

Clinical Step Working Guide

Steps 4-5: Inventory

For SUD and mental health counselors

Step Four

"Made a searching and fearless moral inventory of ourselves."

The step of honest self-examination—identifying patterns, wrongs, fears, and harms.

Step Five

"Admitted to God, to ourselves, and to another human being the exact nature of our wrongs."

The step of confession—breaking isolation through vulnerable disclosure.

Clinician Resources

Understanding Steps Four and Five deeply allows you to support patients through the difficult work of honest self-examination and vulnerable disclosure—the foundation for all the character change that follows.

Recommended Reading

Alcoholics Anonymous "Big Book" - Chapter 5: "How It Works" (pp. 64-75)

Clinical Training

12-Step Facilitation Therapy (TSF) - NIAAA/NIDA Evidence-Based Treatment

Step Four: Foundation

Understanding the "searching and fearless moral inventory"

The Meaning of "Searching and Fearless"

OVERVIEW

Step Four states: "Made a searching and fearless moral inventory of ourselves." The adjectives matter. "Searching" means thorough, comprehensive, leaving no stone unturned. "Fearless" doesn't mean without fear—it means proceeding despite fear. This inventory requires courage because it will uncover what patients have spent years hiding, even from themselves.

KEY POINTS FOR CLINICIANS

- "Searching" means comprehensive, thorough, not superficial
- "Fearless" means courageous despite fear, not absence of fear
- This is self-examination, not self-flagellation
- The inventory is about patterns, not just events
- Both assets and liabilities are part of a complete inventory
- The goal is accurate self-knowledge, not self-punishment

CLINICAL INSIGHT

Many patients approach Step Four with dread, expecting it to be a brutal experience of self-condemnation. Reframe the purpose: this is a fact-finding mission, not a fault-finding mission. A good inventory is honest, not harsh. It seeks to understand, not to punish.

THE PATIENT EXPERIENCE

Patients often say: "I know everything that's wrong with me already—I think about it constantly." But ruminating about failures is different from systematic inventory. The self-criticism they engage in is usually selective, repetitive, and shame-based—not the thorough, balanced examination Step Four requires.

CLINICAL REFLECTION

How do you help patients approach inventory with curiosity rather than dread? How do you distinguish between healthy self-examination and destructive self-criticism?

CLINICAL EXERCISE / ASSESSMENT TOOL

Reframing Step Four:

- "An inventory in business isn't about judging the merchandise—it's about knowing what you have"
- "What if this were about understanding yourself rather than condemning yourself?"
- "What would a kind but honest friend say about your patterns?"
- "Can you be thorough without being brutal?"
- "What strengths might you discover alongside the struggles?"

ACTION STEP FOR YOUR PRACTICE

Help a patient approaching Step Four understand the difference between honest self-examination and shame-based self-attack. Create a frame of curiosity rather than condemnation.

Why a "Moral" Inventory?

OVERVIEW

The word "moral" can trigger resistance—it sounds religious or judgmental. But in this context, "moral" simply means examining how we've lived in relation to our values and in relation to others. It's about right and wrong as the patient understands it, not as imposed by external authorities. Every person has a sense of how they want to live; the inventory examines gaps between ideal and actual.

KEY POINTS FOR CLINICIANS

- "Moral" means examining behavior against values, not religious judgment
- Every person has internal standards they've violated
- The inventory examines gaps between who we want to be and how we've acted
- Right and wrong are defined by the patient's own conscience
- This isn't about external judgment but internal honesty
- The inventory reveals where addiction forced compromise of values

CLINICAL INSIGHT

For patients resistant to "moral" language, explore their own values: "What kind of person do you want to be? How did your behavior during addiction align with that?" This personalizes the inventory without imposing external moral frameworks.

THE PATIENT EXPERIENCE

Patients may say: "I don't want to be judged by some religious standard." Validate this: "This isn't about anyone else's standards. This is about your own sense of right and wrong. Where did addiction make you act against your own values?"

CLINICAL REFLECTION

How do you work with patients who resist "moral" language? How do you help them connect to their own internal values system?

CLINICAL EXERCISE / ASSESSMENT TOOL

Values-based inventory framing:

- "What kind of person do you want to be?"

- "What values matter most to you?"
 - "Where has your behavior conflicted with those values?"
 - "When you imagine your best self, what does that person look like?"
 - "What does your own conscience tell you about how you've lived?"
-
-
-

ACTION STEP FOR YOUR PRACTICE

With a patient resistant to "moral" language, explore their personal values first. Then frame the inventory as examining gaps between values and behavior.

The Purpose of Written Inventory

OVERVIEW

Step Four specifies that we "made" an inventory—implying a tangible product, not just thinking about things. Writing serves several crucial functions: it forces specificity, prevents avoidance, creates a document that can be shared (Step Five), and makes abstract patterns concrete. Thinking about problems is not the same as inventorying them.

KEY POINTS FOR CLINICIANS

- Writing forces specificity and prevents vague generalization
- A written inventory can't be unconsciously revised or avoided
- Writing makes the abstract concrete and tangible
- The document becomes the basis for Step Five sharing
- Writing slows the mind and deepens reflection
- A written record allows pattern recognition across entries

CLINICAL INSIGHT

Some patients want to "just talk through" their inventory rather than write it. While clinical flexibility is appropriate, help them understand what's lost without writing: the discipline of specificity, the inability to unconsciously edit, and the concrete document that makes Step Five possible.

THE PATIENT EXPERIENCE

Patients may resist writing: "I'm not a writer," "I process better verbally," "Writing it down makes it too real." These resistances are often avoidance. The "too real" objection reveals exactly why writing matters—it makes things undeniable.

CLINICAL REFLECTION

How do you encourage written inventory when patients resist? What adaptations might be appropriate for patients with literacy challenges or learning differences?

CLINICAL EXERCISE / ASSESSMENT TOOL

Encouraging written inventory:

- "What changes when you write something versus just thinking it?"
 - "If it feels too real written down, what does that tell us?"
 - "Writing prevents the mind from sliding away from hard truths"
 - "Your Step Five listener will need something concrete to respond to"
 - For literacy challenges: voice recording, dictation, or structured templates
-
-
-

ACTION STEP FOR YOUR PRACTICE

If a patient is resisting written inventory, explore the resistance. Is it practical (literacy) or avoidance? Address accordingly.

Step Four Builds on Steps One Through Three

OVERVIEW

Step Four doesn't stand alone—it requires the foundation of Steps One through Three. Without admitting powerlessness (Step 1), patients lack motivation for honest self-examination. Without hope in a Higher Power (Step 2), the inventory feels hopeless. Without decision to turn will over (Step 3), patients lack the spiritual support to face difficult truths.

KEY POINTS FOR CLINICIANS

- Step One provides motivation: "My way isn't working"
- Step Two provides hope: "Change is possible"
- Step Three provides support: "I don't face this alone"
- Without this foundation, inventory becomes self-punishment
- Premature inventory often lacks depth or leads to despair
- Return to earlier steps if Four seems impossible

CLINICAL INSIGHT

If a patient is stuck at Step Four, examine whether earlier steps were thoroughly worked. Incomplete Step One (still believing they can control use) makes honest inventory feel unnecessary. Incomplete Step Two (no hope) makes inventory feel pointless. Incomplete Step Three (going it alone) makes inventory overwhelming.

THE PATIENT EXPERIENCE

Patients who rush to Step Four without adequate foundation often experience it as crushing rather than clarifying. They may say: "I see all my faults but nothing changes." This suggests Step Two hope or Step Three support is missing.

CLINICAL REFLECTION

How do you assess whether a patient has adequate Step One through Three foundation before beginning Step Four? What signs indicate incomplete earlier work?

CLINICAL EXERCISE / ASSESSMENT TOOL

Foundation assessment:

- "Why do you believe this inventory is necessary?" (Step 1 motivation)
 - "Do you have hope that things can be different?" (Step 2 hope)
 - "What support do you have for facing difficult truths?" (Step 3 support)
 - "Are you doing this to understand yourself or to punish yourself?"
 - If answers reveal weak foundation, return to earlier steps
-
-
-

ACTION STEP FOR YOUR PRACTICE

Before a patient begins Step Four, assess their Step One through Three foundation. Shore up any weak areas before proceeding.

The Inventory is About the Self, Not Others

OVERVIEW

A common pitfall in Step Four is focusing on what others did wrong. While the inventory includes resentments toward others, the purpose is to examine the patient's response, not to catalog others' offenses. The question isn't "What did they do to me?" but "How did I respond, and what does that reveal about my patterns?"

KEY POINTS FOR CLINICIANS

- The inventory examines self, not others
- Others' wrongs are noted but not the focus
- The key question: "What was my part?"
- Even when wronged, we examine our response patterns
- This isn't about blame but about self-knowledge
- We can only change ourselves, not others

CLINICAL INSIGHT

Patients often want to use inventory to prove how badly they've been treated. While validating genuine harm is important, gently redirect: "Yes, that was wrong. And what we're examining here is how you responded, what patterns you see in yourself, what you can learn about you—because that's what you can change."

THE PATIENT EXPERIENCE

Patients may protest: "But they were wrong! Why am I examining myself when they're the problem?" The answer: "Because you're the one doing the inventory. You can't inventory someone else. You can only examine your own patterns, responses, and choices."

CLINICAL REFLECTION

How do you redirect patients from cataloging others' wrongs to examining their own patterns?
How do you validate real harm while maintaining self-examination focus?

