapsed multiple times, appears to be in the same cycle, and shows minimal progress despite significant clinical effort

What is your honest internal reaction when you encounter this presentation? Describe the thought, the feeling, and any physical sensation.

Write with honesty and self-compassion...

What does your acceptance look like — or fail to look like — with this client? How might the client perceive your regard for them?

Write with honesty and self-compassion...

What is the clinical impact of conditional acceptance on this type of client? What are they likely to feel and do in response?

Write with honesty and self-compassion...

What would you need to understand about this person — their history, their experience, their world — to be able to access genuine compassion and acceptance?

Write with honesty and self-compassion...

A client who consistently minimizes the severity of their use, dismisses clinical concern, and maintains they do not really have a problem

What is your honest internal reaction when you encounter this presentation? Describe the thought, the feeling, and any physical sensation.

Write with honesty and self-compassion...

What does your acceptance look like — or fail to look like — with this client? How might the client perceive your regard for them?

Write with honesty and self-compassion...

What is the clinical impact of conditional acceptance on this type of client? What are they likely to feel and do in response?

Write with honesty and self-compassion...

What would you need to understand about this person — their history, their experience, their world — to be able to access genuine compassion and acceptance?

Write with honesty and self-compassion...

A client who makes a decision you believe is clearly dangerous — returning to a using relationship, leaving treatment prematurely, or refusing medication

What is your honest internal reaction when you encounter this presentation? Describe the thought, the feeling, and any physical sensation.

Write with honesty and self-compassion...

What does your acceptance look like — or fail to look like — with this client? How might the client perceive your regard for them?

Write with honesty and self-compassion...

What is the clinical impact of conditional acceptance on this type of client? What are they likely to feel and do in response?

Write with honesty and self-compassion...

What would you need to understand about this person — their history, their experience, their world — to be able to access genuine compassion and acceptance?

Write with honesty and self-compassion...

A client whose values, lifestyle, or choices differ sharply from your own in ways you find difficult to understand or relate to

What is your honest internal reaction when you encounter this presentation? Describe the thought, the feeling, and any physical sensation.

Write with honesty and self-compassion...

What does your acceptance look like — or fail to look like — with this client? How might the client perceive your regard for them?

Write with honesty and self-compassion...

What is the clinical impact of conditional acceptance on this type of client? What are they likely to feel and do in response?

Write with honesty and self-compassion...

What would you need to understand about this person — their history, their experience, their world — to be able to access genuine compassion and acceptance?

Write with honesty and self-compassion...

A client who consistently misses sessions, doesn't complete assignments, and seems to be going through the motions of treatment without genuine engagement

What is your honest internal reaction when you encounter this presentation? Describe the thought, the feeling, and any physical sensation.

Write with honesty and self-compassion...

What does your acceptance look like — or fail to look like — with this client? How might the client perceive your regard for them?

Write with honesty and self-compassion...

What is the clinical impact of conditional acceptance on this type of client? What are they likely to feel and do in response?

Write with honesty and self-compassion...

What would you need to understand about this person — their history, their experience, their world — to be able to access genuine compassion and acceptance?

Write with honesty and self-compassion...

A client who is frequently critical of the program, challenges your competence, makes demands, or engages with hostility or contempt

What is your honest internal reaction when you encounter this presentation? Describe the thought, the feeling, and any physical sensation.

Write with honesty and self-compassion...

What does your acceptance look like — or fail to look like — with this client? How might the client perceive your regard for them?

Write with honesty and self-compassion...

What is the clinical impact of conditional acceptance on this type of client? What are they likely to feel and do in response?

Write with honesty and self-compassion...

What would you need to understand about this person — their history, their experience, their world — to be able to access genuine compassion and acceptance?

Write with honesty and self-compassion...

1. Which client type challenges your acceptance most significantly? What does this tell you about yourself — your values, your history, your needs?

Synthesize your acceptance work...

2. Is there a common thread across the presentations that challenge your acceptance? What is the pattern in what activates your conditional regard?

Synthesize your acceptance work...