CLINICAL EXERCISE / ASSESSMENT TOOL

Redirecting to self:

- "What they did was wrong. Now, what was your part in the situation?"
 - "How did you respond? What pattern does that fit?"
 - "If you could change only one person in this story, it would have to be you"
 - "What does your reaction tell you about yourself?"
 - "Even when we're wronged, we choose how to respond"
-
-
-

ACTION STEP FOR YOUR PRACTICE

When reviewing a patient's inventory, notice where focus drifts to others' wrongs. Gently redirect to self-examination without invalidating their experience.

The Inventory Process

The mechanics and methodology of taking inventory

The Four-Column Resentment Inventory

OVERVIEW

The Big Book outlines a specific format for inventorying resentments using columns: (1) I'm resentful at, (2) The cause, (3) Affects my (self-esteem, security, ambitions, personal/sex relations), (4) What was my part? This structure prevents rambling, ensures comprehensive examination, and reveals patterns patients might otherwise miss.

KEY POINTS FOR CLINICIANS

- Column 1: Who or what am I resentful toward?
- Column 2: What specifically happened?
- Column 3: What part of me was affected?
- Column 4: What was my role or part in this?
- The structure prevents victim narratives
- Patterns emerge across multiple entries

CLINICAL INSIGHT

The four-column format is clinically elegant. Column 3 (what was affected) reveals core vulnerabilities—where self-esteem is fragile, what securities feel threatened, which ambitions are frustrated. Column 4 (my part) may be the hardest but most transformative—it shifts from victim to agent.

THE PATIENT EXPERIENCE

Patients often struggle with Column 4: "I didn't have a part—they just did this to me." For genuine victimization, the part might be: "I stayed in the situation," "I didn't set boundaries," "I put myself at risk," or simply "I hold onto this resentment." There's always something to examine.

CLINICAL REFLECTION

How do you guide patients through the four-column process? How do you help with Column 4 when patients genuinely were victimized?

CLINICAL EXERCISE / ASSESSMENT TOOL

Four-column guidance:

- Start with the most pressing resentment as a teaching example
- Column 1: Be specific—names, institutions, principles
- Column 2: What exactly happened? When? How often?
- Column 3: Did it affect your pride? Security? Relationships?
- Column 4: "What did you do before, during, or after? What's your ongoing role?"

ACTION STEP FOR YOUR PRACTICE

Walk through one complete four-column resentment inventory with a patient, modeling the process and explaining the purpose of each column.

The Fear Inventory

OVERVIEW

After resentments, the Big Book directs attention to fears: "We reviewed our fears thoroughly. We put them on paper." Fear is identified as the root of most troubles. The fear inventory asks: What am I afraid of? Why do I have this fear? How has fear affected my life? This reveals the anxieties driving much of patients' dysfunctional behavior.

KEY POINTS FOR CLINICIANS

- Fear inventory follows resentment inventory
- List all fears—rational and irrational
- Examine the origin of each fear
- Identify how fear has affected behavior
- Many resentments are actually fear-based
- Fear often drives the defects identified later

CLINICAL INSIGHT

The fear inventory often reveals that many resentments are actually fears in disguise. The patient resentful of a boss may actually fear job loss. The patient resentful of a spouse may fear abandonment. Connecting resentments to underlying fears provides deeper insight.

THE PATIENT EXPERIENCE

Some patients, especially men or those with bravado defenses, resist acknowledging fear: "I'm not afraid of anything." Explore gently: fears of rejection, abandonment, failure, exposure, vulnerability, death, meaninglessness—these are universal, even if defended against.

CLINICAL REFLECTION

How do you help patients who resist acknowledging fear? How do you help them connect surface resentments to underlying fears?

CLINICAL EXERCISE / ASSESSMENT TOOL

Fear inventory process:

- "What worries keep you up at night?"
- "What would be the worst thing that could happen?"

- "What are you protecting yourself from?"
 - "If you weren't afraid of anything, how would you live differently?"
 - "What fears have controlled your decisions?"
-
-
-

ACTION STEP FOR YOUR PRACTICE

Guide a patient through fear inventory, helping them acknowledge fears they may have defended against and connecting them to behavioral patterns.

The Sex Inventory

OVERVIEW

The Big Book includes specific inventory of sexual conduct: "We reviewed our own conduct over the years past. Where had we been selfish, dishonest, or inconsiderate? Whom had we hurt? Did we arouse jealousy, suspicion or bitterness? Where were we at fault?" This often-avoided area requires careful, shame-sensitive clinical support.

KEY POINTS FOR CLINICIANS

- Sex inventory examines patterns, not just events
- Focus on harm caused, not moralistic judgment
- Includes dishonesty, manipulation, exploitation
- Considers how substances affected sexual behavior
- May surface trauma history requiring clinical attention
- Requires particular sensitivity and safety

CLINICAL INSIGHT

Sex inventory can surface trauma—both perpetration and victimization. Be prepared for disclosures. Create clear safety: this inventory examines the patient's choices and behaviors, not to judge sexuality but to identify patterns of harm. Distinguish between sexual shame (often toxic) and genuine accountability for harm caused.

THE PATIENT EXPERIENCE

Patients may avoid this section entirely or treat it superficially due to shame. Others may over-confess, using it for self-punishment. The goal is honest examination of patterns: Where was there manipulation? Exploitation? Dishonesty? Who was hurt? How did addiction affect sexual choices?

CLINICAL REFLECTION

How do you create safety for sex inventory while ensuring thoroughness? How do you distinguish healthy sexuality from problematic patterns?

CLINICAL EXERCISE / ASSESSMENT TOOL

Sex inventory guidance:

- Create explicit safety: "This is about understanding patterns, not judgment"
 - "Where have your sexual choices hurt others?"
 - "How did substances affect your sexual decisions?"
 - "What dishonesty has been involved in your sexual relationships?"
 - Be prepared to refer if trauma surfaces beyond your scope
-
-
-

ACTION STEP FOR YOUR PRACTICE

Before a patient approaches sex inventory, assess their readiness and ensure adequate safety. Be prepared to slow down or refer if trauma surfaces.

The Harms Inventory

OVERVIEW

Beyond resentments, fears, and sex conduct, the inventory examines harms done to others. This is the material that will eventually become the Step Eight list. The question is: Whom have I hurt, and how? This includes lies told, promises broken, responsibilities abandoned, manipulation, theft, emotional damage, and all the wreckage of addiction.

KEY POINTS FOR CLINICIANS

- Comprehensive list of people harmed
- Includes all types of harm: emotional, financial, physical, relational
- Notes the nature of the harm, not just the person
- Includes harms from before addiction, not just during
- This becomes the foundation for Step Eight amends list
- Requires honesty about impact, not just intention

CLINICAL INSIGHT

Patients often minimize harm: "They got over it," "It wasn't that bad," "They did worse to me." Help them examine impact from others' perspective, not just their own assessment. The question isn't "Did they forgive me?" but "What was the actual impact of my behavior?"

THE PATIENT EXPERIENCE

This section often triggers shame spirals. Patients may become overwhelmed by the accumulation of harm. Pace accordingly. Remind them: the purpose isn't to crush them but to create a complete picture that can eventually be addressed through amends.

CLINICAL REFLECTION

How do you help patients be thorough without becoming overwhelmed? How do you balance honest accounting with preventing shame spirals?

CLINICAL EXERCISE / ASSESSMENT TOOL

Harms inventory process:

- Go through life domains: family, friends, work, community, self
 - "Who have you lied to? What promises have you broken?"
 - "Who counted on you when you weren't reliable?"
 - "What financial harm have you caused?"
 - "Whose trust have you violated?"
-
-

ACTION STEP FOR YOUR PRACTICE

Help a patient create a structured harms inventory by life domain, pacing to prevent overwhelm while ensuring thoroughness.

Including Assets, Not Just Liabilities

OVERVIEW

A complete inventory includes assets—strengths, positive qualities, things done well—not just defects and harms. Many patients and sponsors overlook this, creating a distorted picture. True inventory is a complete stock-taking: what's in the warehouse, both valuable and damaged. Recovery builds on strengths as well as addressing weaknesses.

KEY POINTS FOR CLINICIANS

- True inventory includes both assets and liabilities
- Many patients skip the assets due to shame or false humility
- Strengths are resources for recovery
- Balanced self-knowledge is healthier than pure deficit focus
- Assets can become excesses (strength become defects)
- This isn't self-congratulation but accurate stock-taking

CLINICAL INSIGHT

Patients steeped in shame may resist identifying assets: "That feels like bragging," "I don't deserve to feel good about anything." Challenge this: "An inventory that only counts damaged goods isn't accurate. What are your genuine strengths?" This isn't about ego inflation but accurate self-knowledge.

THE PATIENT EXPERIENCE

Some patients find listing strengths harder than listing faults. They're practiced at self-criticism but not self-recognition. Others may use assets defensively to avoid examining liabilities. Balance is key: both accurate acknowledgment of strengths and honest examination of problems.

CLINICAL REFLECTION

Do you ensure patients include assets in their inventory? How do you balance strength-building with honest examination of problems?

CLINICAL EXERCISE / ASSESSMENT TOOL

Asset inventory:

- "What are you genuinely good at?"
 - "What positive qualities do others see in you?"
 - "What strengths helped you survive?"
 - "When were you at your best? What qualities showed up?"
 - "What would you want to build on in recovery?"
-
-
-

ACTION STEP FOR YOUR PRACTICE

Ensure patients include an assets inventory alongside liabilities. Help those who struggle with this section identify genuine strengths.