3. What is the relationship between your conditional acceptance of certain clients and your own recovery from perfectionism, judgment, or the need to feel effective?

Synthesize your acceptance work...

4. Write an acceptance statement for the client type that challenges you most: "Even when [specific behavior/presentation], I commit to holding [person] with genuine regard because [reason rooted in their humanity]."

Synthesize your acceptance work...

Part 12 · Exercise 4: Compassion Fatigue Assessment

Exercise 4: Compassion Fatigue Assessment

Evaluating the sustainability of your empathic engagement

The Sustainability Question

Genuine MI compassion requires an internal resource — a reservoir of authentic care and empathic capacity — that can be depleted. Compassion fatigue is not a character failure. It is an occupational hazard. This assessment maps your current compassion reserves and identifies where investment in your own wellbeing is most urgently needed.

Rate how much each statement describes your current experience: 1 (Not at all) to 5 (Very much)

Chronic fatigue that doesn't improve with rest

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

Physical tension or pain concentrated in head, neck, shoulders, or gut

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

Sleep disturbance — difficulty falling asleep, staying asleep, or feeling rested

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

Increased susceptibility to illness

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

Physical dread of going to work

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

Somatic symptoms on workdays that improve on days off

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

Rate how much each statement describes your current experience: 1 (Not at all) to 5 (Very much)

Emotional numbness or reduced capacity for empathy

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

Cynicism or bitterness about clients or the recovery field

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

Disproportionate emotional reactions to minor clinical challenges

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

Sense of dread or hopelessness about a client's capacity to change

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

Increased irritability with clients, colleagues, or family after work

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

Loss of satisfaction from work that previously felt meaningful

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

Rate how much each statement describes your current experience: 1 (Not at all) to 5 (Very much)

Intrusive thoughts about clients' situations outside of work hours

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

Difficulty concentrating or making decisions in sessions

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

Reduced creativity or flexibility in clinical problem-solving

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

Avoidance of certain clients, topics, or clinical challenges

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

Increased administrative errors or lapses in clinical documentation

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

Disconnection between clinical performance and personal values

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

1. Which domain (Physical, Emotional, Cognitive/Behavioral) scored highest? What does this pattern tell you about how compassion fatigue is primarily manifesting for you right now?

Reflect honestly about your current state and needs...

2. How is your current compassion fatigue level affecting the authenticity of your PACE with clients? Be specific about which component — Partnership, Acceptance, Compassion, or Evocation — is most compromised.

Reflect honestly about your current state and needs...

3. What are your current practices for restoring empathic capacity — supervision, peer consultation, self-care, time away from the work? Are these practices sufficient?

Reflect honestly about your current state and needs...

4. What specifically would most replenish your compassion reserves right now? Name three concrete actions you could take in the next two weeks.

Reflect honestly about your current state and needs...

5. What organizational or structural factors are contributing to your compassion fatigue? Which of these can you influence, and how?

Reflect honestly about your current state and needs...

6. Write a compassion self-statement — the kind of acceptance and care you extend to clients, directed toward yourself: "Even when I am depleted and imperfect in my clinical presence, I am..."

Reflect honestly about your current state and needs...

Part 13 · Exercise 5: Evocation Skills Builder

Exercise 5: Evocation Skills Builder

Transforming direction into discovery — building evocative clinical language

The Transformation Practice

The righting reflex produces directive statements. MI spirit produces evocative questions. This exercise builds the habit of transforming directive impulses into genuine inquiries — not as a strategic technique but as an expression of genuine belief in the client's own wisdom.

Study these transformations. Notice not just the linguistic shift but the internal attitude change they require.

DIRECTIVE (RIGHTING REFLEX)

"You should think about what's motivating your use."

EVOCATIVE (MI SPIRIT)

"What do you think is driving the pull toward using right now?"

DIRECTIVE (RIGHTING REFLEX)

"Abstinence gives you the best chance for recovery."

EVOCATIVE (MI SPIRIT)

"What does recovery look like to you? What would your life need to look like for it to feel like recovery?"