Pattern Recognition Across the Inventory

OVERVIEW

The real power of Step Four emerges when patterns become visible across individual entries. Multiple resentments may share the same Column 3 vulnerability (e.g., self-esteem). Multiple fears may point to the same core terror. The inventory isn't just a list—it's a map of the patient's psychological landscape.

KEY POINTS FOR CLINICIANS

- Individual entries reveal patterns when viewed together
- Same vulnerabilities appear across different resentments
- Core fears underlie multiple surface fears
- Recurring themes in harms show character defects
- Pattern recognition provides deeper self-understanding
- Patterns identified here become Step Six focus

CLINICAL INSIGHT

Help patients step back and see themes: "What shows up again and again?" "What vulnerability keeps getting triggered?" "What fears drive multiple behaviors?" This meta-level insight is often more transformative than any individual inventory item.

THE PATIENT EXPERIENCE

Patients often need help seeing patterns they're too close to recognize: "I never noticed that self-esteem shows up in almost every resentment." "All my fears seem to come back to abandonment." These realizations create profound self-understanding.

CLINICAL REFLECTION

How do you help patients identify patterns across their inventory? What common patterns do you see in SUD populations?

CLINICAL EXERCISE / ASSESSMENT TOOL

Pattern analysis:

- Review completed inventory sections together
- "What themes keep appearing?"
- "Which Column 3 areas show up most frequently?"
- "What core fears underlie multiple entries?"
- "What does this pattern tell you about yourself?"

ACTION STEP FOR YOUR PRACTICE

After a patient completes significant inventory work, schedule a pattern-recognition session to identify themes and core issues.

Inventory Content Areas

Resentments, fears, sex conduct, and harms

Understanding Resentment in Depth

OVERVIEW

The Big Book calls resentment "the number one offender" that "destroys more alcoholics than anything else." Understanding why resentment is so central to addiction—and to inventory—helps clinicians support this work. Resentment is re-feeling old hurts, keeping wounds fresh, maintaining victim identity, and poisoning the present with the past.

KEY POINTS FOR CLINICIANS

- Resentment = re + sentire (to feel again)
- It's drinking poison expecting others to die
- Resentment maintains victim identity and moral superiority
- It provides excuse for continued use
- Resentment blocks spiritual and emotional growth
- Releasing resentment is essential for recovery

CLINICAL INSIGHT

Resentment serves functions: it provides identity (the wronged party), maintains distance (from intimacy and vulnerability), offers excuse (for continued dysfunction), and creates moral high ground. Patients won't release resentments until they understand what they're getting from them.

THE PATIENT EXPERIENCE

Patients often cling to resentments: "But I'm right! They really did wrong me!" Validate the wrong while exploring the cost: "Yes, that was wrong. And carrying this resentment—who is it hurting now? Is it changing them or poisoning you?"

CLINICAL REFLECTION

How do you help patients see the function of their resentments? How do you validate harm while encouraging release?

CLINICAL EXERCISE / ASSESSMENT TOOL

Resentment exploration:

- "What do you gain from holding this resentment?"
- "How does the person you resent feel about you carrying this?"
- "What would you lose if you let this go?"
- "How is this resentment affecting your recovery?"
- "What emotion is underneath the resentment?"

ACTION STEP FOR YOUR PRACTICE

Help a patient examine one major resentment for its function: what does holding it provide? What does it cost?

Understanding Fear in Depth

OVERVIEW

The Big Book describes fear as an evil and corroding thread running through the fabric of our lives. Fear sits underneath much of what shows up elsewhere in the inventory: resentment, dishonesty, control, and isolation. The Big Book connects fear to self-reliance: when people depend entirely on themselves, they have reason to be afraid, because self-reliance keeps failing them. Understanding fear in depth helps patients see what has been driving their behavior all along.

KEY POINTS FOR CLINICIANS

- Fear runs through and underneath the whole inventory
- Many resentments, lies, and controlling behaviors are fear-driven
- Fear is linked to self-reliance that keeps failing
- Substances often served to quiet fear
- Naming fear reduces its hidden power
- The answer the Big Book offers is trust, not more self-reliance

CLINICAL INSIGHT

Help patients trace behaviors back to the fear beneath them. The patient who controls everyone around them may fear chaos or abandonment. The patient who lies constantly may fear being seen as inadequate. When fear is named, the behavior starts to make sense, and patients can begin addressing the fear directly instead of acting it out.

THE PATIENT EXPERIENCE

Patients often do not experience themselves as fearful. They experience themselves as angry, busy, in charge, or numb. It can be a surprise to discover how much of life has been organized around fear. Some patients feel relief: "So that's why I couldn't stop." Others feel exposed, especially those whose identity is built on toughness.

CLINICAL REFLECTION

How do you help patients see fear underneath behaviors that look like anger or control? How do you work with patients whose identity depends on appearing fearless?

CLINICAL EXERCISE / ASSESSMENT TOOL

Tracing fear:

- "When you were most controlling, what were you afraid would happen?"
 - "What did using do for your fear?"
 - "What fear sits under your biggest resentment?"
 - "Where have you relied on yourself alone, and how has that worked?"
 - "What would it look like to face this fear with support instead of alone?"
-
-
-

ACTION STEP FOR YOUR PRACTICE

Choose one of a patient's recurring behaviors and trace it back to the fear underneath it. Help them name the fear in their own words.

Sexual Conduct: Ideals, Not Moral Judgment**OVERVIEW**

The Big Book takes care not to make itself the judge of anyone's sexual conduct. Instead, it asks people to examine where they were selfish, dishonest, or inconsiderate, and to shape a sane and sound ideal for their future sex life, one they arrive at themselves. This is a content area about harm and honesty in relationships, not about sexual morality imposed from outside.

KEY POINTS FOR CLINICIANS

- The focus is selfishness, dishonesty, and inconsideration, not sexuality itself
- No one else's moral code is imposed
- Patients shape their own ideal for future conduct
- Harm to others is the central question
- Shame about sexuality is different from accountability for harm
- Substance use often shaped sexual choices in ways patients regret

CLINICAL INSIGHT

Be explicit that this area is not a judgment on sexual orientation, identity, or consensual choices. Patients from shame-heavy backgrounds may need to hear this more than once. Help them separate harm they caused, which belongs in the inventory, from sexuality they were taught to be ashamed of, which does not. The ideal they shape should be theirs.

THE PATIENT EXPERIENCE

Patients may expect this area to condemn who they are. When they learn the focus is on how they treated people, many can engage honestly for the first time. Others may realize that their shame was never about harm at all, and that letting go of it is part of recovery too.

CLINICAL REFLECTION

How do you help patients separate accountability for harm from shame about sexuality? How do you support patients in shaping their own ideal rather than adopting someone else's?

CLINICAL EXERCISE / ASSESSMENT TOOL

Shaping an ideal:

- "Where were you selfish, dishonest, or inconsiderate in relationships?"
 - "Who was hurt, and how?"
 - "What part of your shame is about harm, and what part was taught to you?"
 - "How did using affect your choices?"
 - "What kind of partner do you want to be going forward?"
-
-

ACTION STEP FOR YOUR PRACTICE

With a patient working this area, help them write a short description of the ideal they want for future relationships, in their own words.

Understanding Harm in Depth

OVERVIEW

Harm is broader than the obvious damage. Beyond lies, theft, and broken promises, addiction causes harm through absence, unpredictability, fear, and the slow erosion of trust. Family members may have been harmed most by what did not happen: the missed events, the conversations that never took place, the worry. Understanding harm in depth prepares patients for an honest Step Eight list and helps them see the full impact of their disease on others.

KEY POINTS FOR CLINICIANS

- Harm includes what was done and what was not done
- Absence and neglect are real harms
- Living with someone's unpredictability causes harm
- Harm to oneself is part of the picture too
- Impact matters more than intention
- This understanding prepares the ground for Steps Eight and Nine

CLINICAL INSIGHT

Patients tend to list harms they actively caused and overlook harms of omission. Ask about the people who waited, worried, or covered for them. Ask about the children who learned to walk on eggshells. Harm of omission is often the hardest to see and the most important to acknowledge, especially in families.

THE PATIENT EXPERIENCE

Patients may say: "I never hit anyone. I paid the bills. I wasn't that bad." They measure harm by the worst things they did not do. When they begin to see the harm of absence and fear, it can be

painful. It can also open the door to the kind of amends that rebuild relationships.

CLINICAL REFLECTION

How do you help patients see harms of omission? How do you support them when the full picture of harm becomes painful?

CLINICAL EXERCISE / ASSESSMENT TOOL

Seeing the full impact:

- "Who waited for you or worried about you?"
- "What events or moments did you miss?"
- "What was it like for your family not to know what state you'd be in?"
- "Who covered for you, and what did that cost them?"
- "How have you harmed yourself along the way?"

ACTION STEP FOR YOUR PRACTICE

Help a patient expand their harms inventory to include harms of omission, especially toward family members.

The Patterns Underneath: Selfishness, Dishonesty, Self-Seeking, and Fear

OVERVIEW

As the Big Book reviews resentments, fears, and sex conduct, the same handful of defects keeps appearing: selfishness, dishonesty, self-seeking, and fear. These four run through almost every inventory. Identifying which of them shows up most for a particular patient connects the content of Step Four to the character work of Steps Six and Seven. The inventory shows what happened; these patterns show why.