DIRECTIVE (RIGHTING REFLEX)

"You need to get a sponsor and work the steps."

EVOCATIVE (MI SPIRIT)

"What have you heard about the steps that sounds useful — or not? What kind of support would actually help you?"

DIRECTIVE (RIGHTING REFLEX)

"Your drinking is affecting your family."

EVOCATIVE (MI SPIRIT)

"How do you think your use has been affecting the people you care most about?"

DIRECTIVE (RIGHTING REFLEX)

"Going back to that relationship will put your recovery at risk."

EVOCATIVE (MI SPIRIT)

"When you think about what this relationship means to your recovery — in either direction — what comes up for you?"

For each directive statement below, write (a) the evocative transformation and (b) the internal attitude shift required to make it genuine rather than strategic.

DIRECTIVE STATEMENT

"You need to be honest with your family about what's been going on."

Your evocative transformation:

Rewrite as an evocative question or reflection...

Internal attitude shift required:

What would you need to genuinely believe to make this transformation authentic?

DIRECTIVE STATEMENT

"Making meetings a priority will really strengthen your recovery."

Your evocative transformation:

Rewrite as an evocative question or reflection...

Internal attitude shift required:

What would you need to genuinely believe to make this transformation authentic?

DIRECTIVE STATEMENT

"That sounds like a rationalization to me."

Your evocative transformation:

Rewrite as an evocative question or reflection...

Internal attitude shift required:

What would you need to genuinely believe to make this transformation authentic?

DIRECTIVE STATEMENT

"You've been here before — you know what happens when you stop coming to sessions."

Your evocative transformation:

Rewrite as an evocative question or reflection...

Internal attitude shift required:

What would you need to genuinely believe to make this transformation authentic?

DIRECTIVE STATEMENT

"Your plan doesn't seem realistic to me."

Your evocative transformation:

Rewrite as an evocative question or reflection...

Internal attitude shift required:

What would you need to genuinely believe to make this transformation authentic?

1. Write three directive statements you regularly find yourself making in sessions — statements that reflect your righting reflex in action.

Write, then rewrite...

2. Now transform each of those three statements into a genuinely evocative question or reflection. What internal shift did that require?

Write, then rewrite...

3. What is the most consistent pattern in your directive language? What clinical belief or anxiety tends to drive it?

Write, then rewrite...

4. What would your sessions sound like — and feel like, to both you and your clients — if you replaced your three most common directive statements with evocative questions for one full week?

Write, then rewrite...

Part 14 · Exercise 6: Righting Reflex Awareness Log

Exercise 6: Righting Reflex Awareness Log

Catching the moment before direction replaces collaboration

The Righting Reflex

The righting reflex is the nearly automatic impulse to correct, advise, and steer clients toward what we believe is the right path. It is not a character flaw — it is evidence of genuine care. But it often produces the opposite of what we intend. Learning to catch it before it becomes behavior is foundational MI spirit work.

1. List the top five client statements or situations that most reliably activate your righting reflex. Be specific.

Write with clinical honesty...

2. For each trigger, describe the internal experience: What do you think? What do you feel? What does your body do?

Write with clinical honesty...

3. What is the belief underneath the righting reflex in each case? What are you afraid will happen if you don't correct, advise, or steer?

Write with clinical honesty...

4. How quickly do you typically move from trigger to directive response? Is there a pause — a moment of awareness — before the reflex becomes behavior?

Write with clinical honesty...

1. Describe a specific session where your righting reflex drove the interaction. What happened?
How did the client respond?

Write with clinical honesty...

2. What is the typical client response to your most common directive interventions —
engagement and motivation, or resistance and withdrawal?

Write with clinical honesty...

3. What is the cumulative effect, over a course of treatment, of a clinician operating primarily
from the righting reflex rather than from genuine evocation?

Write with clinical honesty...

4. What might you be missing — about the client, about their readiness, about their experience —
when the righting reflex is running?

Write with clinical honesty...

1. What internal signal — thought, feeling, or physical sensation — could serve as your "righting
reflex alarm"? What do you notice that reliably precedes directive behavior?

Write with clinical honesty...

2. Describe a specific practice for pausing between trigger and response — a deliberate moment of MI spirit recalibration. What would you do, say to yourself, or attend to?

Write with clinical honesty...

3. Write a "righting reflex antidote" question — one evocative question you can default to when you notice the reflex activating, that will reliably move you back into MI spirit.

Write with clinical honesty...

4. What would you need from supervision, peer consultation, or clinical culture to sustain increased righting reflex awareness over time?

Write with clinical honesty...

Part 15 · Exercise 7: Client Ambivalence Mapping

Exercise 7: Client Ambivalence Mapping

Understanding and working with the natural complexity of change

Ambivalence as Normal

Ambivalence is not pathological resistance — it is the normal human experience of contemplating significant change. Every type of ambivalence listed below is real, rational, and informative. Our job is not to resolve it through persuasion but to explore it with genuine curiosity until the client's own clarity emerges.

Client genuinely sees benefits to continued use and costs to changing — a real, rational weighing of competing desires and needs

Think of a client currently experiencing this type of ambivalence. How does their ambivalence present — what do they say and do that reveals it?

Reflect on your clinical experience...

What has been your instinctive clinical response to this ambivalence? Have you tended to acknowledge both sides equally, or to push toward the change side?

Reflect on your clinical experience...

What would a genuinely ambivalence-exploratory response look like — one that gave full and equal expression to both sides without pushing toward resolution?

Reflect on your clinical experience...

What does this client's ambivalence tell you about what actually needs attention in the work — not the ambivalence itself, but what it is protecting or expressing?

Reflect on your clinical experience...

Client wants recovery but is uncertain about this particular treatment approach, program, or professional relationship

Think of a client currently experiencing this type of ambivalence. How does their ambivalence present — what do they say and do that reveals it?

Reflect on your clinical experience...

What has been your instinctive clinical response to this ambivalence? Have you tended to acknowledge both sides equally, or to push toward the change side?

Reflect on your clinical experience...

What would a genuinely ambivalence-exploratory response look like — one that gave full and equal expression to both sides without pushing toward resolution?

Reflect on your clinical experience...

What does this client's ambivalence tell you about what actually needs attention in the work — not the ambivalence itself, but what it is protecting or expressing?

Reflect on your clinical experience...

Client's sense of self is entangled with the using lifestyle, relationships, or culture — change feels like losing who they are

Think of a client currently experiencing this type of ambivalence. How does their ambivalence present — what do they say and do that reveals it?

Reflect on your clinical experience...

What has been your instinctive clinical response to this ambivalence? Have you tended to acknowledge both sides equally, or to push toward the change side?

Reflect on your clinical experience...

What would a genuinely ambivalence-exploratory response look like — one that gave full and equal expression to both sides without pushing toward resolution?

Reflect on your clinical experience...

What does this client's ambivalence tell you about what actually needs attention in the work — not the ambivalence itself, but what it is protecting or expressing?

Reflect on your clinical experience...

Client can see the benefits of change but does not believe the timing, circumstances, or personal resources are right

Think of a client currently experiencing this type of ambivalence. How does their ambivalence present — what do they say and do that reveals it?

Reflect on your clinical experience...

What has been your instinctive clinical response to this ambivalence? Have you tended to acknowledge both sides equally, or to push toward the change side?

Reflect on your clinical experience...

What would a genuinely ambivalence-exploratory response look like — one that gave full and equal expression to both sides without pushing toward resolution?

Reflect on your clinical experience...

What does this client's ambivalence tell you about what actually needs attention in the work — not the ambivalence itself, but what it is protecting or expressing?

Reflect on your clinical experience...

Client wants to change but fundamentally doubts their own ability to succeed — previous failures have eroded self-efficacy

Think of a client currently experiencing this type of ambivalence. How does their ambivalence present — what do they say and do that reveals it?

Reflect on your clinical experience...

What has been your instinctive clinical response to this ambivalence? Have you tended to acknowledge both sides equally, or to push toward the change side?

Reflect on your clinical experience...