KEY POINTS FOR CLINICIANS

- Four patterns recur throughout the inventory
- Selfishness: putting one's own wants first at others' expense
- Dishonesty: with others and with oneself
- Self-seeking: acting for image, approval, or advantage
- Fear: underlying and often driving the other three
- These patterns become the focus of Steps Six and Seven

CLINICAL INSIGHT

These four words can sound harsh. Frame them as patterns, not verdicts on the person's worth. Help the patient find which pattern appears most often across their entries. Most find that one or

two dominate. Naming the main patterns gives Steps Six and Seven a clear, personal focus.

THE PATIENT EXPERIENCE

Patients may resist: "I'm not selfish; I gave everything to everyone." Sometimes that's true, and sometimes the giving was itself self-seeking, a way to be needed or approved of. Gentle exploration helps patients see the pattern without feeling condemned.

CLINICAL REFLECTION

How do you help patients identify their main patterns without the words feeling like labels? How do you link this work to Steps Six and Seven?

CLINICAL EXERCISE / ASSESSMENT TOOL

Finding the patterns:

- "Looking across your inventory, where does selfishness show up?"
- "Where were you dishonest, including with yourself?"
- "Where were you acting for image or approval?"
- "Where was fear driving things?"
- "Which one or two patterns show up most?"

ACTION STEP FOR YOUR PRACTICE

After a patient completes their inventory, help them identify their one or two dominant patterns and write them down as a bridge to Steps Six and Seven.

Step Five: Foundation

Understanding the three-part admission process

The Three-Part Admission

OVERVIEW

Step Five states: "Admitted to God, to ourselves, and to another human being the exact nature of our wrongs." Note the three recipients: God (or Higher Power), self, and another person. Each serves a different function. Admission to self overcomes denial. Admission to Higher Power creates accountability beyond self. Admission to another person breaks isolation.

KEY POINTS FOR CLINICIANS

- Three recipients: Higher Power, self, and another human
- Admission to self overcomes denial and self-deception
- Admission to Higher Power creates spiritual accountability
- Admission to another person breaks isolation and shame
- All three are necessary for complete effect
- The order suggests a progression of vulnerability

CLINICAL INSIGHT

Patients sometimes want to skip parts: "I'll just tell God," or "I admitted it to myself—isn't that enough?" Help them understand each element's unique function. The human witness is often the most difficult and most transformative.

THE PATIENT EXPERIENCE

Patients may resist the human element: "Why do I have to tell someone else? This is between me and God." The answer: isolation is where addiction thrives. Being known by another human—and accepted—breaks shame's power in ways private confession cannot.

CLINICAL REFLECTION

How do you explain the necessity of all three elements of Step Five? Which element do your patients most often try to skip?

CLINICAL EXERCISE / ASSESSMENT TOOL

Three-part exploration:

- "What changes when you admit something to yourself versus just knowing it vaguely?"
- "What does it mean to admit something to your Higher Power?"
- "What happens in you when another person truly knows you?"
- "Which of these three feels scariest? Why?"
- "What would it be like to be fully known and still accepted?"

ACTION STEP FOR YOUR PRACTICE

Help a patient understand why all three elements of Step Five are necessary, exploring their resistance to any element they want to skip.

The "Exact Nature" of Our Wrongs

OVERVIEW

Step Five specifies admitting the "exact nature" of wrongs—not just what we did but why, what it reveals about us, what patterns it represents. Surface confession ("I lied") differs from admitting exact nature ("I lie to protect my image because I'm terrified of being seen as flawed, and I'll sacrifice relationships to maintain the facade").

KEY POINTS FOR CLINICIANS

- "Exact nature" means getting to the why, not just what
- Surface behavior vs. underlying pattern
- What does this behavior reveal about me?
- Connecting specific wrongs to character defects
- Moving from event description to self-understanding
- This depth prepares for Steps Six and Seven character work

CLINICAL INSIGHT

The "exact nature" insight is what Step Four's pattern recognition produces. A patient doesn't just admit to multiple lies—they admit that they're fundamentally dishonest out of fear, that they've built a life on image management, that dishonesty is a character pattern, not just isolated events.

THE PATIENT EXPERIENCE

Patients may want to stay surface-level: listing behaviors without examining meaning. Push gently deeper: "That's what you did. What does it tell you about yourself? What pattern does it fit? What was the exact nature of this wrong?"

CLINICAL REFLECTION

How do you help patients move from surface confession to "exact nature" insight? What questions help them go deeper?

CLINICAL EXERCISE / ASSESSMENT TOOL

Exact nature exploration:

- "That's what happened. What does it reveal about you?"
- "What pattern does this fit with other behaviors?"

- "Why did you do this? What were you protecting or seeking?"
 - "If this were a symptom, what would the underlying condition be?"
 - "What character defect does this point to?"
-
-
-

ACTION STEP FOR YOUR PRACTICE

In reviewing a patient's Step Five preparation, ensure they're addressing exact nature (patterns and character) not just surface behaviors.

Step Five and Humility

OVERVIEW

Step Five is often described as the step where humility begins in earnest. Admitting wrongs to another person requires giving up the image patients have worked hard to protect. Humility here does not mean humiliation or thinking less of oneself. It means seeing oneself accurately, with neither grandiosity nor self-hatred, and being willing to be seen that way by someone else.

KEY POINTS FOR CLINICIANS

- Step Five is a practical exercise in humility
- Humility means accurate self-perception, not humiliation
- It requires letting go of image management
- Both grandiosity and self-hatred are distortions
- Being seen accurately by another builds humility
- Humility prepares patients for Steps Six and Seven

CLINICAL INSIGHT

Many patients confuse humility with humiliation and fear that Step Five will degrade them. Clarify the difference. Humiliation is being diminished; humility is being right-sized. Patients with grandiose defenses and patients with deep shame both need humility, but they need it in opposite directions: one needs to come down to size, the other to come up.

THE PATIENT EXPERIENCE

Patients may say: "I'm afraid I'll be humiliated." Or, more quietly: "I don't think I'm worth this much attention." Both reflect distorted self-perception. Many patients describe Step Five as the first time they felt ordinary, no better and no worse than anyone else, and found that ordinary felt like relief.

CLINICAL REFLECTION

How do you help patients distinguish humility from humiliation? How do you work with patients who need to come down to size versus those who need to come up?

CLINICAL EXERCISE / ASSESSMENT TOOL

Exploring humility:

- "What does humility mean to you?"
 - "What's the difference between being humble and being humiliated?"
 - "What image have you been protecting?"
 - "Do you tend to see yourself as better or worse than others?"
 - "What would it feel like to be just one person among many?"
-
-
-

ACTION STEP FOR YOUR PRACTICE

With a patient preparing for Step Five, explore their understanding of humility and clarify the difference between humility and humiliation.

Admitting to Ourselves: The End of Self-Deception

OVERVIEW

Admitting wrongs to ourselves sounds like the easiest of the three parts, but it is often the deepest. Addiction depends on self-deception: minimizing, rationalizing, and forgetting. Patients may have written an inventory and still not fully admitted its contents to themselves. This part of Step Five means letting the truth land, without the stories that have kept it at a distance.

KEY POINTS FOR CLINICIANS

- Self-deception is central to addiction
- Writing something down is not the same as admitting it
- Minimizing, rationalizing, and forgetting are common defenses
- Admitting to oneself means letting the truth land
- Self-honesty is the foundation for honesty with others
- This part often happens gradually, not all at once

CLINICAL INSIGHT

Listen for the defenses that remain even after inventory: "But I was drunk," "Everyone did it," "It wasn't that bad." These are signs that the admission to self is incomplete. You don't need to argue. Reflect what you hear and ask what it would mean to let that explanation go.

THE PATIENT EXPERIENCE

Patients may say: "I know I did those things, but it doesn't feel real." Or they may find themselves explaining each entry as they read it. Letting the truth land without explanation can bring grief. It can also bring a steadiness that comes from no longer having to manage the story.

CLINICAL REFLECTION

How do you recognize incomplete admission to self? How do you help patients let the truth land without overwhelming them?

CLINICAL EXERCISE / ASSESSMENT TOOL

Admitting to self:

- "As you read this entry, what explanation comes up?"
 - "What would it be like to say it without the explanation?"
 - "What part of this are you still not quite believing?"
 - "What have you told yourself to make this easier to live with?"
 - "What do you feel when you let it be true?"
-
-
-

ACTION STEP FOR YOUR PRACTICE

When a patient reviews their inventory, notice where explanations and minimizing remain. Help them practice stating one entry plainly, without the defense.

Admitting to God as We Understand Him

OVERVIEW

For some patients, admitting wrongs to God is natural. For others, it raises hard questions: about belief, about religious wounds, or about whether anyone is listening. Step Five uses the same "God as we understood Him" language that Step Three does, leaving the understanding to the patient. Admitting to a Higher Power can mean prayer, a spoken admission in a quiet place, or acknowledging one's wrongs to something larger than oneself.

KEY POINTS FOR CLINICIANS

- Admission to a Higher Power is defined by the patient's own understanding
- For some it is prayer; for others it is a more general acknowledgment
- Religious wounds can make this part painful
- Agnostic and atheist patients can still find meaning in this part
- It creates accountability beyond oneself and one listener
- Many patients experience it as a sense of release or forgiveness

CLINICAL INSIGHT

Don't assume what this part means for a patient. Ask. For patients with religious wounds, admission to God may stir fear of punishment. Help them separate the Higher Power they understand now from the one they may have been taught to fear. For patients without belief, explore what "something larger than me" could mean: the group, the principles, the recovery community.