What would a genuinely ambivalence-exploratory response look like — one that gave full and equal expression to both sides without pushing toward resolution?

Reflect on your clinical experience...

What does this client's ambivalence tell you about what actually needs attention in the work — not the ambivalence itself, but what it is protecting or expressing?

Reflect on your clinical experience...

1. Which type of ambivalence do you find most difficult to sit with — to explore without pushing toward resolution? Why?

Synthesize your ambivalence mapping work...

2. How has your response to client ambivalence changed (or not changed) since you began learning MI? What specific practices have shifted your relationship with ambivalence?

Synthesize your ambivalence mapping work...

3. What would your caseload look like if you genuinely held the belief that every instance of client ambivalence contains valuable information about what is actually needed for change?

Synthesize your ambivalence mapping work...

4. Write a clinical principle about ambivalence that you want to carry into your practice: "When a client is ambivalent, I will remember that..."

Synthesize your ambivalence mapping work...

Part 16 · Exercise 8: Reflective Listening Workshop

Exercise 8: Reflective Listening Workshop

Building the reflective vocabulary that expresses genuine MI spirit

Reflection as Expression of Spirit

A reflection is not a paraphrase or a trick. A genuine reflection — one that lands as heard, understood, and valued — emerges from the clinician actually listening with full presence and genuine curiosity. This workshop distinguishes mechanical reflection from authentic reflection and builds the internal capacity behind the skill.

Simple Reflection

Repeats or closely paraphrases what the client said. Communicates: "I heard you." Best for: ensuring accurate reception, early sessions, building trust.

Complex Reflection

Adds meaning, emotion, or implication beyond the words. Communicates: "I understand what this means to you." Best for: deepening exploration, evoking emotion.

Amplified Reflection

Slightly overstates the client's position. Communicates: "Here is where your statement leads." Best for: gently inviting re-evaluation without argument.

Double-Sided Reflection

Acknowledges both sides of ambivalence. Communicates: "I can hold the complexity of your experience." Best for: exploring ambivalence without pushing toward resolution.

Metaphorical Reflection

Uses an image or metaphor to capture the emotional texture. Communicates: "I'm trying to truly understand your experience." Best for: clients who respond to imagery, resistant moments.

CLIENT SAYS:

"I don't know if I can do this. I've tried to quit before and it never works. I just end up back where I started."

Context: Early recovery client, third treatment episode

Write a Simple Reflection:

Closely paraphrase what the client said...

Write a Complex Reflection:

Add the meaning, emotion, or implication beneath the words...

Write a Double-Sided Reflection:

Acknowledge both sides of the ambivalence you hear...

Write a Metaphorical Reflection:

Capture the emotional texture with an image...

Which reflection do you think would land best with this client and why?

Explain your clinical reasoning...

CLIENT SAYS:

"I don't really see the point of all these groups. Nobody here is like me, and I don't think talking is going to fix anything."

Context: High-functioning professional client, court-mandated treatment

Write a Simple Reflection:

Closely paraphrase what the client said...

Write a Complex Reflection:

Add the meaning, emotion, or implication beneath the words...

Write a Double-Sided Reflection:

Acknowledge both sides of the ambivalence you hear...

Write a Metaphorical Reflection:

Capture the emotional texture with an image...

Which reflection do you think would land best with this client and why?

Explain your clinical reasoning...

CLIENT SAYS:

"My family keeps saying I'm doing great, but honestly I feel worse than I did when I was using. At least then I felt something."

Context: Client three months into recovery, significant depression

Write a Simple Reflection:

Closely paraphrase what the client said...

Write a Complex Reflection:

Add the meaning, emotion, or implication beneath the words...

Write a Double-Sided Reflection:

Acknowledge both sides of the ambivalence you hear...

Write a Metaphorical Reflection:

Capture the emotional texture with an image...

Which reflection do you think would land best with this client and why?

Explain your clinical reasoning...

CLIENT SAYS:

"I went to a party last weekend. I didn't drink, but I wanted to. I felt like an alien. Like everyone else knows how to live and I don't anymore."