THE PATIENT EXPERIENCE

Patients may say: "I don't believe in God, so I'll skip that part." Or: "God already knows; why would I tell Him?" Exploring these responses often reveals deeper fears of judgment or abandonment. Many patients find that some form of admission beyond themselves and their listener adds something they did not expect.

CLINICAL REFLECTION

How do you support patients with very different beliefs in this part of Step Five? How do you work with religious wounds that surface here?

CLINICAL EXERCISE / ASSESSMENT TOOL

Exploring admission to a Higher Power:

- "What does 'admitting to God' mean to you?"
- "What do you imagine your Higher Power would think of what you've written?"
- "Is that image of God one you chose or one you were given?"
- "If you don't believe in God, what is larger than you that you could be honest with?"
- "What would it mean to feel accepted by something larger than yourself?"

ACTION STEP FOR YOUR PRACTICE

Explore with a patient what admission to a Higher Power means in their own understanding, and help them find a form of it that is honest for them.

The Sharing Process

How to share and with whom

Choosing the Step Five Listener

OVERVIEW

The Big Book is careful about who hears a Fifth Step. The listener should be someone who can keep a confidence, who understands what the patient is doing and why, and who will not be harmed or burdened by what they hear. For most people this is a sponsor. For some it is a member of the clergy, a counselor, or another trusted person in recovery. The choice matters because the experience of being heard well is a large part of what makes Step Five work.

KEY POINTS FOR CLINICIANS

- The listener must be able to keep a confidence
- They should understand the purpose of Step Five
- They should not be someone who will be hurt by what they hear
- A spouse, partner, or family member is usually the wrong choice
- Experience with the steps matters more than credentials
- Patients should feel safe enough to be completely honest

CLINICAL INSIGHT

Patients sometimes choose a listener for the wrong reasons: someone they expect to go easy on them, someone they want to impress, or someone they barely know so that the admission feels less real. Ask what draws them to a particular person. The best listener is often the one the patient feels most exposed in front of, and least judged by.

THE PATIENT EXPERIENCE

Patients may say: "I'll just tell my wife; she knows most of it anyway." Or: "I'd rather tell a stranger I'll never see again." Both are understandable and both usually miss the point. A partner may be wounded by details they don't need, and a stranger can't offer the ongoing relationship in which being known and accepted keeps working.

CLINICAL REFLECTION

How do you help patients think through who should hear their Fifth Step? What do you do when a patient's choice seems driven by avoidance?

CLINICAL EXERCISE / ASSESSMENT TOOL

Choosing a listener:

- "Who do you trust to keep what you say private?"
- "Who understands what this step is for?"
- "Is there anyone who would be hurt by hearing some of this?"
- "Are you choosing this person because they'll be easy on you?"

- "Whose acceptance would mean the most to you?"
-
-
-

ACTION STEP FOR YOUR PRACTICE

With a patient preparing for Step Five, talk through their choice of listener. Help them name what they want from that person and whether their choice can provide it.

Preparing for the Fifth Step Session

OVERVIEW

A Fifth Step is not a conversation squeezed into a coffee break. It usually takes hours, sometimes more than one sitting. Patients do better when the time, place, and expectations are set in advance: a private setting with no interruptions, enough time not to rush, the written inventory in hand, and a shared understanding of how the listener will respond. Preparation reduces the chance that fear will cut the admission short.

KEY POINTS FOR CLINICIANS

- Set aside enough time; a Fifth Step should not be rushed
- Choose a private place free of interruptions
- Bring the written inventory and read from it
- Agree with the listener on how the session will go
- Plan for the hours afterward, not just the session itself
- Preparation lowers the pull to edit or hold back

CLINICAL INSIGHT

Fear often shows up as logistics: the patient can't find a time, the listener is always busy, the inventory "isn't quite finished." Treat repeated scheduling problems as information. Gently name the pattern and help the patient commit to a specific date.

THE PATIENT EXPERIENCE

Patients often say they want to "get it over with." That urgency can lead to rushing through the inventory and skipping the hardest parts. Others put off scheduling indefinitely. Both responses come from the same fear. A planned session gives them a container that is neither rushed nor endlessly delayed.

CLINICAL REFLECTION

How do you help patients prepare practically for Step Five? What signs tell you a patient is avoiding the step through logistics?

CLINICAL EXERCISE / ASSESSMENT TOOL

Fifth Step preparation:

- "When and where will you meet? How long have you set aside?"
 - "Will anyone interrupt you there?"
 - "Do you have your written inventory ready to read from?"
 - "What have you and your listener agreed about how this will go?"
 - "What will you do in the hours after you finish?"
-
-
-

ACTION STEP FOR YOUR PRACTICE

Help a patient who has finished Step Four set a specific date, place, and time for Step Five, and make a plan for the rest of that day.

Holding Nothing Back

OVERVIEW

The Big Book warns that people who keep certain facts to themselves in the Fifth Step often do not find the relief the step offers, and many return to drinking. Almost every patient has one item they plan to leave out: the thing they have never told anyone. That item is usually the one that most needs saying. Withholding it keeps the secret alive and keeps the shame in charge.

KEY POINTS FOR CLINICIANS

- Partial admission tends to bring partial relief
- The withheld item is usually the most important one
- Secrets keep shame active and isolation intact
- Patients often plan in advance what they will leave out
- Telling the one thing is often the turning point of the step
- Holding back can set up later relapse

CLINICAL INSIGHT

Ask directly and kindly: "Is there anything on your list you are planning not to say?" Many patients will admit there is. You don't need the content. Explore what they fear will happen if they say it, and what keeping it has cost them. Saying it to the listener, not to you, is the goal.

THE PATIENT EXPERIENCE

Patients may say: "I'll tell everything except that. That one goes to the grave with me." Behind this is usually a belief that this one thing makes them uniquely unacceptable. Being heard and accepted with that item in the open is often what finally breaks the belief.

CLINICAL REFLECTION

How do you raise the possibility of a withheld item without pressuring the patient to tell you? How do you work with the belief that one secret makes them unforgivable?

CLINICAL EXERCISE / ASSESSMENT TOOL

Exploring the withheld item:

- "Is there anything you are planning to leave out?"
 - "What do you imagine will happen if you say it?"
 - "What has keeping it secret cost you?"
 - "Do you think you are the only person who has done something like this?"
 - "What would it mean to be fully known and still accepted?"
-
-

ACTION STEP FOR YOUR PRACTICE

Before a patient's Fifth Step, ask whether there is anything they plan to withhold. Work with the fear behind it, without asking for the content.

The Listener's Role

OVERVIEW

A good Fifth Step listener does more than nod. They listen without shock or judgment, ask questions that help the patient see the exact nature of their wrongs, point out patterns, and often share something of their own story so the patient knows they are not alone. They do not absolve, lecture, or minimize. Understanding the listener's role helps patients know what to expect and helps clinicians prepare sponsors and family to support the process.

KEY POINTS FOR CLINICIANS

- The listener receives without shock or condemnation
- They help the patient move from events to patterns
- They often share from their own experience
- They do not grant forgiveness or assign penance
- They do not minimize real harm ("that's nothing")
- They keep what they hear in confidence

CLINICAL INSIGHT

Minimizing is the most common listener error, and it is usually meant kindly. "Everyone does that" can leave the patient feeling unheard. The more helpful response acknowledges the wrong and accepts the person: "That did harm. And you are still welcome here." Acceptance of the person, not dismissal of the act, is what heals.

THE PATIENT EXPERIENCE

Patients often expect the listener to react with disgust. When the listener instead says, "I've done things like that too," many describe it as the first time they felt like a member rather than an

outsider. Others feel cheated if the listener brushes their admissions aside; they came to be taken seriously.

CLINICAL REFLECTION

How do you prepare patients for what a good listener does and doesn't do? What would you want a sponsor to know before hearing a patient's Fifth Step?

CLINICAL EXERCISE / ASSESSMENT TOOL

Understanding the listener's role:

- "What do you expect your listener to do when you say the hardest parts?"
 - "What response would help you most?"
 - "What response would make it harder?"
 - "How would it feel if they shared something similar from their own life?"
 - "What would it mean if they took your wrongs seriously and still accepted you?"
-
-
-

ACTION STEP FOR YOUR PRACTICE

Help a patient form realistic expectations of their Fifth Step listener. If appropriate, talk with the patient about whether their sponsor understands the role.

After the Fifth Step: The Hour of Reflection

OVERVIEW

The Big Book's directions do not end when the talking stops. After the Fifth Step, the person is told to go home, find a quiet place for an hour, and carefully review the work of the first five steps, asking whether anything has been left out and whether the foundation is solid. This hour of reflection turns the admission into an ending and a beginning, and leads directly into Step Six.

KEY POINTS FOR CLINICIANS

- The Fifth Step is followed by a quiet period of review
- The patient checks whether anything was omitted
- They review Steps One through Five as a whole
- Many people report relief, calm, or a sense of closeness to a Higher Power
- Others feel tired, raw, or flat, and that is also normal
- The review leads directly into Steps Six and Seven

CLINICAL INSIGHT

In treatment settings, the hour after a Fifth Step is often filled with groups, phone calls, or chores. Protect it where you can. Patients who go straight from a Fifth Step back into routine can miss the relief and only feel the exposure. A planned period of quiet helps the experience settle.