Context: Client nine months sober, struggling with social isolation

Write a Simple Reflection:

Closely paraphrase what the client said...

Write a Complex Reflection:

Add the meaning, emotion, or implication beneath the words...

Write a Double-Sided Reflection:

Acknowledge both sides of the ambivalence you hear...

Write a Metaphorical Reflection:

Capture the emotional texture with an image...

Which reflection do you think would land best with this client and why?

Explain your clinical reasoning...

CLIENT SAYS:

"I'm not sure AA is for me. I tried it and all people do is talk about how bad things were. I don't want to live in the past."

Context: Client resistant to peer support, ambivalent about recovery support networks

Write a Simple Reflection:

Closely paraphrase what the client said...

Write a Complex Reflection:

Add the meaning, emotion, or implication beneath the words...

Write a Double-Sided Reflection:

Acknowledge both sides of the ambivalence you hear...

Write a Metaphorical Reflection:

Capture the emotional texture with an image...

Which reflection do you think would land best with this client and why?

Explain your clinical reasoning...

Part 17 • Exercise 9: 7-Day MI Spirit Check-In

Exercise 9: 7-Day MI Spirit Check-In

Daily practice for building PACE consistency across a full clinical week

The Practice Week

MI spirit develops through consistent daily attention — not through occasional intensive work. This seven-day check-in creates a framework for bringing deliberate PACE awareness into each clinical day and reflecting on what you are learning in real time.

TODAY'S PRACTICE

At least once today, deliberately ask for the client's perspective before offering your own. Notice what happens — in them and in you.

Morning intention: How will you bring this focus into your day?

Set your intention for the day...

End-of-day reflection: What did you notice? What happened when you practiced this focus?

Reflect on the day's practice...

One thing you will do differently tomorrow based on today:

Name one specific change...

TODAY'S PRACTICE

Identify one client today whose behavior you find most challenging. Practice finding one genuine strength or understandable reason for their current behavior.

Morning intention: How will you bring this focus into your day?

Set your intention for the day...

End-of-day reflection: What did you notice? What happened when you practiced this focus?

Reflect on the day's practice...

One thing you will do differently tomorrow based on today:

Name one specific change...

TODAY'S PRACTICE

Check your compassion reserves at the start, middle, and end of your workday. Notice what depletes them and what restores them.

Morning intention: How will you bring this focus into your day?

Set your intention for the day...

End-of-day reflection: What did you notice? What happened when you practiced this focus?

Reflect on the day's practice...

One thing you will do differently tomorrow based on today:

Name one specific change...

TODAY'S PRACTICE

Count the ratio of evocative questions to directive statements in one session today. What was the ratio? What would a 3:1 ratio sound like?

Morning intention: How will you bring this focus into your day?

Set your intention for the day...

End-of-day reflection: What did you notice? What happened when you practiced this focus?

Reflect on the day's practice...

One thing you will do differently tomorrow based on today:

Name one specific change...

TODAY'S PRACTICE

Catch yourself at least once activating your righting reflex. Pause. Choose an evocative response instead. Note what happens.

Morning intention: How will you bring this focus into your day?

Set your intention for the day...

End-of-day reflection: What did you notice? What happened when you practiced this focus?

Reflect on the day's practice...

One thing you will do differently tomorrow based on today:

Name one specific change...

TODAY'S PRACTICE

When a client expresses ambivalence today, explore both sides equally before moving on. Notice your impulse to resolve the ambivalence — and let it be.

Morning intention: How will you bring this focus into your day?

Set your intention for the day...

End-of-day reflection: What did you notice? What happened when you practiced this focus?

Reflect on the day's practice...

One thing you will do differently tomorrow based on today:

Name one specific change...

TODAY'S PRACTICE

Review your week. Where was your MI spirit most present? Where did it most fully absent itself? What do you most want to carry forward?

Morning intention: How will you bring this focus into your day?

Set your intention for the day...

End-of-day reflection: What did you notice? What happened when you practiced this focus?

Reflect on the day's practice...