THE PATIENT EXPERIENCE

Patients describe the hours after a Fifth Step in very different ways: "I felt lighter than I had in years." "I just wanted to sleep." "I kept waiting for the relief and it didn't come right away." All of these are common. Relief sometimes arrives in the days after rather than immediately.

CLINICAL REFLECTION

How do you support patients in the hours and days after Step Five? How do you respond when a patient doesn't feel the relief they were promised?

CLINICAL EXERCISE / ASSESSMENT TOOL

After Step Five:

- "Where will you go afterward to be quiet for a while?"
- "Did you leave anything out? What would you want to add?"
- "Looking back at Steps One through Five, does the foundation feel solid?"
- "What are you feeling right now, even if it isn't relief?"
- "What tells you that you are ready to move toward Step Six?"

ACTION STEP FOR YOUR PRACTICE

When a patient schedules Step Five, help them plan a protected period of quiet reflection afterward and follow up with them in the next day or two.

The Patient Experience

What patients actually experience during Steps Four and Five

Dread and Delay Before Starting

OVERVIEW

Step Four has a reputation. Patients hear about it long before they reach it, and many arrive dreading it. Delay is common: "I'm not ready yet," "I need to stabilize first," "I'll start after the holidays." Some delay is wise; some is fear. Patients who wait indefinitely often find that the dread grows larger than the inventory itself would have been.

KEY POINTS FOR CLINICIANS

- Many patients fear Step Four before they begin
- The step's reputation can be worse than the reality
- Some delay reflects real readiness concerns
- Much delay is fear presented as readiness
- Dread usually shrinks once writing begins
- Starting small makes starting possible

CLINICAL INSIGHT

Help patients separate readiness from avoidance. Real readiness concerns include acute withdrawal, active crisis, or unprocessed trauma that needs stabilization first. Avoidance sounds like endless conditions that are never met. When avoidance is the issue, suggest a small, concrete start: one resentment, written today.

THE PATIENT EXPERIENCE

Patients may say: "I've heard people say Step Four almost killed them." Or: "Once I start, I'm afraid I won't be able to stop remembering." The fear is that the inventory will release more than they can handle. Most patients find that writing the first entry is the hardest part.

CLINICAL REFLECTION

How do you tell the difference between a patient who needs to wait and a patient who is avoiding? What helps patients take the first step into writing?

CLINICAL EXERCISE / ASSESSMENT TOOL

Moving past dread:

- "What have you heard about Step Four? Where did that come from?"
- "What specifically are you afraid will happen?"
- "Is there a real reason to wait, or is this fear talking?"
- "What is the smallest piece you could write today?"
- "Who could you call after you write it?"

ACTION STEP FOR YOUR PRACTICE

With a patient who keeps postponing Step Four, separate readiness concerns from avoidance. If it is avoidance, agree on one small entry to write before your next session.

Stalling in the Middle

OVERVIEW

Many patients start Step Four with energy and then stall. The resentment list gets long, the fear section gets uncomfortable, or the sex and harms sections loom. Some get stuck rewriting the early parts to make them perfect. A stalled inventory can sit unfinished for months, becoming another source of shame. Helping patients get through the middle is often more important than helping them start.

KEY POINTS FOR CLINICIANS

- Stalling mid-inventory is very common
- Patients often stall right before the most difficult section
- Perfectionism can disguise itself as thoroughness
- An unfinished inventory becomes its own source of shame
- Momentum matters; regular small sessions work better than marathons
- "Good enough and finished" beats "perfect and unfinished"

CLINICAL INSIGHT

Look at where the patient stopped. The section they stalled before usually holds the material they fear most. Name this gently: "You stopped right before the harms section. What's waiting there?" Also watch for perfectionism. A patient rewriting the resentment list for the third time may be avoiding what comes next.

THE PATIENT EXPERIENCE

Patients may say: "I did the resentments, but I just haven't gotten back to it." Or: "I want to make sure I get it right before I move on." Both often hide fear of what comes next. They may also feel embarrassed to admit the inventory has stalled.

CLINICAL REFLECTION

How do you help patients restart a stalled inventory without adding shame? How do you recognize perfectionism as avoidance?

CLINICAL EXERCISE / ASSESSMENT TOOL

Restarting a stalled inventory:

- "Where exactly did you stop?"
 - "What is in the next section that you might be avoiding?"
 - "Are you improving the inventory or avoiding finishing it?"
 - "What would 'good enough' look like for this section?"
 - "Can you commit to 20 minutes of writing three times this week?"
-
-
-

ACTION STEP FOR YOUR PRACTICE

Ask a patient working Step Four exactly where they are in their inventory. If they have stalled, identify the section they are avoiding and set a small, specific writing plan.

The Emotional Surge of Writing

OVERVIEW

Writing an inventory brings up memories, feelings, and body responses that patients have kept at a distance, often with substances. Grief, anger, guilt, and shame can surface in waves. Cravings may increase. Sleep may be disturbed. This is a normal part of the work, but it is also a period of real relapse risk. Patients need to know what to expect and have support in place before it arrives.

KEY POINTS FOR CLINICIANS

- Writing inventory brings up long-avoided feelings
- Grief, anger, guilt, and shame often surface together
- Cravings can increase during inventory work
- Sleep, appetite, and mood may be disturbed
- This is normal, but it is a period of higher relapse risk
- Support should be in place before the surge, not after

CLINICAL INSIGHT

Prepare patients in advance: "You may feel worse before you feel better, and cravings may get louder. That doesn't mean you're doing it wrong." Build a support plan: who they will call, how often they will attend meetings, what coping skills they will use. Check in more often during active inventory work.

THE PATIENT EXPERIENCE

Patients may say: "I thought working the steps was supposed to make me feel better. I feel worse than when I came in." Without preparation, they may conclude the step is harming them or that they're failing at recovery. With preparation, they can recognize the surge as a sign the work is reaching real material.

CLINICAL REFLECTION

How do you prepare patients for the emotional impact of Step Four? How do you monitor relapse risk during active inventory work?

CLINICAL EXERCISE / ASSESSMENT TOOL

Preparing for the surge:

- "What feelings do you expect might come up as you write?"
 - "What did you used to do with these feelings?"
 - "Who will you call when it gets hard?"
 - "What will you do if cravings get stronger?"
 - "How will you take care of yourself after a writing session?"
-
-
-

ACTION STEP FOR YOUR PRACTICE

Before a patient begins active inventory writing, build a written support plan with them. Increase check-ins while the writing is under way.

Relief and Being Known

OVERVIEW

When Step Five goes well, patients often describe a relief they have not felt in years. The secrets they have carried are no longer theirs alone. They have been fully known by another person and not rejected. The Big Book describes this as feeling close to a Higher Power and beginning to feel free. This experience of acceptance can be one of the most powerful moments in early recovery.

KEY POINTS FOR CLINICIANS

- Many patients feel deep relief after a thorough Fifth Step
- The relief comes from being fully known and still accepted
- Isolation and secrecy lose some of their hold
- Patients often feel closer to others and to their Higher Power
- Relief may come immediately or over the following days
- The experience can strengthen commitment to recovery

CLINICAL INSIGHT

Help patients put words to the experience and connect it to recovery. Relief that is named is more likely to be remembered when the next hard moment comes. Also help them notice that acceptance came from another person, which is evidence against shame's message that they are uniquely unlovable.

THE PATIENT EXPERIENCE

Patients may say: "He didn't flinch. He just nodded and told me about something he'd done." Or: "I walked out and the sky looked different." Many say they did not realize how much energy the secrets were taking until they were gone.

CLINICAL REFLECTION

How do you help patients name and hold on to the relief after Step Five? How do you use this experience to strengthen their recovery?

CLINICAL EXERCISE / ASSESSMENT TOOL

Naming the relief:

- "What was it like to say all of it out loud?"
 - "How did your listener respond to the hardest parts?"
 - "What feels different in you now?"
 - "What did you learn about being accepted?"
 - "How might you remember this the next time shame shows up?"
-
-
-

ACTION STEP FOR YOUR PRACTICE

After a patient completes Step Five, give time in session to name what they experienced. Help them connect the experience of acceptance to their ongoing recovery.

The Vulnerability Hangover

OVERVIEW

Not every Fifth Step ends in relief. Some patients feel exposed afterward: regret about what they said, fear of how the listener now sees them, or an urge to avoid the listener entirely. This "vulnerability hangover" can lead patients to pull away from their sponsor or meetings just when connection matters most. Knowing it can happen helps patients recognize it and stay connected.

KEY POINTS FOR CLINICIANS

- Some patients feel exposed or regretful after Step Five
- They may fear the listener now thinks less of them
- The urge to avoid the listener is common
- Withdrawal after a Fifth Step increases relapse risk
- The hangover usually passes with continued contact
- Staying connected disproves the fear

CLINICAL INSIGHT

Name the possibility before the Fifth Step so it doesn't surprise the patient. Afterward, ask directly whether they have been in contact with their listener. Encourage a simple next contact, even a short phone call. Continued contact is what proves that being known did not end the relationship.

THE PATIENT EXPERIENCE

Patients may say: "I can't look my sponsor in the eye now." Or: "I keep replaying what I said and wishing I hadn't." They may skip the meeting where they would see their listener. Without support, this withdrawal can grow into isolation.

CLINICAL REFLECTION

How do you prepare patients for the possibility of feeling worse after Step Five? How do you help patients who start avoiding their listener?

CLINICAL EXERCISE / ASSESSMENT TOOL

Working with the hangover:

- "How have you felt since your Fifth Step?"
- "Have you talked with your listener since? What has stopped you?"
- "What do you imagine they think of you now?"
- "What evidence do you have for that?"
- "What is one small way you could reconnect this week?"

ACTION STEP FOR YOUR PRACTICE

Follow up with patients in the days after Step Five. If they are avoiding their listener, help them plan one specific point of contact.

Clinical Applications

Translating Step Four & Five understanding into clinical practice

Pacing Inventory Work to the Level of Care

OVERVIEW

Steps Four and Five do not fit neatly into every treatment setting. A short residential stay, an IOP schedule, and outpatient therapy each offer different amounts of time, structure, and support. Clinicians need to pace inventory work to what the setting can safely hold. Sometimes that means beginning the inventory in treatment and handing it off to a sponsor for completion after discharge.

KEY POINTS FOR CLINICIANS

- Different levels of care support different depths of inventory work
- Short stays may allow only the start of Step Four
- Starting the inventory can be a valid treatment goal
- Completion often belongs with a sponsor after discharge
- Support after discharge matters as much as work in treatment
- Pacing should follow the patient's stability, not the program calendar

CLINICAL INSIGHT

Be honest with patients about what can be done in the time available. A partial inventory with a clear handoff is better than a rushed, complete one. Before discharge, make sure the patient knows who will help them continue, and ideally has a sponsor who has seen the work so far.

THE PATIENT EXPERIENCE

Patients may say: "I'm leaving in ten days; I need to finish my Fourth Step before I go." This urgency can lead to rushing. Others feel discouraged that they won't finish in treatment.

Reframe: "Your job here is to start well and know how to continue."

CLINICAL REFLECTION

How does your setting shape what Step Four and Five work is realistic? How do you hand off unfinished inventory work at discharge?

CLINICAL EXERCISE / ASSESSMENT TOOL

Pacing assessment:

- "How much time do we realistically have together?"
- "What part of the inventory makes sense to start here?"
- "Who will help you continue after you leave?"
- "Has your sponsor seen the work you've done so far?"
- "What will you do if the work becomes overwhelming after discharge?"

ACTION STEP FOR YOUR PRACTICE

Review how your program currently approaches Steps Four and Five. Identify a clear handoff process for patients who leave with unfinished inventory work.

Trauma-Informed Steps Four and Five

OVERVIEW

Many patients with substance use disorders have trauma histories. Inventory work can bring traumatic memories to the surface, and the Column 4 question ("What was my part?") can feel like blame when the patient was a victim. Trauma-informed practice does not skip Steps Four and Five. It adjusts pace, frames questions carefully, and makes sure the patient is stable enough for the work.

KEY POINTS FOR CLINICIANS

- Trauma is common in SUD populations
- Inventory can surface traumatic memories
- "My part" must never mean blaming a victim for abuse
- Stabilization may be needed before deep inventory work
- Patients should control the pace and level of detail
- Trauma-specific treatment may need to run alongside the steps

CLINICAL INSIGHT

Be clear with patients: when someone was abused, especially as a child, the abuse was not their fault, and it does not belong in the "my part" column. Their part may be how they have carried the resentment since, or how the pain has shaped their choices as adults. Watch for signs of dissociation, flashbacks, or destabilization, and slow down or refer when they appear.

THE PATIENT EXPERIENCE

Patients may say: "My sponsor asked what my part was in what my stepfather did to me." This can be devastating. Patients need to hear clearly that victimization is not a character defect. Many feel deep relief when someone separates what was done to them from what they are accountable for.

CLINICAL REFLECTION

How do you adapt Step Four for patients with trauma histories? How do you help sponsors understand the difference between accountability and victim blaming?

CLINICAL EXERCISE / ASSESSMENT TOOL

Trauma-informed inventory:

- "You can decide how much detail to include."
 - "What was done to you as a child was not your fault."
 - "How has carrying this affected the way you live now?"
 - "What do you need in place to feel safe doing this work?"
 - "Would it help to work on this with a trauma therapist alongside your sponsor?"
-
-
-

ACTION STEP FOR YOUR PRACTICE

Screen for trauma before a patient begins Step Four. Adjust the pace and framing, and coordinate with trauma-specific treatment where needed.

Confidentiality and Disclosures

OVERVIEW

Step Four and Five work can bring disclosures of past crimes, harm to others, or ongoing risk. Clinicians operate under legal and ethical limits on confidentiality that sponsors and other listeners do not. Patients need to understand those limits before they share inventory content in a clinical setting, and clinicians need to know their own reporting duties and their program's policies.

KEY POINTS FOR CLINICIANS

- Clinical confidentiality has legal and ethical limits
- Mandated reporting duties may apply to some disclosures
- Patients should know the limits before sharing inventory content
- Conversations with sponsors are not legally privileged
- Clinicians should know their program's policies and seek consultation
- Clear limits protect the patient and the therapeutic relationship

CLINICAL INSIGHT

Review the limits of confidentiality when inventory work begins, not after a disclosure. Patients have a right to know what you must report so they can choose what to share with you and what to keep for their Fifth Step listener. When a disclosure raises a question about your duties, consult your supervisor and follow your program's policy rather than deciding alone.

THE PATIENT EXPERIENCE

Patients may say: "If I write this down, can it be used against me?" This is a real question and deserves an honest answer. Some patients, including first responders and others with professional licenses, may have specific concerns about records and disclosure. Honest information helps them make safe decisions.

CLINICAL REFLECTION

Do your patients understand the limits of confidentiality before beginning inventory work? Do you know your program's policies on disclosures that may arise?

CLINICAL EXERCISE / ASSESSMENT TOOL

Discussing confidentiality limits:

- "Before you start, here is what I can keep private and what I can't."
 - "What questions do you have about who will see your inventory?"
 - "Where will you keep your written inventory safe?"
 - "Some things may be better shared with your sponsor than written in your chart."
 - "If something comes up that worries you, we can talk about it first."
-
-

ACTION STEP FOR YOUR PRACTICE

Review your program's confidentiality policies and reporting duties as they relate to step work. Build a short explanation of the limits into how you introduce Step Four.

Integrating Inventory with Cognitive and Schema Approaches

OVERVIEW

The Step Four inventory fits well with evidence-based approaches. Column 3 ("affects my self-esteem, security, ambitions, relations") points to core beliefs and vulnerabilities. Recurring patterns across entries resemble the schemas identified in schema therapy. Fears connect to the automatic thoughts examined in CBT. Clinicians can use the inventory as rich clinical data while respecting it as the patient's step work.

KEY POINTS FOR CLINICIANS

- Column 3 highlights core vulnerabilities and beliefs
- Patterns across entries resemble cognitive schemas
- The fear inventory connects to automatic thoughts
- Inventory content can guide treatment planning
- Clinical frameworks can deepen the patient's insight
- The inventory remains the patient's work, not a clinical worksheet

CLINICAL INSIGHT

Ask the patient's permission before using inventory content in therapy. When they agree, help them connect patterns to clinical language: "Self-esteem shows up in most of your resentments. What do you believe about yourself when someone criticizes you?" This links step work and therapy without replacing one with the other.

THE PATIENT EXPERIENCE

Patients may find that therapy and the steps start to make sense together: "My therapist talks about core beliefs, and my sponsor talks about character defects. They're pointing at the same

thing." For others, it helps to keep the two separate so the step work stays their own.

CLINICAL REFLECTION

How do you integrate Step Four material into evidence-based treatment? How do you respect the patient's ownership of their step work?

CLINICAL EXERCISE / ASSESSMENT TOOL

Linking inventory and therapy:

- "Would it be helpful to look at your inventory together in session?"
 - "Which Column 3 area shows up most often?"
 - "What belief about yourself sits underneath that?"
 - "What automatic thought shows up when that fear is triggered?"
 - "How might this pattern show up in your relationships now?"
-
-
-

ACTION STEP FOR YOUR PRACTICE

With a patient's permission, review their inventory for patterns and connect one recurring theme to a core belief or schema you can work on in therapy.

Steps Four and Five in Group Treatment

OVERVIEW

Group settings are well suited to teaching Steps Four and Five, normalizing fears, and supporting patients through the work. They are not the place for a full Fifth Step. Clinicians can use groups to explain the inventory format, practice with sample entries, share what the experience is like, and help members support each other, while protecting the confidentiality and safety of individual inventory content.

KEY POINTS FOR CLINICIANS

- Groups are good for teaching the inventory format
- Sharing fears about Step Four normalizes them
- Members further along can share their experience
- Full Fifth Steps belong with an individual listener, not a group
- Individual inventory details should not be shared in group
- Group support can reduce isolation during the work

CLINICAL INSIGHT

Set clear boundaries in group: members can talk about the experience of doing inventory, but not the specific content of their inventories or anyone else's. Members who have finished Step Five can describe what it was like, which offers hope to those who haven't started.

THE PATIENT EXPERIENCE

Patients often feel less alone when they hear others share the same dread: "I thought I was the only one terrified of this." Some may be tempted to share specific details in group for relief or attention. Clear boundaries protect them and the other members.

CLINICAL REFLECTION

How do you use group time to support Step Four and Five work? How do you keep inventory content safe in a group setting?

CLINICAL EXERCISE / ASSESSMENT TOOL

Group activities:

- Teach the four-column format with a made-up example
- "What fears do you have about Step Four?"
- Invite members who have completed Step Five to describe the experience
- "What helped you keep going when it got hard?"
- Remind members that inventory content stays with the individual listener

ACTION STEP FOR YOUR PRACTICE

Design a group session that teaches the Step Four format and normalizes fear, with clear rules about not sharing inventory content.