One thing you will do differently tomorrow based on today:

Name one specific change...

1. Across the full week, which PACE component showed the most development? Which was most consistently difficult?

Synthesize your week...

2. What did you discover about your clinical style that you had not consciously recognized before this week?

Synthesize your week...

3. What is the most significant shift in your internal attitude that occurred during this practice week?

Synthesize your week...

4. What one practice from this week will you commit to sustaining as a permanent feature of your clinical presence?

Synthesize your week...

Part 18 • Exercise 10: Personal MI Development Plan

Exercise 10: Personal MI Development Plan

A structured roadmap for sustained MI spirit growth

From Intensive to Ongoing Practice

The work of developing MI spirit does not end with the completion of this intensive — it begins here. This development plan translates the insights, self-assessments, and exercises of this intensive into a structured, sustainable ongoing practice.

1. Based on everything in this intensive, summarize your current MI spirit profile: your genuine strengths, your development edges, and the clinical patterns that most need attention.

Write with the specificity that will make this plan actionable...

2. Identify your single highest-priority MI spirit development goal — the one internal shift that would most significantly improve your clinical effectiveness and client outcomes.

Write with the specificity that will make this plan actionable...

3. What specific evidence from your clinical practice tells you this is the right priority? What do your clients experience when this aspect of your MI spirit is underdeveloped?

Write with the specificity that will make this plan actionable...

1. Goal 1 — PACE Component Focus: Which specific PACE component are you committing to developing first? What will "development" look like — what will be measurably different in your practice?

Write with the specificity that will make this plan actionable...

2. Goal 2 — Clinical Behavior Change: Name one specific directive clinical behavior you are committing to reducing, and the evocative behavior you will practice in its place.

Write with the specificity that will make this plan actionable...

3. Goal 3 — Internal Attitude Development: Identify the internal attitude shift — the belief change, the assumption revision, the value alignment — that will most develop your MI spirit.

Write with the specificity that will make this plan actionable...

1. Daily practice (5–10 minutes): What will you do each workday to maintain awareness of and commitment to MI spirit? Be specific about the practice, timing, and how you will remember to do it.

Write with the specificity that will make this plan actionable...

2. Weekly reflection (15–30 minutes): What structured review will you conduct each week to assess your MI spirit development progress? Who will you share it with?

Write with the specificity that will make this plan actionable...

3. Supervision/consultation focus: What specific MI spirit questions will you bring to your next supervision or peer consultation? How will you use those relationships to support ongoing development?

Write with the specificity that will make this plan actionable...

1. Who in your professional life will you ask to support your MI spirit development — to give you honest feedback about their observations of your PACE in clinical interactions?

Write with the specificity that will make this plan actionable...

2. What organizational structures, clinical culture elements, or team dynamics currently support genuine MI practice in your workplace? What works against it?

Write with the specificity that will make this plan actionable...

3. What additional training, supervision, or resources would most accelerate your MI spirit development? What is your commitment to pursuing these?

Write with the specificity that will make this plan actionable...

4. How will you know, in 90 days, that your MI spirit has developed in the way you have committed to? What will you see, hear, feel, or know that will tell you the development is real?

Write with the specificity that will make this plan actionable...

1. Write a comprehensive MI spirit commitment statement — addressing all four PACE components, your specific development priorities, and the clinician you are committed to becoming. This is for you, written in your own voice, as specific and honest as you can make it.

Write with the specificity that will make this plan actionable...

2. Identify the single most important reason — for your clients, for your professional integrity, for your own growth — that this development matters enough to sustain.

Write with the specificity that will make this plan actionable...

3. What is one thing you will do in the next 24 hours to begin acting on this commitment?

Write with the specificity that will make this plan actionable...

Intensive Complete

You have completed a comprehensive exploration of MI spirit across five reading modules, a 48-item self-assessment, and ten guided exercises. The insights you have developed here are the beginning of a practice that will deepen throughout your career. MI spirit is not a destination — it is a daily orientation, a professional discipline, and ultimately a profound expression of genuine respect for the people we are privileged to serve.