Clinical Pitfalls

Common mistakes clinicians make with Steps Four and Five

Rushing the Inventory

OVERVIEW

Program timelines, insurance authorizations, and discharge dates can push clinicians to move patients through Step Four quickly. A rushed inventory tends to be shallow, missing the patterns that make the step useful. It can also overwhelm patients who are not ready. Rushing turns a process of self-discovery into a box to check.

KEY POINTS FOR CLINICIANS

- Program timelines can pressure clinicians to rush
- Rushed inventories tend to be shallow
- Patients may write what they think is expected rather than what is true
- Overwhelming patients increases relapse risk
- Completion is not the same as thoroughness
- The patient's readiness should set the pace

CLINICAL INSIGHT

Notice when you are pushing because of the calendar rather than the patient. A partial, honest inventory has more value than a complete, superficial one. If your program requires completion by a certain point, advocate for flexibility or for a clear handoff to continued work after discharge.

THE PATIENT EXPERIENCE

Patients may say: "I just wrote down whatever I could think of so I could turn it in." When inventory becomes a treatment requirement, some patients complete it to satisfy staff rather than to understand themselves. The result can feel empty and leave them believing they have "done" a step they barely touched.

CLINICAL REFLECTION

Do program pressures shape how you approach Step Four? How do you balance requirements with the patient's real readiness?

CLINICAL EXERCISE / ASSESSMENT TOOL

Checking for rushing:

- "Am I pushing because of the patient or because of the schedule?"
- "Does this inventory show patterns, or just a list?"
- "Did the patient write what they think, or what they think I want?"
- "What would continued work look like after discharge?"
- "Who will support the patient in going deeper?"

ACTION STEP FOR YOUR PRACTICE

Review a recent patient's Step Four with a supervisor. Ask whether it reflects real depth or was shaped by time pressure.

Stepping into the Sponsor's Role

OVERVIEW

Clinicians who know the steps well may find themselves acting as the patient's sponsor: assigning inventory work, reviewing every entry, and hearing the Fifth Step. In some programs, staff hearing Fifth Steps is part of the model. Elsewhere, it can blur roles, create dependency on treatment staff, and leave the patient without a recovery relationship that continues after discharge.

KEY POINTS FOR CLINICIANS

- Clinician and sponsor roles are different
- Taking the sponsor's role can create dependency on treatment
- The therapeutic relationship ends; the sponsor relationship can continue
- Hearing a Fifth Step carries specific confidentiality questions
- Some programs include staff-heard Fifth Steps by design
- The goal is to connect patients to ongoing recovery support

CLINICAL INSIGHT

Ask yourself whose recovery relationship you are building. When you do the sponsor's job, the patient may never find a sponsor. Support the step work clinically, and actively encourage the patient to find a sponsor or other listener who will still be there after treatment. If your program does have staff hear Fifth Steps, follow its protocol and be clear about how documentation and confidentiality are handled.

THE PATIENT EXPERIENCE

Patients may say: "You already know everything. Can't I just do my Fifth Step with you?" This can feel like trust, and it is, but it can also be a way to avoid the vulnerability of building a relationship in the recovery community.

CLINICAL REFLECTION

Where is the line between supporting step work and sponsoring? How do you help patients build recovery relationships outside of treatment?

CLINICAL EXERCISE / ASSESSMENT TOOL

Role clarity check:

- "Am I doing work that belongs with a sponsor?"
 - "Does this patient have a sponsor or other recovery support?"
 - "Who will be there for this patient after discharge?"
 - "Am I comfortable being needed in this way? Why?"
 - "What would help this patient connect with a sponsor?"
-
-
-

ACTION STEP FOR YOUR PRACTICE

Review your current caseload. For each patient working Steps Four or Five, note whether they have a sponsor and how you are supporting that connection.

Letting Inventory Become Self-Punishment

OVERVIEW

Step Four is meant to be honest, not brutal. Some patients turn it into a long act of self-punishment, listing every failure in harsh language and finding nothing worth keeping. Clinicians may miss this because the patient looks committed and thorough. An inventory driven by shame tends to deepen depression and hopelessness rather than lead to change.

KEY POINTS FOR CLINICIANS

- Some patients use inventory to punish themselves
- Harsh self-judgment can look like thoroughness
- Shame-driven inventory deepens depression and hopelessness
- A missing assets section is a warning sign
- Self-punishment can be a step toward relapse or self-harm
- Honest and kind can go together

CLINICAL INSIGHT

Read the tone of the inventory, not just its contents. Words like "worthless," "disgusting," or "beyond help" signal shame, not accountability. Bring back the purpose of the step: understanding patterns so they can change. Ask for the assets section. If shame is severe or the patient shows signs of depression or hopelessness, assess for safety.

THE PATIENT EXPERIENCE

Patients may say: "I deserve to feel this bad. Look at what I did." Or they may proudly present a long list of faults with no strengths at all. To them, harshness feels like honesty. They may need help seeing that punishing themselves has never produced lasting change.

CLINICAL REFLECTION

How do you notice when inventory has turned into self-punishment? How do you help patients be honest without being cruel to themselves?

CLINICAL EXERCISE / ASSESSMENT TOOL

Checking for self-punishment:

- "How would you describe the tone of what you've written?"
 - "Would you speak to a friend this way?"
 - "What strengths did you include?"
 - "Is this helping you understand yourself or punish yourself?"
 - "What would an honest and kind version of this entry say?"
-
-

ACTION STEP FOR YOUR PRACTICE

When reviewing a patient's inventory, read for tone as well as content. If you find harsh self-condemnation, return to the purpose of the step and assess mood and safety.

Missing Risk During and After the Work

OVERVIEW

Steps Four and Five are among the most emotionally demanding parts of early recovery. Relapse, sharp drops in mood, and occasionally thoughts of self-harm can follow intense inventory work or a difficult Fifth Step. Clinicians who see these steps only as progress may miss signs of risk. Regular monitoring during this period is part of supporting the work safely.

KEY POINTS FOR CLINICIANS

- Inventory work is emotionally demanding
- Relapse risk can rise during and after Steps Four and Five
- Mood can drop sharply, especially with heavy shame
- Thoughts of self-harm can surface and must be assessed
- Withdrawal from support is an early warning sign
- Monitoring should increase during active step work

CLINICAL INSIGHT

Treat active inventory work as a time to check in more, not less. Ask about cravings, sleep, mood, and contact with supports. If a patient shows hopelessness or mentions not wanting to be here, assess for safety directly and follow your program's protocol. The steps can wait; safety cannot.

THE PATIENT EXPERIENCE

Patients may not volunteer that they are struggling: "I'm fine, just tired." They may feel that admitting distress means they are failing at the step. Others may see a relapse after Step Five as proof they are hopeless. Normalizing that this is a hard time makes it easier to tell the truth.

CLINICAL REFLECTION

How do you monitor risk during a patient's Step Four and Five work? What signs prompt you to slow down or assess for safety?

CLINICAL EXERCISE / ASSESSMENT TOOL

Risk check-in:

- "How have your cravings been since you started writing?"
 - "How are you sleeping and eating?"
 - "Who have you talked to about how this is going?"
 - "Have you had any thoughts of hurting yourself or not wanting to be here?"
 - "What would tell you it's time to slow down?"
-
-
-

ACTION STEP FOR YOUR PRACTICE

Add a brief risk check-in to every session with patients actively working Steps Four or Five, and know your program's protocol if risk is identified.

Reacting Poorly to Disclosures

OVERVIEW

When patients share inventory material, clinicians have their own reactions: shock, discomfort, judgment, sadness, or curiosity. How those reactions show up can either confirm the patient's fear of being unacceptable or help disprove it. Visible shock, over-reassurance, too many questions about details, or rushing to fix can all leave the patient feeling exposed rather than accepted.

KEY POINTS FOR CLINICIANS

- Clinicians have real reactions to disclosures
- Visible shock can confirm the patient's shame
- Over-reassurance can feel dismissive
- Asking for unnecessary detail can feel intrusive
- Countertransference should be noticed and taken to supervision
- A steady, accepting response is part of the healing

CLINICAL INSIGHT

Notice your reaction before you respond. A calm, warm response that takes the disclosure seriously is usually enough: "Thank you for trusting me with that." Avoid asking for details you don't need clinically. If a disclosure stays with you or connects to your own history, bring it to supervision rather than carrying it alone.

THE PATIENT EXPERIENCE

Patients watch closely for how you react. They may say: "I saw your face change," and pull back. Or, if you rush to say "That's not so bad," they may feel you didn't really hear them. A steady response tells them what they most need to know: that they can be known and still accepted.

CLINICAL REFLECTION

How do you manage your own reactions when patients share difficult material? When do you take a disclosure to supervision?

CLINICAL EXERCISE / ASSESSMENT TOOL

Responding to disclosures:

- Pause and notice your own reaction before speaking
- "Thank you for telling me. That took courage."
- "How is it for you to have said that out loud?"
- Ask only for details you need for clinical or safety reasons
- Bring strong reactions to supervision

ACTION STEP FOR YOUR PRACTICE

Reflect on a recent disclosure that affected you. Consider how your reaction may have come across and discuss it with a supervisor or colleague.

Your clinical notes

Changes to my practice

(Specific changes you plan to implement based on this training...)
